

**UNIVERSITY OF EAST LONDON**

**STUDENTS NAME: JACKLINE KENDI MUTUGI**

**SUPERVISORS NAMES: 1. PROF SONNY NWANKWO**

**2. DR AYANTUNJI GBADAMOSI**

**Research Title:**

**A CULTURAL-CONTEXTUAL ASSESSMENT OF THE USE OF  
SOCIAL MARKETING APPROACH IN HIV/AIDS  
PROGRAMMES IN KENYA**

## **Acknowledgements**

Firstly, I would like to thank God for his grace and mercy that have brought me this far. Next I sincerely thank my supervisors Professor Sonny and Dr Ayantunji for their support, wise counselling and guidance throughout this tough academic journey. Many thanks for believing in me and never giving up on me.

I sincerely thank my beloved husband Blaise Mutugi for his love, support, understanding and encouragement. I also thank our three beautiful babies: Angela, Austin and Adeline Mutugi for their cooperation, support and prayers. Not forgetting my beautiful mother Mirriam. Thank you for all the sacrifices you made in your life for giving me and my siblings the best you could afford and teaching the value of hard work and resilience. Many thanks to my beloved brothers Joe and Tonie, auntie Florence and uncle Isaac and other family members and friends for their encouragement, support and prayers too.

I also sincerely thank all the programmers that took the time to fill my two long questionnaires. I deeply appreciate their time, effort and contributions. To my research assistants, I could not have done without your support, many thanks for your help and cooperation. Lastly, I thank all my friends and family who assisted me in any way. I appreciate all their support.

## **Acronyms**

A4A1- Alliance for Affordable Internet

ADCA 2010- Alcoholic Drink Control Act

AED- Academy for Education Development

AIDS- Acquired Immune Deficiency Syndrome

APHRC- African Population and Health Research Centre

ARVs- Antiretroviral drugs/medication

BBC- British Broadcasting Corporation

CBT- Cognitive Behavioural Therapy

CCK- Communication Commission of Kenya

CDC- Centre for Disease Control and Prevention

COTU- Kenya Central Organisation of Trade Union- Kenya

CRA- Commission on Revenue Allocation

CSWS- Commercial Sex Worker

DFID- Department for International Development (United Kingdom)

DKT International- Deep Tyagi assistant commissioner of family planning greatly contributed to India's family planning effort. The social marketing organisation named after him.

EABL- East African Breweries Ltd

EAL- Elephant Action League- South African

ELM- Elaboration Likelihood Model by Petty and Cacciopo 1984- Central and peripheral route.

FGM- Female Genital Mutilation

FKE- Federation of Kenya Employers

FTA- Free Trade Areas

HAART- Highly Active Antiretroviral Therapy

HIV- Human Immunodeficiency Virus

HISP- Health Insurance Subsidy Programme

HSM- Heuristic Systematic Model- Chaiken (1984)

HTC- HIV/AIDS Testing and Counselling

IBM- International Business Machine

ICT- Information Communication Technology

IDPs-Internally Displaced Persons

IGA- Income Generating Activities

INCB- International Narcotics Control Board

IRIN- Integrated Regional Information Networks

ISP- Internet Service Providers

JKUAT- Jommo Kenyatta University of Agriculture and Technology- Kenya

KANAU- Kenya African National Union

KANCO- Kenya AIDS NGO Consortium

KDF- Kenya Defence Force

KELIN- Kenya Legal and Ethical Issues Network on HIV and AIDS

KEMSA- Kenya Medical Suppliers Agency

KENET- Kenya Education Network Trust

KETAM- Kenya Treatment Access Movement

KFW- Kreditanstalt für Wiederaufbau, meaning Reconstruction Credit Institute- German owned development bank.

KHRC- Kenya Human Rights Commission

KMP&B- Kenya Medical Practice and Dentist Board

KP&TC- Kenya Post and Telecommunication Corporation

KSH- Kenya Shilling

KUDHEIHA- Kenya Union of Domestic Hotels, Educational Institutions, Hospitals and Allied Workers

LGBT- Lesbians, Gay, Bisexual and Transgender

LGBTI- Lesbians, Gay, Bisexual, Transgender and Intersexual

LGBTQ- Lesbians, Gay, Bisexual, Transgender and Queer/Questioning

LIONS2- Lower Indian Ocean Network

MOH- Ministry of Health

MOU- Memorandum of Understanding

MPESA- Mobile- Pesa (money in Kiswahili)

NACADA- National Authority for Campaign Against Alcohol and Drug Abuse

NACC- National AIDS Control Council (Kenya)

NARC- National Rainbow Coalition Party

NASCOP- National AIDS and Sexually Transmitted Diseases Control Programme Kenya

NCCK- National Council of Churches of Kenya

NCS- National Communication Secretariat

NGOs- Nongovernmental Organisations

NHA- Nairobi Herbalist Association

NHIF- National Hospital Insurance Fund

NQCL- National Quality Control Laboratory

NSHIF- National Social Health Insurance Fund

NTHPA- National Traditional Health Practitioners Association

ODM- Orange Democratic Party of Kenya

OOP- Out of Pocket Payment System

OVC- Orphaned and Vulnerable Children

PKI- Public Key Infrastructure- digital certification

PLWA/ PLWH- People Living with HIV/Aids

PMTC- Prevention Mother to Child

PNU- Party of National Unity- Kibaki's

PSI- Population Service International

SRC- Self-Reference Criterion- (Lee 1966)

STD- Sexually Transmitted Diseases

STI- Sexually Transmitted Infections

SM-Social Marketing

T.I- Transparency International

TBA- Traditional Birth Attendant

TEAMS- East African Marine Systems

TRIPs-Trade Related Aspects of Intellectual Property Rights

UNAIDS- Joint United Nations Programme on HIV/AIDS

UNDP- United Nations Development Programme

UNESCO- United Nations Educational, Scientific and Cultural Organisation

USAID- United States Agency for International Development

VCT- Voluntary Counselling and Testing

VMC- Voluntary Male Circumcision

VMMC- Voluntary Medical Male Circumcision

WHO- World Health Organisation

## **Abstract**

The Kenyan HIV/AIDS burden differs greatly among its various regions. There are 42 different ethnic groups each with its unique culture. Nyanza province, the home of the Luos shares the highest HIV/AIDs prevalence of 15.1% while in the North Eastern region, the home of Somalis is at 0.5%. Nyanza province is the home of the counties with the highest HIV/AIDs prevalence rates: Homabay-26%, Siaya 24.8%, Kisumu 19.9% and Migori 14.3% while Wajir county in Northern Eastern province has 0.4% prevalence rate. The HIV/AIDS burden also is greatest among females between 15-49 years.

Culture and ethnicity are generally associated with risky sexual behaviour in relation to HIV/AIDs. Paradoxically, this relationship has not been deeply investigated within the Kenyan context. Therefore, set against the backdrop of HIV/AIDs scourge in Kenya, the need to understand cultural meaning related to this problem and how social marketing intervention can be appropriately used is a necessary study area.

This study explores the link between culture and risky sexual behaviour in relation to HIV/AIDs, for the purpose of seeking situated understanding of the consequences and possible intervention strategies. It explores the contextual and cultural realities faced by intervention programmers using a social marketing approach in a multi-culturally rich environment as Kenya.

A Qualitative approach is used to probe cultural and contextual realities faced by intervention programme leaders to understand the barriers and opportunities presented by context and culture to their work. Instruments of open-ended questions and qualitative interviews are used to provide in-depth insights of their experiences from their own point of views. The results greatly link contextual realities and tribal cultures to the spread of HIV/AIDs.

The findings imply that cultures and context of a market or target audiences greatly impact on social marketing programmes. A good understanding of the two should indeed be the foundations that guide the planning, implementing, monitoring and evaluating of cultural specific social marketing initiatives, rather than the use of generic or blanket campaigns. They should also guide the application of upstream, in-stream and downstream social marketing approaches. There is need for

programmers and other stakeholders to invest in cultural competency to avoid culturally incongruence in decision-making, policies and programmes. More resources are necessary to change deprived contexts for successful programme work.

The study makes important contributions to social marketing and related disciplines. Firstly, it suggests cultural context assessment composite model and cultural-contextual assessment model for use by social marketers. These models can greatly help programmers understand their target audiences' cultural and contextual environments, in order to actively use this intelligence in social marketing programmes. Secondly the study contributes to an understanding of the Kenyan tribal groups' culturally sensitive knowledge on sexual beliefs and practices that have impact on HIV/AIDS. This knowledge greatly contributes to an understanding of patterns of HIV transmission within the country, as the significant aspects of seven major and three minor Kenyan tribes, accounting for 81.22% of the Kenyan population, are well explored and discussed in this study. Lastly, the study makes important recommendations in relations to cultural and contextual aspects, which social marketers, policy makers, the government and other stakeholders can work on for more effective social marketing interventions.



## Table of Contents

<b>Chapter 1: General Introduction .....</b>	<b>14</b>
<b>1.0 Introduction .....</b>	<b>14</b>
<b>1.2 Background Information .....</b>	<b>20</b>
<b>1.2 The Nature of the Problem .....</b>	<b>28</b>
<b>1.3 Research Questions .....</b>	<b>33</b>
<b>1.4 Scope of Research.....</b>	<b>34</b>
<b>1.6 Thesis Layout.....</b>	<b>35</b>
<b>1.7 Chapter Summary .....</b>	<b>37</b>
<b>Chapter Two: The Kenyan Cultural Context .....</b>	<b>39</b>
<b>2.0 Introduction .....</b>	<b>39</b>
<b>2.1 Kenya's HIV Burden.....</b>	<b>39</b>
<b>2.2 An overview of culture .....</b>	<b>44</b>
<b>2.3 Major Ethnic Groups in Kenya- A Cultural Perspective.....</b>	<b>47</b>
2.3.1 (a) Kikuyus- 15.4% .....	47
2.3.2 (b) Luyia- 12.4% .....	52
2.3.3 (c) The Luos- 9.4% .....	55
2.3.4. (d). The Kalenjins- 11.5%.....	60
2.3.5 (e). Kambas 9.05% .....	64
2.3.6 (f). Merus- (3.9%).....	67
2.3.7. (g). Kisii/Gusii- 5.13% .....	71
2.3.8 (h). The Mijikenda- 4.6%.....	75
2.3.9 (i). Somalis- 5.54% .....	78
2.3.10. (j). Maasais- 2% .....	82
<b>2.4 Chapter Summary .....</b>	<b>89</b>
<b>Chapter 3: Culture and Health: Exploring the Link. ....</b>	<b>91</b>
<b>3.0 Chapter Introduction .....</b>	<b>91</b>
<b>3.1 Defining the concept of culture .....</b>	<b>91</b>
<b>3.2 Classification of culture.....</b>	<b>92</b>
<b>3.3 Elements and layers of culture .....</b>	<b>96</b>
<b>3.4. Culture and health related models.....</b>	<b>98</b>
<b>3.5. Cultural elements in relation to Health and HIV/AIDS .....</b>	<b>106</b>
3.5.1. (a). Beliefs, attitudes, values and their impact on health and HIV/AIDS.....	106
3.5.2 (b). Language and its impact on health and HIV/AIDS.....	114
3.5.3. (c). Education.....	117
3.5.4 (d). Aesthetics.....	120
3.5.5 (e). Social organisation.....	122
3.5.6 (f). Religion and health .....	123
3.5.7 (g). Material life .....	125
<b>3.6. Can culture be blamed for all health maladies?.....</b>	<b>126</b>
<b>3.7. How can programmers possibly engage with culture? .....</b>	<b>127</b>
<b>3.8. Models of engaging culture in health .....</b>	<b>133</b>
<b>3.9 A discussion of the formulated composite model .....</b>	<b>137</b>
3.9.1. Beliefs, attitudes, values, norms, practices, symbols, taboos.....	137
3.9.2. Material life.....	137
3.9.3. Language.....	138

3.9.4. Aesthetics .....	138
3.9.5. Education.....	139
3.9.6. Social structure and organisation.....	139
3.9.7. Religion .....	139
3.9.8. Play/recreation.....	140
3.9.9. The physical and manmade environment.....	140
3.9.10. Cultural competency/incompetency of the programmers .....	141
3.9.11. Health care systems available .....	141
3.9.12. Competition .....	141
3.9.13. Ethics .....	142
3.9.14. National and international trends .....	142
3.9.15. Stakeholders.....	143
3.9.16. Legal environment.....	144
3.9.17. Technological environment.....	144
3.9.18. Economic environment .....	145
3.9.19. Political environment.....	146
<b>4. Chapter Four- Social Marketing Theory and Practice.....</b>	<b>149</b>
<b>4.0 Chapter Introduction .....</b>	<b>149</b>
<b>4.1 The Genesis and Meaning of Social Marketing.....</b>	<b>149</b>
<b>4.2. Why is the social marketing approach superior to other social change management approaches? .....</b>	<b>157</b>
<b>4.3. The social marketing framework and process.....</b>	<b>160</b>
<b>4.4. Social Marketing in the Developing and Developed Countries Contexts ..</b>	<b>164</b>
<b>4.5. Social Marketing and Culture.....</b>	<b>170</b>
<b>4.6. Chapter Summary .....</b>	<b>182</b>
<b>5. Chapter Five Research Methodology.....</b>	<b>184</b>
<b>5.0. Chapter Introduction .....</b>	<b>184</b>
<b>5.1 Research Paradigms.....</b>	<b>184</b>
<b>5.2 Why the qualitative Research Approach for this study?.....</b>	<b>190</b>
<b>5.3. Research Methods.....</b>	<b>193</b>
<b>5.4. The Qualitative open ended guide and qualitative interviews .....</b>	<b>195</b>
<b>5.5. Ethical issues .....</b>	<b>197</b>
<b>5.6. Sampling and data collection process .....</b>	<b>197</b>
<b>5.7. Data Analysis .....</b>	<b>200</b>
<b>5. 8. The analysis process .....</b>	<b>203</b>
<b>5.9. Validity and reliability.....</b>	<b>208</b>
<b>5. 10. Chapter Summary .....</b>	<b>211</b>
<b>Chapter 6: The Research Findings .....</b>	<b>212</b>
<b>Introduction .....</b>	<b>212</b>
<b>6.1 Infrastructure.....</b>	<b>213</b>
<b>6.2 Prostitution/commercial sex work and the Fishing Communities.....</b>	<b>214</b>
<b>6.3 Illicit Brews, alcoholic drinks and drugs use .....</b>	<b>215</b>
<b>6.4 Secrecy surrounding sexuality and sex .....</b>	<b>216</b>
<b>6.5 Illiteracy .....</b>	<b>216</b>
<b>6.6 Sexual Violence .....</b>	<b>218</b>
<b>6.7. Stigma and discrimination .....</b>	<b>219</b>

6.8 Myths and beliefs .....	221
6.9 Early sexual debut and childhood marriages .....	223
6.10 FGM and Male Circumcision.....	224
6.11 Extra Marital sex and polygamy .....	225
6.12 Taboos- Homosexuality, rape and incest related issues .....	227
6.13 HIV/AIDS related treatment and religion .....	228
6.14 Cultural enablers .....	231
6.15 Political, Legal, Donors and funding related issues .....	231
6.16 Chapter Summary.....	233
<b>Chapter 7.0 Discussion of Research Findings .....</b>	<b>234</b>
7.0. Chapter introduction .....	235
7.1 Infrastructure.....	235
7.1.1 Slums and informal Settlements .....	235
7.1.2 Pubs and alcohol serving dens.....	236
7.1.3 Reproductive health services for the youth and men .....	237
7.1.4 Cultural training.....	240
7.2 Prostitution .....	242
7.2.1 Fishing communities .....	244
7.3 Illicit brews and Branded Alcohol .....	245
7.3.1 Drugs use and substance abuse.....	247
7.4 Secrecy surrounding sexuality and sex education.....	250
7.5 Illiteracy .....	251
7.6 Sexual and gender related violence .....	253
7.7 Stigma and discrimination.....	257
7.8 Myths and beliefs .....	260
7.9 Early sexual debut.....	262
7.9.1 Childhood marriages.....	263
7.10 FGM.....	264
7.11 Extra marital sexual affairs and Polygamy .....	266
7.12 Taboos- rape, incest and homosexuality .....	267
7.13 HIV/AIDS related treatment and religion .....	270
7.13.1 Folk health care system.....	270
7.13.2 Popular Health Care .....	275
7.13.3 Professional Health Care System.....	276
7.14 Cultural enablers .....	278
7.15 Political, legal and donor funding.....	281
7.15.1 Political Issues .....	281
7.15.2 Legal related issues.....	283
7.15.3 Donors and funding related issues.....	285
7.16 Chapter Summary.....	288
<b>8. Chapter Eight Conclusion and Recommendations, contribution to knowledge and areas for future research work.....</b>	<b>290</b>
8.0. Chapter introduction .....	290
8.1. Revisiting Research objectives and questions .....	290
8.2. Conclusions .....	293
8.3. Recommendations .....	295

<b>8.4. Contribution to knowledge .....</b>	<b>306</b>
<b>8.5. Limitations of the study and areas of further research .....</b>	<b>314</b>
<b>8.6. Chapter Summary .....</b>	<b>315</b>
<b>Appendices- Two Qualitative Open Ended Questionnaires.....</b>	<b>362</b>

## **List of Figures**

Figure 1- HIV/AIDS burden distribution across Kenya's provinces (2007).....	42
Figure 2- HIV prevalence among 15-64 years age group across Kenya's provinces (2012).....	42
Figure 3- HIV prevalence among 15-64 years age group across Kenya's counties (2016).....	44
Figure 4 - Classification culture-adopted from Murdock (1945).....	97
Figure 5 - Cultural classification adopted from Hall (1959).....	98
Figure 6 - Cultural map adapted from Hall (1959).....	98
Figure 7 - Biopsychosocial model of health by Engel (1977) .....	100
Figure 8- Force field paradigm (Blum 1974; 1985).....	101
Figure 9 - Mandala of health by Hancock and Perkins (1985).....	102
Figure 10 - Cultural intelligence levels adapted from Winkelman (1998) .....	132
Figure 11 - Cultural-context composite assessment model (2013), adapted from: Hall (1959); Humprey (1960); Kleinman (1980); Airhihenbuwa (1995) and Katobe and Helnsen (2011).....	136
Figure 12 - Kendi-Mutugi (2015)- Cultural-context assessment model (2015). .....	288
Figure 13- synthesised Kendi-Mutugi (2016)- cultural-context assessment model (2016)...	307

## List of tables

Table 1- National HIV/AIDS prevalence rates- 1990--2013 .....	40
Table 2-Kenya's ethnic groups demographic percentages in 1999 and 2009 censuses. .....	44
Table 3- Key cultural barriers and enablers in the spread of HIV/AIDS among the Kikuyu's of Kenya .....	52
Table 4- Key cultural barriers and enablers in the spread of HIV/AIDS among the Luyia's of Kenya. ....	55
Table 5- Key cultural barriers and enablers in the spread of HIV/AIDS among the Luo's of Kenya. ....	59
Table 6- Key cultural barriers and enablers in the spread of HIV/AIDS among the Kalenjin's of Kenya.....	63
Table 7- Key cultural barriers and enablers in the spread of HIV/AIDs among the Kamba's of Kenya. ....	67
Table 8- Key cultural barriers and enablers in the spread of HIV/AIDs among the Meru's of Kenya.....	70
Table 9- Key cultural barriers and enablers in the spread of HIV/AIDs among the Kisii's of Kenya.....	74
Table 10- Key cultural barriers and enablers in the spread of HIV/AIDs among the Mijikenda's of Kenya. ....	78
Table 11- Key cultural barriers and enablers in the spread of HIV/AIDs among the Somali's of Kenya. ....	82
Table 12 - Cultural barriers and enablers in the spread of HIV/AIDs among the Maasai's of Kenya.....	89
Table 13- relationship between methods and methodologies adapted from Silverman (2001).....	190

## **Chapter 1: General Introduction**

### **1.0 Introduction**

This chapter briefly clarifies the need for this study and explores the nature of the problem. It also explains the aim of this study, highlights the research questions, the research scope and gives a broad overview of the thesis.

### **1.1. Marketing and social marketing (SM)- a brief introduction and the need for this study**

Historically, marketing language and theory mainly focussed on explaining how goods and services were provided priced and distributed in commercial markets by profit-oriented firms. Non-commercial organisations were viewed as outside the purview of marketing and its concepts (Kotler, 2005). In the late 1960's, there was a belief that non-commercial organisations faced marketing like problems such as product, pricing, distribution and promotion related problems that could be addressed within the marketing logic. Later, Kotler and Levy (1969) argued for the need to broaden the concept of marketing beyond commercial boundaries to include social entities.

They claimed that marketing is a pervasive societal activity that goes beyond selling of toothpaste, soap and steel. They argued that no organisations could avoid marketing, as they must develop appropriate products to serve their consuming groups and use communication to reach their consumers. They stressed that marketing indeed helps practitioners in non-commercial sector in the pursuit of their goals, even though these organisations explicitly did not consider their activities to be marketing related. Kotler and Levy (1971) further said that marketing could benefit by recognising new issues and developing new concept, which may offer insight into commercial marketing practice. They suggested that by expanding its territory beyond commercial realms; marketing can gain more attention and respect for what it can produce. They submitted that marketing could indeed become more attractive as a discipline for study to a wider audience of people that may have little interest in the commercial world.

Some scholars like Luck (1969), Laczniaak and Michie (1979) were against the concept of broadening marketing. They argued that the broadening movement would damage and dilute the substance of marketing. They reasoned that if marketing has so many aspects, then it is nothing and should only exist where there are real products and markets only unlike in the social arena. The matter was however settled when marketing educators overwhelmingly favoured broadening of marketing. The broadening movement subsequently introduced new areas of study of marketing such as educational marketing, health marketing, cultural marketing of arts and museums, church marketing, Social Marketing (SM) among other areas of study.

The invasion of marketing into non-commercial arena has been a drama laden with setbacks, opposition and victories. Kotler (2005) however maintains that the general consensus is that broadening marketing has been good for marketing and the areas it invaded. For instance, social marketers are active in selling causes such as healthy eating, exercising for health, anti-littering, recycling, smoking cessation, responsible sexual behaviour to avoid HIV/AIDS virus, health screening for cancer among other social related causes.

Kotler and Zaltman coined the terms social marketing-(SM) in 1971. They underscored that social marketing uses marketing principles and tools for social good purposes rather than only for monetary gains as earlier used by business/commercial organisations. The marketing concepts that Kotler and Levy (1969) suggest should be used in SM includes firstly, product definition based on the need to understand basic customer needs being served. Secondly, target group definition and segmentation for better use of resources; thirdly the need of product and communication differentiation to better serve different segment groups. Fourthly, the need for customer behaviour analysis to understand consumer needs; fifth, the need for differentiated advantages by creating special value in the minds of potential customers.

For the fifth point, the need for multiple marketing tools to sell products and communicate effectively with customers. Sixth, the need for integrated marketing planning to avoid marketing tools operating at cross purposes. Seventh, the need for continuous marketing feedback; eighth, the need for marketing audit to cope with environmental change and lastly the need for continuous marketing feedback to ensure continuous progress towards customer satisfaction.

The discipline has grown from its earliest attempts to improve the well-being of individuals by harnessing marketing principles and tools, to its current status as an innovating approach to social change. SM aims to affect behaviour either by eliminating or weakening an undesirable behaviour or maintaining or strengthening a desired behaviour (Dibb and Carrigan, 2013). Andreasen (2005) proposed the need to use SM at three levels: downstream to influence target markets, mid-level/in stream to influence peers, relatives or those with a positive influence on individuals or target groups and upstream by influencing the policy makers. It uses three levels as a systems wise approach to influence behaviour positively. It is a formal discipline with explicit processes and tools used to understand social changes, their causes, influences and manifestations, with the objective of bringing about desirable behaviour change for the good of individuals and the society at large (Kotler, 2013 in Dibb and Carrigan, 2013).

Much as it borrows from its parent root marketing, SM differs from commercial marketing. Firstly, SM products include social behavioural issues that are typically more complex than those in commercial marketing. SM products require integrated approaches that address upstream, midstream and downstream stakeholders simultaneously (Polonsky, 2013 in Dibb and Carrigan, 2013). Developing integrated inter-departmental or inter-agency solution is indeed challenging for social marketers. Secondly social marketers work on constrained budgets; thus, require lots of innovation unlike commercial marketers that may have generous budgets for their marketing activities.

Thirdly, success evaluation parameters of SM may differ from those used in commercial marketing. Short-term impacts cannot be solely used to measure its success. Indeed, many of the benefits of SM are long-term in nature such as the benefits of quitting smoking, compared to short term campaign parameters used in commercial marketing such as increase in sales or market share or share value used to measure the success of a campaign. Fourthly, SM also borrows liberally from both of its parents, social sciences and marketing to appropriately engage social issues. This makes it a distinct approach in behaviour change as it seeks to promote and enhance public engagement, agency and democracy on social problems (Hastings, 2013 in Dibb and Carrigan, 2013). Fifth, much as marketing as oxymoron, is viewed as deceitful and manipulative, the core job of SM is to encourage critical thinking and to



a large extent, correct the wrongs created by commercial marketing. Stiglitz (2011) contends that cooperative marketing has served the interests of small elite by pretending to lionise the needs of the individuals. Classical marketing can and must overturn commercial marketing's selfishness and ensure that there is a balance in the satisfaction of genuine individual needs with collective and planetary needs. SM is indeed a balanced approach that seeks to critically check the power and wrongs created by commercial marketing. This is clearly seen in its efforts to address complex social issues such as binge drinking, drink driving, smoking, obesity caused by foods and drinks with high sugar, salts and unhealthy chemicals and unsafe sexual behaviour among other complex social problems.

This study focuses on the complex issue of the HIV/AIDS pandemic in Kenya. HIV is a virus spread via sexual contact, sharing of sharp objects, from body fluids and passed on to unborn babies by their mothers during pregnancy. SM approaches are applied in the HIV/AIDS pandemic to help bring desirable changes by firstly, encouraging safe sexual behaviour via correct and consistent use of condoms to prevent the spread of the virus and other sexually transmitted diseases. Secondly, encouraging the uptake of HIV testing and counselling to facilitate early interventions. Thirdly, it is used to discourage the sharing of sharp objects as seen in harm reduction strategies among injecting drug users and fourthly, encouraging the uptake of anti-retroviral medication to avoid the mother to child transmission among pregnant women and among the infected individuals who need treatment to minimise opportunistic infections. This study focuses on the HIV/AIDS burden in Kenya. It seeks to understand how cultural and contextual related issues impact on social marketing programmes targeting HIV/AIDS in a multi-cultural set up as Kenya, how programmers engage the two variables and how they could engage the two more appropriately for more successful programmes work.

Culture is the lens through which individuals view phenomena and determine how the phenomena will be apprehended and assimilated (McCracken, 1986). Sexual behaviour indeed differs across cultures (Gould, 1995). However, these cultural differences and their impact on HIV/AIDS related social marketing projects, have not been investigated, hence the need for this study to understand how these cultural contextual nuances impact on the HIV/AIDS pandemic and programme work. Indeed, an interest in culture has been explicit throughout marketing (Arnould and Thompson, 2005).

SM has however been critiqued, for its tendency to be preoccupied with theories that put emphasis on the cognitive and self-reflexive decision making surrounding a behaviour, rather than hidden cultural influences, which underpin these seemingly rational choices (Rothman, 2000; Niggs, et al., 2002). Spotswood and Tapp (2013) suggest that understanding problem behaviour through cultural lens may offer multifarious layers of insight and provide opportunities for more effective intervention than classical psychological perspectives and cognitive models. They indeed challenge social marketers to consider the role of SM in cultural change and role of culture change in behaviour shift. No Kenyan study has explored the role and impact of culture and context on social marketing programmes targeting HIV/AIDS pandemic, necessitating this kind of study.

Apart from the SM logic that maps this study under marketing, consumer culture theory (CCT) can also explain this cultural investigation. CCT is concerned with the cultural meanings, socio historic influences and social dynamics that shape consumer experiences and identities in the myriad messy context of everyday life (Wallendorf and Anould, 1991; Penaloza, 1994; Fournier, 1998). There is indeed a gap in investigating how cultural reality of different tribal groups in Kenya, influence responses to HIV/AIDS interventions. No study has explored this area deeply, necessitating this kind of investigation.

Gould (1994) suggests that sexuality in consumer behaviour is mainly used in the advertising context despite its omnipresence in many aspects of consumption. He contends that sexuality consumption may be viewed at various levels of phenomenological manifestation. Firstly, the act itself and consumption objects directly involved such as condoms, as well as the exchange terms between sexual partners as seen in prostitution. Secondly, consumption that surrounds the act both directly such as brothels and indirectly like in the ritualistic use of consumption to attract sexual partners. Thirdly, investments of sexual libido in symbolic re-enactments like in pole dancing among other practices. He encourages consumer researchers to stop ignoring sexual consumption as a research topic in order to understand libidinous consumer behaviour better. Indeed, sexual consumption may be mapped under hedonic consumption that consists of the facets of consumer behaviour that relate to the multi-sensory, fantasy and emotive aspects of consumer experiences with products (Hirschman and Holbrook, 1982). Sexual consumption may also be

viewed under the utilitarian motives due to its functional and necessary role in propagation of life, necessary for continuity of families and societies. No studies have explored these areas and there is indeed the need to study and explores sexual consumption through both the hedonistic and utilitarian cultural lenses among the various tribal groups in Kenya; in order to understand how they impact positively and/or negatives on the HIV/AIDS interventions.

The Kenyan HIV/AIDS prevalence rates differ based on geographical realities. The highest provincial prevalence being Nyanza province, the home of the Luos of Kenya with a regional high HIV prevalence of 14.9% in 2007 and an increase to 15.1% in 2012 compared to the lowest regional prevalence of North Eastern Province, the home of the Somalis of Kenya with 0.9% in 2007 and 0.5% 2012 (Kenya National Bureau of Statistics, 2010; Kenya AIDS Indicator Survey, 2012). Nyanza is the home of the counties with the highest HIV/AIDS prevalence rates: Homabay-26%, Siaya 24.8%, Kisumu 19.9% and Migori 14.3% while Wajir county in Northern Eastern has 0.4% prevalence rate (NACC, 2015). Other provinces also differ in their prevalence rates. The HIV/AIDS burden in Kenya also differs in relation to age groups. The 15-65 years' group is heavily burdened; however, women take a 6.9% share compared to 4.4% of the burden (Kenya AIDS Indicator Survey, 2013). The burden on women has not changed much with 6.5%, compared to 4.7% on men (NACC, 2015). The rural area is 5.1% compared to 6.5% urban HIV/AIDS burden (KAIS, 2013; NACC, 2015).

These highlights and disparities in the HIV/AIDS burden have not been deeply investigated, necessitating the need to study and understand these differences within Kenya regions. This study indeed covers this gap by exploring the tribal groups living in the different regions of Kenya to understand these important highlights of the HIV/AIDS pandemic in Kenya.

The fight against the HIV/AIDS pandemic in Kenya has involved many approaches such as social advertising, health education and downstream social marketing. Programmes are evident in all parts of the country. No study has however explored the evolution of these approaches and the social marketing logic and tools used by programmers and other relevant stakeholders in the fight against HIV pandemic. This indeed necessitates the need to explore these issues to understand the knowledge and practice gaps in important areas such as social marketing and culture.

## **1.2 Background information**

HIV/AIDS has presented one of the greatest challenges to the Kenya's social-economic environment since the country's independence in 1963. The epidemic has torn apart the social structures and networks of the Kenyan population. The infections have led to the need to settle high medical bills due to many opportunistic infections that set in when the virus ravages individuals' immune systems, in the face of abject poverty and led to the untimely deaths of loved ones (Hancock, et al., 1996). It has further ravaged the economy and deepened poverty by disabling and causing the deaths of Kenyans at the prime of their economic productivity and reproduction. Indeed, the worst hit group demographically is the 15-54 years (Kenya Aids Indicator Survey-KAIS, 2013), the ages meant to be at the peak and lead of economic productivity.

The virus has led to reversed social roles and responsibilities, with many children having to look after themselves and their ailing or dying parents. Many grandparents have been forced to become heads of families and chief carers in their old age due to the demise of the younger population. The epidemic has discriminately burdened women and children (UNAIDS, 2012; KAIS, 2013). Villages, towns and homes have been turned into mourning centres and graveyards and indeed, many Kenyan tribes and families have experienced the ugly scars of the HIV/AIDS pandemic.

HIV/AIDS was first identified in Kenya in 1984, when a 34-year-old Ugandan journalist died in Kenyatta Hospital on 8<sup>th</sup> May 1984 (Kamaara, 2005). The Kenyan dailies at this early stage depicted HIV/AIDS as a mysterious sex disease that had come to Kenya from distant lands of America, Australia, Britain and other western countries. They described it as a horrible sexual disease affecting homosexuals that could be transmitted to heterosexuals. It was said to afflict people of low moral standing and prostitutes. Consequently, the few who got diagnosed mainly committed suicide due to the strong moral perception and high stigma that were associated with this early HIV era (Mwangi, 2013).

It was indeed an era of fear and confusion as doctors and researchers did not understand how to manage the virus. They mainly used gloves and masks to handle patients. Such was the fear that pathologists declined to handle bodies of those who had died from the virus. Indeed, the dead were stuffed in polythene bags and during burials, relatives were required to keep a distance from coffins by the provincial and district administrators, to avoid catching the virus.

At this early stage, the Kenyan government did not take HIV/AIDS pandemic seriously, as the press and policy makers described and associated it with western and American homosexuals. They did not see it as a Kenyan problem due to its link to homosexuality and immorality. Indeed, homosexuality is traditionally considered a taboo among many Kenyan tribal groups and is punishable by death. It was also considered a problem of the Ugandans (a neighbouring country), as the first person diagnosed in Kenya was a Ugandan journalist operating in Nairobi. It therefore was not given much policy and political attention because the Kenyan government and public did not own the problem. However, the virus was spreading fast as nothing significant was being done about it. By 1985, twenty-six cases affecting sex workers were reported in Nairobi and by 1987, over 286 individuals infected had been reported with over 38 deaths (ibid).

The outlook changed in 1987, when the British armed forces cautioned their soldiers against the use of commercial sex workers in the Kenyan coastal town of Mombasa owing to the rising HIV infections. British tourists began cancelling visits to Kenya due to blood safety concerns (Kwena, 2004). The drop in tourism negatively affected foreign exchange since tourism had previously been the largest source of Kenya's foreign exchange. This was a wakeup call because the government realised that tourism indeed had been threatened and so was the economy (Booth, 2004). World Health Organisation (WHO) also played a key role by pressurising the government to acknowledge that HIV/AIDS was becoming a key concern. HIV therefore contentiously caught the attention of the government and was considered as a health agenda under the Ministry of Health. In 1986, WHO created a special programme on AIDS (SPA). The WHO Director then pressured East African countries (Kenya, Uganda and Tanzania) to launch AIDS control programmes (Ahlberg, 1991).

The Kenya government reluctantly accepted WHO's assistance but did not commit any financial budget towards the programme. This was in sharp contrast to Uganda's government's early and remarkable response under President Museveni. He responded positively to the challenge and launched a multi-sectorial approach with the support of international agencies to address the HIV/AIDS issue (Morisky, et al., 2006). Kenya's then President Mr Moi was willing to accept donor funding but did nothing more to commit government financial resources to contain the virus. In 1987, National AIDS Control Programme (NACP) under Ministry of Health (MOH) in collaboration with WHO was launched to mainly coordinate with the limited HIV/AIDS related activities that mainly focussed on education of the public and health professional on HIV/AIDS matters. Interestingly, the government was meant to provide 8% of NACP's operating costs but it did not provide a dime (Booth, 2004), a clear evidence of the political unwillingness to commit any resource to fighting HIV/AIDS in Kenya despite HIV/AIDS national prevalence rising to 13% by 1990.

On a positive note, the government reluctantly started giving NACP a budget after 1992, five years after it had been launched. The government interference was also noted, when the Ministry of Health officials forced NACP to sway from their key prevention objectives of educating health professionals and the public on HIV/AIDS and contributing to public policy issues, to make blood contamination a key concern. This was a public relations gimmick targeted at the British government and tourists to show case government was concerned about blood safety (Kwena, 2004). NACP eventually collapsed due to the lack of government promised 8%-\$300,000 operating budget and a lack of government's support for their activities, as it was largely perceived as a western fronted organisation interfering with government activities (Booth, 2004).

The Kenyan government decided to start their own initiative and created National HIV/AIDS and Sexually Transmitted Diseases Control Programme (NASCO) in 1992. NASCO was given the mandate of promoting and coordinating the awareness of HIV/AIDS prevention and taking up the blood screening priority for the sake of tourism (Kamaara, 2005). The move to create and fund it may arguably have been deemed as a move to attract donor funding channelled via the government rather than through the previously western led NACP.

NASCOP seemed to be working hard as for the first time in 1993, the first national conference on HIV/AIDS was held to deliberate on the rising HIV infections and related deaths. HIV data on deaths and illnesses was also released to the public for the very first time. The data however greatly angered the public, as over 100,000 deaths were reported and the national prevalence rate had peaked to 13%. The public demanded policy guide from the government on the crisis (Kwena, 2004). The government under the leadership of NASCOP also responded actively by including HIV/AIDS for the first time in the development plans of 1994-1997 and in sessional papers no 4 of 1997, where they provided a general policy framework guide to future HIV/AIDS policy action, although no resources were committed to the plans.

Sadly, the period 1996 - 1999 saw a rise in HIV infections from 11.2% to 13.8% national prevalence rates, with almost 50% government hospital beds occupied by HIV patients (NASCOP, 2003). Health leaders and NASCOP sensitised and advised the president and government on the devastating impact of HIV/AIDS, culminating in President Moi declaring HIV/AIDS a national disaster on the 25<sup>th</sup> November 1999. This saw the creation of The National AIDS Control Council (NACC) under the office of the president to coordinate all HIV/AIDS activities and funding in Kenya. All funding was to be channelled via NACC not through Non-Governmental organisations (NGO). Placing NACC under the office of the president raises arguments of the president's control over donor funding (Hershey, 2009).

The mandate of NACC to involve and coordinate all Kenyan sectors in fighting HIV such as local and international agencies, government ministries, community based organisations, nongovernmental organisations and the private sector presented the strongest government's response to the HIV/AIDS epidemic since 1984's first case. This multi-sectorial approach was similar to one adopted by Uganda's government under Museveni, after WHO's prompted East African leaders to act on the pandemic in 1986. Kenya was indeed acting thirteen (13) years later after the virus had caused much havoc on its citizens.

Declaring HIV/AIDS a national disaster in 1999 also marked the end of the silence by government officials on HIV/AIDS, as the president and other government officials began to freely and openly speak about the pandemic. It also was an open invitation for various sectors within Kenya to offer their ideas and initiatives in containing the

pandemic. This era saw many interesting initiatives, approaches and debates such as the drive and promotion of the use of condoms, the need to introduce sex education in school curriculum, the need to remove confidentiality clauses in HIV testing to enable spouses and partners to protect themselves or at least to know the status of their partners, the need to criminalise deliberate spreading of HIV and the efficacy of different proposed anti-retroviral drugs including herbal ones administered by herbalists (Kwena, 2004) among other interesting proposals.

This free speech and debate era certainly gave rise to controversies. President Moi's leadership of the HIV/AIDS was indeed ridden with controversies. He openly supported the need for youth abstinence from sex and rejected government's and NGOs' endorsement of condom use. He suggested that condoms would give the youth a passport to casual sex and suggested that condoms were for people that cannot control their sexual urges (Daily Nation, 1999; Dawes, 1999). In December 1999, while officiating a university graduation, he changed his mind and gave a fatherly advice to the nation suggesting that condoms were absolutely necessary as the threat of AIDS had reached alarming proportions for the issue to be treated casually. Another controversy was in relation to shelving of a sessional paper on family life education. The paper highlighted the need to introduce sex education and create awareness among students on dangers of teenage pregnancies, abortion, drug abuse, HIV and other sexually transmitted diseases (STIs). The paper had also proposed integration of family life education with primary health care (Kigotho, 1997).

Moi however succumbed to the pressure of religious leaders that vehemently rejected the introduction of sex education in schools. Religious leaders burnt condoms and literature on sex education in public to protest against the sessional paper. His rejection of the sessional paper without any consultations was seen as a gimmick to win religious leaders and followers' votes for the general elections, without due regard to its benefits on the fight against HIV/AIDS and teenage related pregnancies. Moi certainly won the general elections in 1998, however owing to failing economic situation in Kenya, his party Kenya African National Union (KANU) that had ruled since 1963 (independence time) historically lost grip of power to President Kibaki in 2002 under the National Alliance Rainbow Coalition party.



Kibaki continued with the strong response to the pandemic by spearheading a ministry of health campaign Total war on HIV/AIDS – (TOWA) campaign in 2003. The campaign stressed the need for Kenyans to change their sexual behaviour, need for treatment access via government's subsidised anti-retroviral drugs in government hospitals. It also promoted mother to child HIV control by encouraging the HIV/AIDS testing of all pregnant women that access government hospitals (Hershey, 2009). Donors responded positively to Kibaki's efforts. The USA president's Emergency Plan for AIDS Relief (PEPFAR) chooses Kenya as one of the target countries that received grants in excess of \$142 million in 2005. By 2009, the country had received \$ 1,912 million (United States Department of State, 2011) and a further \$548,119,441 was received from USA from its various donor agencies in 2010 (United States PEPFAR, 2010). Clearly much funding has been channelled to HIV/AIDS initiatives in Kenya by different donor countries especially from the USA and other bilateral partners and donors.

The current situation of HIV/AIDS in Kenya is certainly getting better, due to the resources being channelled to the pandemic (UNAIDS, 2012; Kenya National Bureau of Statistics- KBS, 2012). By 2011, the national HIV prevalence rate had dropped to 6.2%, and in 2013 to 5.6% (KAIS, 2013). This 5.6% translates to 1.2m Kenyans between the ages 15-64 years, living with the HIV virus out of the current 38.6 million population of Kenya, compared to 1.6 Million in 2011 (KAIS, 2013). Sadly, the decline may be attributed to HIV/AIDS related deaths. There are also over 104,000 infected children between ages 18 months to 14 years. There were over 100,501 new adult infections in 2013, with 43,193 males and 55,309 females and 11,210 infected children, 5,679 males and 5,531 females (KAIS, 2013). This is a significant drop in new infection cases as reported in 1993 that had 350,000 new infections (NACC, 2009).

The current situation however suggests significant issues on the epidemic. Firstly, the epidemic prevalence varies geographically. The highest provincial prevalence being Nyanza province the home of the Luos of Kenya with a regional high HIV prevalence of 14.9% in 2007 and an increase to 15.1% in 2012 compared to the lowest regional prevalence of North Eastern Province, the home of the Somalis of Kenya with 0.9% in 2007 and 0.5% 2012 (Kenya National Bureau of Statistics, 2010; Kenya AIDS Indicator Survey, 2012). Nyanza province is the home of the counties with the highest

HIV/AIDs prevalence rates: Homabay-26%, Siaya 24.8%, Kisumu 19.9%, Migori 14.3% and Nyamira at 6.4%, while Wajir county in Northern Eastern province has 0.4% prevalence rate (NACC, 2015). Other provinces include: Nairobi province 4.9%, currently Nairobi county is at 6.1%, Western province 4.7%, currently Busia county is at 6.7% and Kakamega 4.7%. Coast Province 4.3%, currently Mombasa county is at 7.5%, while Taita Taveta is at 6.3%, Kwale county 5.9% and Kilifi 4.5%. Rift Valley province 3.6%, however counties like Trans Nzoia is at 5.2%, Uasin Gishu 4.7% and Laikipia 3.2%, Eastern province 3.7% however counties like Makueni 5.1%, Machakos 4.5% and Kitui 4.4% and Central province 3.8%, however currently, counties like Kiambu 5.6%, Muranga 4.2%, all based on KAIS (2012) and NACC (2015) reports.

Another interesting highlight of the epidemic is that among the 15 to 64 year olds, the virus disproportionately affects women, accounting for 6.9 % compared to men at 4.4% of all total infected cases. (Kenya AIDS Indicator Survey-KAIS, 2013). The trend has not changed much with women taking 6.5% while men take 4.5% of the HIV burden in the NACC (2015) estimate. Rural areas of Kenya accounted for 5.1% while urban areas 6.5% of the HIV/AIDS burden in Kenya (KAIS, 2013; NACC, 2015).

These epidemic highlights suggest the need to look deeper into the causes of these regional variations and possibly the need to understand what can be done about them. Although the government inactivity under President Moi can be partially blamed for the rise in HIV/AIDS related infections and death from 1984 to 2001, could cultural and contextual nuances be to blame more for the lack of change in sexual behaviour and attitudes toward HIV/AIDS since 1984? Could cultural and contextual realities be the hindrance towards the UNAIDS ambitious getting to zero campaign, aimed at realising zero new HIV infections, zero discrimination and zero AIDS related deaths in all countries between 2011 and 2015?

In relation to the use of SM interventions, the early era of HIV/AIDS in Kenya was marked by use of social advertising rather than SM approach. Social advertising assigns promotion the primary and exclusive role in accomplishing social objectives, ignoring other marketing Ps. This is in sharp contrast to SM that uses all the marketing Ps in social change management. Many of the early adverts focussed on the

ABC (abstinence, being faithful and condom use) mantra. The messages were carried on posters in the national dailies, mounted on the walls of health institutions and on television's brief clips. Billboards were also used that depicted wasted individuals with slogans such as 'HIV/AIDS is real and is not witchcraft'. Social advertising is however limited as behaviour change approach. It uses inadequately researched messages, which may not resonate well with the target audiences and may suffer from selective perception. Recipients select what they want from the messages by taking what appeals to them rendering the rest of the message ineffective. These messages also lack a response mechanism, as they do not tell audiences what to do after receiving the messages (Fox and Kotler, 1980).

It can also be argued that many of the early HIV/AIDS related interventions in Kenya centred on health education rather than SM approaches. Rothschild (1999) suggests that education can be used to achieve social change; however, it only provides information and proposes of unforced free choices. It places the burden of costs and risks to individuals and offers a promise of future potential payback; however, it lacks the ability to reinforce individuals directly.

SM however offers a robust sexual behaviour change and management approach. It is a useful social change tool as it is customer centred and driven by choice (LeGrand, 2007). It perceives individuals as consumers with rights rather than as citizens with obligations (French, 2011). It aims to make it easy for individuals to change by producing services and products that deal with barriers or help them get benefits that they care about, making it even more democratic. It is a cost-effective approach as it identifies the most cost effective target segments and sets realistic consumer focussed smart objectively likely to succeed (Lottenberg et al., 2011).

Hence, there is a need to investigate and understand the evolving nature and use of social marketing interventions in Kenya in the HIV/AIDS pandemic; all the way from social advertising, health education, the use of the law and downstream social marketing. This may help identify gaps in the use of social marketing in the HIV/AIDS pandemic in Kenya. They can however only be understood via an in-depth study, necessitating the need to carry this interesting study.

## **1.2 The Nature of the problem**

Kenya has a rich cultural heritage with forty-two (42) tribes, each with its own unique culture relating to their history, values, norms lifestyle, beliefs, practices, language and religion. There are major and minor tribes comprising of Kikuyu 15.4%, Luyia 12.4%, Kalenjin 11.5%, Luo 9.4%, Kamba 9.05%, Somalis 5.54%, Kisii- 5.13%, Mijikenda 4.6%, Meru 3.9%, Turkana 2.3%, Maasai 2.0%, other Africans 2%, Non-Africans (Asia, European and Arabs) 1% as well as other minor ones (Kenya National Bureau of Statistics- KNBS 2011).

HIV/AIDS transmissions are mainly influenced by biological, social, legal, cultural and environmental factors (UNAIDS, 2012), but also differ between and within settings and populations. In 2011, Nyanza province of Kenya, home to the Luos, had a national prevalence of 15.1%, while the North Eastern province - home to the Somalis of Kenya has a prevalence of only 0.5%. Women of the age set 15-49 years have a prevalence rate of 6.9%, compared to men of the same age group of 4.4% (KAIS, 2013). Heterosexual transmissions mode account for 77% of the total infections, while homosexuality (men having sex with men) account for 15.2% of the infections (Kenya National Bureau of Statistics, 2013). The virus affects individuals from all social strata, with the top wealthy quartile in Kenya having a prevalence of 7.2%, second wealthy prevalence 6.8% and the poorest quartile 4.6% (UNAIDS, 2012). Based on religious, the Muslims have the lowest prevalence of 3.3%, Catholics have 5.9% and Protestants 6.6% (Kenya Bureau of Statistics, 2010).

Many initiatives have been designed and implemented to control the HIV scourge in Kenya since 1984. The government, private sector, non-governmental organisations (NGOs), faith based organisations (FBOs) and community based organisations (CBOs) initiatives have all contributed in fighting the pandemic. They have initiated programmes in areas such as public education to create HIV/AIDS awareness, prevention of mother to child transmission (PMTCT) service at the antenatal clinics, free anti-retroviral drugs (ARTS) that help boost the immune systems of people living with AIDS (PLWAs). They have also engaged in opening of many voluntary counselling and testing centres (VCTS) for individuals to know their HIV status as well as orphaned and vulnerable children (OVCs) programmes (Kwena, 2004; UNAIDS, 2012).

The extent to which many of these programmes have made an impact is contentious. For instance, the condom use campaigns have faced many controversies and politics from religious leaders and some government officials who claim that condoms are an open licence to promiscuity. Culturally rooted beliefs, superstitions and fears are also rife such as ancestors never used condoms, while others claim that condoms are a ploy from the west to render Kenyan men sterile and impotent, while culturally children are greatly valued (Daily nation, 1999). These cultural beliefs may impact SM initiatives targeting HIV/AIDS positively or negatively and the extent to which interventions address these cultural barriers need to be understood and engaged with appropriately.

The bone of contention is despite all the great initiatives and almost forty billion Ksh (£280 million) invested in fighting the HIV/AIDS scourge, the new infection rates do not seem to significantly drop, although arguably new infections and national prevalence rates have declined over time. For instance, the HIV/AIDS national prevalence in 2007 was 7.2% compared to 5.6% in 2012 (KAIS 2013). Regionally, places like Nyanza, Nairobi and Coastal provinces seem to be shouldering most of the new infections. One would argue that an epidemic given such serious multi-sectorial attention and lots of local and international resources should by now be recording nearly zero prevalence national rates, but sadly that is not true for HIV/AIDS in Kenya. As much as the political inactivity, under President Moi, has a fair share of blame for the surges in HIV related infections and deaths, it is also debatable the extent to which other Kenyan stakeholders like the community based, non-governmental, faith based, private sector and Kenyans themselves are to blame for their inactivity or their minimal role in containing the epidemic. Much as they may have intervened, their mode of engagement without due consideration to the local cultural and contextual realities may possibly be more to blame than Mr Moi's inactivity.

Much as HIV/AIDS transmissions are mainly influenced by biological, social, legal, cultural and environmental factors (UNAIDS, 2012), cultural and contextual realities and their impact on HIV/AIDS programmes in Kenya, have not been investigated, necessitating this study.

This study explores how cultural and contextual realities are dealt with by programmers targeting HIV/AIDS with SM interventions in a multi-cultural country as Kenya. It seeks to understand the challenges, barriers and opportunities presented by these realities and how perhaps they can appropriately deal with them, for more successful interventions.

Culture can be viewed as a system of interrelated values active enough to influence and conditional vital concepts of perception, judgment, communication and behaviour in a given society (Mazrui, 1986). Airhihenbuwa, et al., (2000) suggest the need to consider and view culture as a central domain in HIV/AIDS prevention care and support in Africa and other multi-racial countries. This is because culture provides the lens through which health behaviour is expressed, defined, understood, regulated and maintained by different groups of people. Airhihenbuwa, et al., (1992) suggests that the role of cultural context in successful implementation of programmes is often omitted even though evidence abounds that culture is a central feature in health behaviours and decision, particularly in the context of behaviours that may predispose people to HIV/AIDS and other health risks. The extent to which culture has been centralised in HIV/AIDS interventions in Kenya is indeed contentious and has not been investigated, necessitating this study.

Caldwell (1999) suggests that several factors may explain the limited sexual behavioural change throughout East Africa (Kenya, Uganda and Tanzania). These factors include adherence to traditional sexual culture, refusal of political leaders to act, acceptance of death, silence about the epidemic and limited number of relationships in which condoms are acceptable. This is arguably a generic view of the Kenyan context, as each of the forty-two Kenyan tribal groups have their own distinct beliefs, practices and sexual culture. Indeed, sex is no longer perceived as merely a biological fact but rather a culturally informed experience shaped by the inner world and the material world in which humans live (Davis and Whitten, 1987). This generic reference to traditional culture and lack of robust investigation as to the specifics of traditional sexual cultural practices and beliefs in Kenya that compound the HIV/AIDS problems, compel the need for this study to explore Kenyan ethnic groups better, in order to understand their sexual cultures and how these nuances impact on the HIV/AIDS pandemic and SM grounded interventions.

Considering the Kenyan context, there is a very little evidence to show that culture has been robustly engaged with in HIV/AIDS related SM interventions. Muturi (2005) contends that cultural beliefs, values, norms and myths have played a role in the rapidly increasing epidemic in the rural communities in Kenya, yet HIV/AIDS communication programmes have not addressed these factors adequately. Ethnicity in terms of tribe of origin in Kenya has been associated with risky sexual behaviour (UNAIDS, 2012), though the relationship between risk and ethnic tribes has quite not been deeply investigated. Ankwaru, Madise and Hinde (2003) argue that there is a need to identify contextual and social factors that influence behaviour among the Kenyan people, although little has been done to understand these factors that may be specific to the tribal groups of Kenya.

These compelling loose and generic references to culture, context, ethnicity, social factors, beliefs, myths and values are considered to be negatively impacting HIV/AIDs pandemic, point to a gap in knowledge and understanding of the Kenyan cultural and context in relation to HIV/AIDs programmes grounded on social marketing logic, compelling the need to undertake this study to explore and understand these cultural and contextual factors in relation to HIV/AIDs within the Kenyan groups.

The Ministry of Health Kenya- MOH (1999) suggests that particular cultural rites and ceremonies are incongruent with the modern way of life and enhance the contraction, containment and spread of HIV. Much as this may explain the differing HIV/AIDS prevalence levels among the various Kenyan groups, they do not provide a detailed understanding of the specific incongruent rites and ceremonies of Kenyan tribal groups and what can be done to engage with them appropriately. Kiiti (2005) argues that indigenous knowledge or wisdom can facilitate an appropriate response to HIV/AIDS. Perhaps there may be cultural enablers that programmers targeting HIV/AIDs can engage for effectiveness interventions. This is another issue that compels this study to investigate whether there are any positives presented by culture and context, that social marketer can harness for more fruitful programme work.

It is difficult to influence attitude and behaviours targeted in SM campaigns without tackling the deeply ingrained cultural dispositions that underpin them (Tapp and Spotswood, 2013). Airhihenbuwa (1995) posits that public health and social and

behavioural sciences mainly pay lip service to the importance of culture in studying and understanding target audiences' behaviours. He argues that interventionists do not inscribe cultural understanding at the root of health promotion and disease prevention programmes. He further suggests that this cultural apathy has led to the use of westernised models of prevention and interventions to drive health promotion and disease prevention practices amongst non-westerners. The extent to which social marketers in Kenya engage cultural and contextual realities of their audiences in programme work has not been investigated, again pointing to a gap that this study can fill.

Successful Commercial marketers do acknowledge that cultures and subcultures affect buying decisions. They do not assume cultural homogeneity within and across nations. They undertake research informed by macro and micro environmental factors analysis to inform their decisions and strategies (Kotler, 2001). Donovan and Henley (2010) contend that the success of SM interventions partly depend on the marketers' accurate analysis of the complex environment of the target audiences. Lefebvre (2011) submits that for SM approach to be effective, it should embrace an understanding of the determinants, content and consequences of current behaviours and desired ones from the point of view of the audiences, not from any one or more set of theories and models. Raval (2004) suggests that failure to recognise the importance of cultural values may yield less than the desired results in many SM programmes. Again the generic and loose references in social marketing of complex environment of target audiences, determinants, content and consequences of current behaviours and desired ones, cultural values by social marketing theorists, all point to a gap in knowledge and understanding. The terms fail to explain as to what culture and context really mean and their impact on programme work, necessitating this study to delve deep into a multi-cultural country as Kenya, to understand how programmers navigate the murky waters of culture and context in their programme work.

Indeed, SM can learn much by using the consumer culture theory (CCT) logic of consumer behaviour. CCT is concerned with cultural meanings, socio historic influences, social dynamics that shape consumer experiences and identities in the myriad messy context of everyday life (Fournier, 1998; Penaloza, 1994; Wallendorf and Arnould, 1991). Social marketers certainly have much learning to do from commercial marketers on how to embrace the cultural and contextual reality, if more



effective SM interventions are to be realised especially within the multi-cultural Kenyan context. The consumer culture theory and cultural adaptation issues have not been explored in social marketing, pointing to a gap that needs to be filled. The question and challenge is, do social marketers really embrace these cultural and contextual realities and incorporate them in their programme work? This study indeed seeks to fill this gap by exploring and understanding these cultural and contextual issues from the point of view of programme leaders that run their programmes in different parts of the country, as they have a sound understanding of how culture and context influences their programmes targeting HIV/AIDS pandemic in Kenya.

### **1.3 Research questions**

While the etics of HIV/AIDS may be similar throughout the world, the emics are indeed very different due to the cultural realities behind the spread of the virus. Jayasuriya (1995) contends that while the biomedical aspects of HIV/AIDS are characteristically uniform across all the geographical regions, cultural dimensions of HIV/AIDS prevention are undeniably important as more than hundred and fifteen (115) countries around the world have been affected by this epidemic. Abramson and Herdt (1990) further argue that there is a need for culturally sensitive knowledge of sexual beliefs and practices. This knowledge could aid in the understanding of patterns of HIV transmission, help in evaluating the impact of AIDS on different communities and help in the designing of more effective intervention programmes. Cultural understanding indeed provides the emics of the virus, while biomedicine provides the etics of HIV/AIDS. This study explores the emics of HIV/AIDS in Kenya. It focuses on understanding the cultural related barriers and enablers that social marketers have to contend with in their HIV/AIDS related programme work, among different culturally diverse groups of Kenya. In order to understand the emics of the HIV/AIDS pandemic in Kenya, it is important to explore the following main research questions:

1. What cultural and contextual opportunities and challenges do social marketers involved in HIV/AIDS interventions face in a multi-cultural environment as Kenya, in relation to their target audiences?

2. How do social marketers targeting HIV/AIDS pandemic in Kenya, deal with the programme work related opportunities and challenges posed by the cultural and contextual realities of their target audiences?
3. What would be the most appropriate ways of dealing with the challenges and opportunities posed by the Kenyan cultural and contextual realities, to HIV/AIDS related SM interventions?

#### **1.4 Research Objectives**

The key research objectives are:

- To understand:
  - How culture is perceived in SM initiatives targeting HIV/AIDS pandemic amongst the various tribal groups in Kenya.
  - The cultural realities faced by social marketers targeting HIV/AIDS issues in Kenya.
  - The contextual realities faced by social marketers targeting HIV/AIDS issues in Kenya.
  - Context and cultural related barriers and enablers to SM initiatives targeting HIV/AIDS in Kenya.
  - How social marketers using SM initiatives in the programmes targeting HIV/AIDS in Kenya, engage with context and cultural barriers and enablers.
  - How context and cultural barriers and enablers could possibly be appropriately engaged with for more successful SM interventions.

#### **1.4 Scope of Research**

The research explores the contextual and cultural realities of SM programmes targeting HIV/AIDS in Kenya. This study considers seven major Kenyan tribes as well as three minor ones. It would have been interesting to examine all the 42 tribes of Kenya, however these ten tribal groups represent each of the former provinces of Kenya, thereby giving a detailed outlook of the target audiences.

While it would be interesting to understand how other multi-cultured countries have dealt with cultural nuances in relation to HIV/AIDS, this research mainly focuses on Kenya, although other countries' examples have been used to explain, compare or contrast relevant and emergent issues.

## **1.6 Thesis Layout**

**Chapter one - The general introduction.** This chapter introduces SM, background information of the HIV/AIDS problem in Kenya, the research questions, scope and objectives and the thesis layout. The study seeks to explore the context and cultural realities of SM programmes targeting HIV/AIDS in Kenya from programmers' perspectives, in order to understand how to better engage the cultural and contextual realities for more successful interventions.

**Chapter two - The Kenyan cultural context.** This chapter mainly focuses on the context of the study. It uses secondary literature review to explore and understand the cultures of seven major tribes of Kenya and three minor ones. It also uses secondary data to understand the cultural and contextual nuances that may be fuelling the spread of HIV/AIDs and hampering programmer efforts in relation to testing, treatment and reducing the spread of HIV in Kenya. The major tribes explored from secondary resources are the Kikuyu, Luhya, Luo, Kalenjin, Kamba, Kisii, Meru, and the minor groups Maasai, Somali and Mijikenda.

**Chapter 3 - Culture and Health-exploring the link.** This chapter provides an understanding of the concept of culture and explores how culture and health may be related. It suggests a composite model emanating from the existing cultural models, which may be used to probe the social and cultural realities of social marketers' markets.

**Chapter 4 – Social Marketing theory and practice in relation to culture and health - Exploring the link.** This chapter focuses on the conceptual understanding surrounding the Social Marketing theory and practice. It also explores the gaps in relation to how SM treats the cultural concept in comparison to how its parent marketing treats it and explores the links among SM, culture and health. It suggests that there is the need to incorporate cultural and contextual realities in the planning, implementation and evaluation of SM programmes.

**Chapter 5- Research methods and methodology-** discusses the methods and methodology to answer the research questions. Qualitative research is well suited to explore cultural and contextual realities. Open ended qualitative questions and qualitative interviews are used to understand the Kenyan context from programmers' point of views. NVIVO software is used to ease data management. Ethical clearance is obtained from the UEL ethical committee for data collection in Kenya.

**Chapter 6- Research findings.** This chapter mainly reports on the programmers' responses based on the themes inferred from the open ended qualitative questions. Major fifteen themes identified include: infrastructure such as slums and informal settlements, pubs, health and educational structures, then the themes of prostitution, illicit brews and branded alcohol, secrecy surrounding sexuality, illiteracy, sexual violence, stigma and discrimination. Other themes include: myths and beliefs, early sexual debut and childhood marriages, FGM and male circumcision, polygamy and extra marital sex, taboos, HIV/AIDs related treatment, religion, cultural enablers, political issues, legal issues and lastly donor and funding related issues.

**Chapter 7- Discussion of the research findings.** Findings are discussed based on the themes emerging from the qualitative questions instruments as noted above and corroborated using other secondary sources of information. A refined cultural-contextual model is also formulated based on the research findings, which could be of great help to programmers in understanding their cultural and contextual realities of their target audiences.

**Chapter 8- Conclusions, recommendations and contribution to knowledge and areas for future research work.** In conclusion, this study clearly establishes that cultural and contextual realities of a market or target audiences greatly impact the SM programmes. It demonstrates the need for programmers to use culture and contextual realities as foundations to guide their planning, implementation and evaluation of their SM initiatives. The study further verifies that context and cultural realities provide challenges as well as opportunities that social marketer may need to address for their programmes to be effective. It also suggests the need for upstream approaches within the Kenyan context not just downstream measures. The study also recommends the need for cultural or tribal groups' segmentation rather than blanket programmes, as each tribe is quite rich and unique in their sexual cultures.

For future research, the study suggests the need to explore all the 42 tribes instead of the seven major and three minor groups and the need for similar regional and continental studies. The study recommends a coordinated concurrent study of each of the African countries in order to understand country specific cultural and contextual realities. This knowledge would possibly inform relevant interventions' design, implementation and evaluation, with the objective of reducing the Sub-Saharan Africa's HIV/AIDS burden. References- based on all the chapters: 1 to 7.

### **1.7 Chapter summary**

Since the first Kenyan HIV/AIDS case was diagnosed in 1984, the pandemic has gone through various upswings and downswings in relation to national prevalence, deaths and new infection rates. The national prevalence peaked in 1999 at 13% and 2000 at 13.4% and by 2010 it was at 6.2% and presently (2015/16) it stands at 5.9%. This drop in prevalence rates may be arguably attributed to AIDS related deaths, although new infection rates have also declined due to SM related campaigns especially on condom use and treatment options.

The pandemic affects provincial regions and demographic groups disproportionately, with Nyanza province, the home of the Luos of Kenya bearing the highest burden at 15.1% and North Eastern province, home to the Somali's of Kenya taking the least at 0.5% (Kenya AIDS Indicator Survey-KAIS, 2014). Nyanza is the home of the counties with the highest HIV/AIDs prevalence rates: Homabay-26%, Siaya 24.8%,

Kisumu 19.9% and Migori 14.3% while Wajir county in Northern Eastern has 0.4% prevalence rate (NACC, 2015). The Kenyan women and children bear the highest burden of HIV/AIDs with the 15-49 years' female demographic group having the highest prevalence at 6.9% compared to the same male group at 4.4% (KAIS 2014). Currently 6.5% women and 4.7% male burden. This points to the need of understanding these regional and tribal disparities via this study.

The SM approach has been suggested as a viable approach in dealing with social issues. This is because it borrows a lot from commercial marketers, who are arguably successful in selling their goods and services at the marketing place. Kotler and Zaltman (1971) argue that the same approach may be used to deal with social issues successfully. Lefebvre (2011) however suggests the need for social marketers to embrace an understanding of the determinants, context and consequences of current and desired behaviours from the point of view of audiences for programme success. SM has further been critiqued for being pre-occupied with theories that emphasise the cognitive, self-reflexive decision making surrounding a behaviour, rather than hidden cultural influences, which underpin these seemingly rational decisions (Rothman, 2000; Niggs, et al., 2002). Tapp and Spotswood (2013) suggest that understanding problem behaviour through cultural lens may offer multifarious layers of insight and provide opportunities for more effective intervention rather than the classical psychological perspectives and cognitive models.

This study, therefore, seeks to understand the existence and nature of this cultural and contextual engagement gap, by exploring the work of the social marketing programmers targeting HIV/AIDs among the various tribal groups in Kenya. It seeks to understand how they engage with these realities of their target audiences in a multi ethnic culturally rich and diverse context as Kenya, in order to identify gaps and understand how to appropriately deal with these realities, for more successful social marketing interventions.

The next chapter provides a secondary research exploration and understanding of the diverse and rich Kenyan cultural tribal groups. It focuses on cultural issues that perhaps may have an impact on HIV/AIDs related programmes among the various diverse tribal groups of Kenya.

## **Chapter Two: The Kenyan Cultural Context**

### **2.0 Introduction**

This chapter gives a secondary literature review exploration of Kenyan tribal groups. It particularly focuses on context, cultural norms, practices and beliefs that could be fuelling the HIV/AIDS situation in Kenya. Seven major tribal groups and three minor ones are explored for a better understanding of the emic cultural and contextual factors that impact on HIV/AIDS prevention, treatment, managements and related deaths.

### **2.1 Kenya's HIV burden**

The first HIV case was diagnosed in 1984 at Kenyatta National Hospital and the patient was a Ugandan journalist. The political and public's view then, was that HIV was not a big problem for the Kenyans since they mainly associated it with the neighbouring Ugandans. This early period of the 1980s also had HIV mainly associated with the homosexuals of the USA, explaining the perception that Kenyans held that HIV is a disease of the gay westerners (Kwena, 2004). The prevalence of HIV grew from 1984 and peaked to a national prevalence of 13% by 1999. This was when the government under President Moi decided to take action by declaring it a national disaster, more than a decade after the first diagnosis.

The table below shows the upswings and downswings of the HIV/AIDS prevalence burden that Kenya has lived with since 1990s, ranging from as low as 5.1% national burden and peaking to 13.4% in 2000. Sadly, the downswings may be largely explained by HIV/AIDS related deaths rather than lower infection rates. As of 2010, the prevalence stood at 6.2% with over 1.6 million people living with HIV, while in 2013, the national prevalence came down to 5.6% with 1,192,000 people living with the HIV virus (PLWAS). Since 1984, an estimate of over 1.7 million people have died from HIV/AIDS related complications leaving over 1.1million orphaned children (UNAIDS 2012).

**Table 1- National HIV/AIDS prevalence rates- 1990--2013**

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
5.1 %	6.3 %	7.4 %	8.5 %	9.5 %	10.4%	11.2%	11.9 %	12.5 %	13.0 %	13.4 %	13.0 %

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
10.2 %	9.4 %	6.1%	5.9%	5.1%	7.8%	7.4%	7%	6.5%	6.2%	5.6%

Source: Adapted from NASCOP (2003); NACC (2009); KAIS (2012)

Reviews of qualitative and quantitative HIV/AIDS data and information from various agencies in Kenya such as The Government of Kenya/AIDS Control Unit- (GOK), Ministry of Health (MOH), National AIDS Control Council -NACC, (2007b, 2009); Kenya AIDS Indicator Survey- KAIS (2007, 2012) reveal significant HIV/AIDS realities in Kenya.

- a) The gender disparity in the HIV/AIDS infections. HIV prevalence among women aged 15-64 years in 2009 was 8.0% compared to 4.3% in men of the same group (Kenya Bureau of Statistics 2010) and 6.9% compared to 4.4% in men in 2012 (KAIS 2013). Currently, women take 6.5% while men take 4.7% of the HIV/AIDS burden (NACC, 2015). Across all age groups, women have the highest prevalence rates. This means that HIV/AIDS burden is more on the females than the males. NACC (2006) attributes this disparity to traditional deep-rooted gender inequalities, often expressed in violence coercion or physical or emotional sexual intimidation.
- b) Based on the KAIS (2007), it appeared that HIV prevalence was declining in urban areas but not in the rural areas. The 2013 KAIS and NACC 2015 reports indicates that the urban area has overtaken at 6.5%, compared to the 5.1% rural burden. These trends could arguably be explained by cultural beliefs and practices heavily established in the rural set up and carried to the multi ethnic urban Kenyan set-ups.
- c) In Kenya, as in the rest of the world, HIV/AIDS preventive measures include, abstinence, faithfulness among partners, condom use, voluntary counselling and testing- (VCT), prevention of mother to child transmission- (PMCT) and



blood screening. These measures are generic in nature and perhaps fail to recognise cultural and tribal diversity within the Kenyan set up with over 42 ethnic groups.

Surprisingly, knowledge about HIV/AIDS among Kenyans is high. National AIDS Control Council-NACC (2007) contentiously suggests high knowledge and awareness about HIV/AIDS at 98% among women and 99% among men. However, UNAIDS (2012) suggests that comprehensive knowledge especially among women, stands at 58.3%, while young people are less likely to exhibit accurate and comprehensive understanding of how to prevent HIV transmissions (Tegang, et al., 2008). The key challenge has been and still remains translating knowledge to behaviour change and it is worth investigating why it is perhaps difficult to achieve behaviour change in the face of such a deadly virus as HIV that can wreck individuals, families, communities and nations.

This problem of behaviour change can perhaps be understood by appreciating the time honoured cultural beliefs and practices that may influence risky behavioural choices. Cultural information is readily available via oral transmission and gets greater weighting in decision making especially among collectivists. Therefore, the question arises, could cultural forces and heuristics be fuelling the spread of HIV/AIDS in Kenya? Can they explain the lack of behaviour change in the face of the HIV virus? Indeed, the maps below compare the regional distribution of the HIV/AIDS prevalence in Kenya. They clearly suggest the need to understand the underlying issues that account for these regional differences.

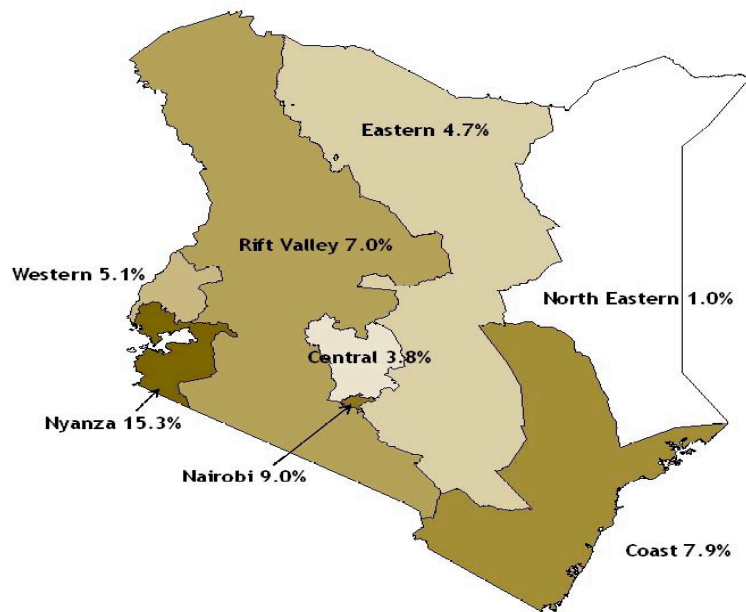


Figure 1- HIV/AIDS burden distribution across Kenya's provinces (2007).

from: [http://www.nacc.or.ke/2007/images/downloads/kais\\_preliminary\\_report\\_july\\_29.pdf](http://www.nacc.or.ke/2007/images/downloads/kais_preliminary_report_july_29.pdf)

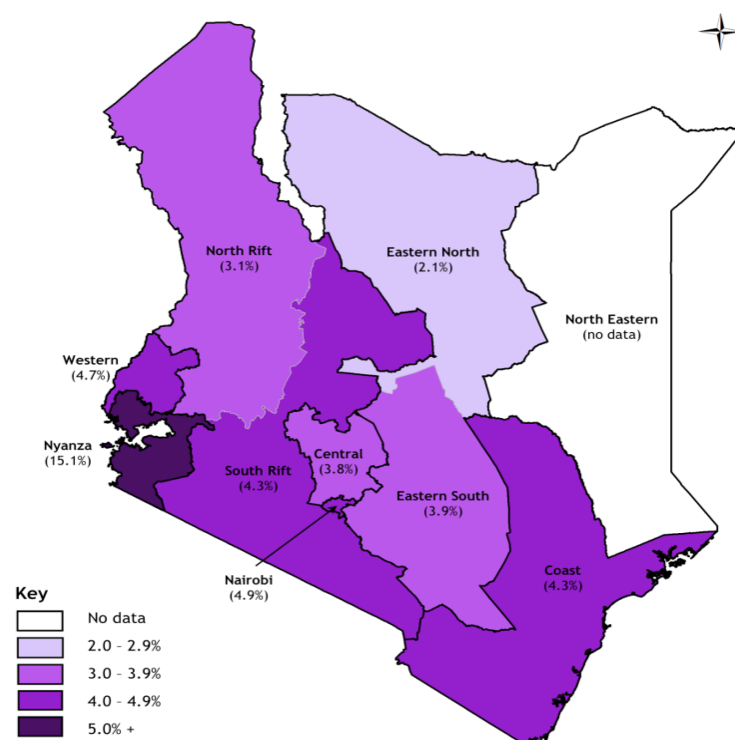
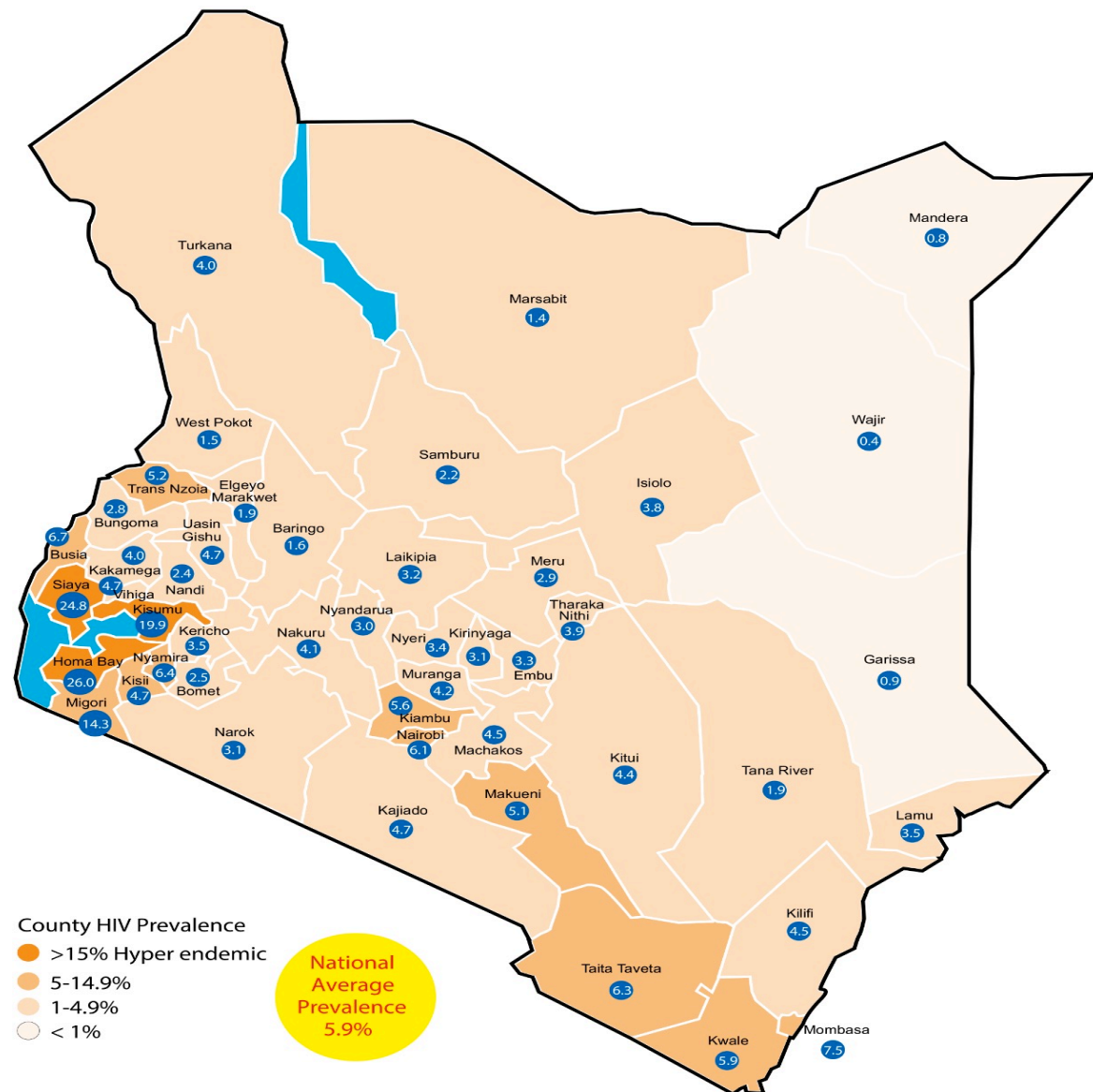


Figure 2- HIV prevalence among 15-64 years age group across Kenya's provinces (2012)

Accessed from: NASCOP region (KAIS 2012)

From the above maps figure 2 and 3, it is clear that Nyanza province was leading in 2007 with 15.3% as well as in 2011 at 15.1%. Nairobi province followed at 9.0% in 2007 and saw a decline to 4.9% in 2011. Coast came next at 7.9% in 2007 and dropped to 4.3% in 2010 then the Great Rift Valley at 7.0% and dropped to 3.7% and Western 5.1% and dropped to 4.7%. Eastern province played it safe at 4.7% and dropped to 3.0%, central 3.8% has remained unchanged with 3.8% in 2010 and the least was North Eastern 1.0%, reduced to 0.9% as at 2010 (KNBS 2010).



**Figure 3- HIV prevalence among 15-64 years age group across Kenya's counties (2016)**

Accessed from: <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>

Kenya's eight provinces were divided into forty-seven (47) counties that represent constituencies and units for devolved government, under the 2010 constitution of Kenya and the county government Act of 2012. However even under the new counties system, Nyanza province the home of counties such as: Homa Bay- 26.0%, Siaya- 24.8%, Kisumu-19.9%, Migori- 14.3%, Nyamira- 6.4% and Kisii- 4.7% still have the highest prevalence rates. North Eastern province home to counties such as: Garissa- 0.9%, Wajir-0.4%, Mandera- 0.8% and Marsabit-1.4%, still have the lowest HIV/AIDS rates.

These regional disparities raise serious questions as to what may be fuelling them. Another question is why some regions had a drop in prevalence rates, could they be attributed to the investment in social marketing approaches targeting HIV/AIDS in those regions and the donor funding for the antiretroviral medication (ARVS)? Could they be explained by the various HIV/AIDS related deaths as indicated by the changes in the ethnic groups demographics indicated by the different censuses in the table shown below?

Census	Kikuyu	Luhya	Luo	Kalenjin	Kamba	Kisii	Meru	Miji kenda	Turkana	Maasai	Other Africans
1999	22%	14%	13%	12%	11%	6%	6%	3.7%	1.3%	1.8%	6%
2009	15%	12.4%	9.4%	11.5%	9.05%	5.0%	3.9%	4.6%	2.3%	2.1%	2%

**Table 2-Kenya's ethnic groups demographic percentages in 1999 and 2009 censuses.**

Source (CIA World Fact 2011 and KNBS 2011)- 2.5

These regional discrepancies point to the need of understanding the cultural nuances of these ethnic groups that live in different provinces of Kenya. This knowledge may aid in understanding how their cultures and context impact on HIV/AIDS spreading, treatment and management.

## **2.2 An overview of culture**

Culture is a complex and slippery concept that defies description, yet too fundamental to be solved through tight definitions (Hofstede, 1983; Tayeb, 1994). There are as many meanings of culture as possibly individuals and disciplines using the term (Ajiferuke and Boddewyn, 1970). From a behaviourist point of view, culture is a set

of schedules of reinforcement as suggested by Skinner (1981). Culture reinforces behaviour based on what may be positively or negatively reinforced punished or disapproved. Culture is to society what memory is to individuals as alleged by Kluckhohn (1954). It encompasses the way people have learned to look at their environment and themselves and their unstated assumptions about the way, the world is and how they should act. It imposes a set of lenses for seeing the world, however it is super organic in a way that members come and go but culture remains. Herskovits (1955) taking an anthropological view suggests that culture is the human made part of the environment. Kroeber and Kluckhohn (1952) view culture as consisting of explicit and implicit patterns of behaviour, mainly acquired and transmitted via symbols that constitute distinctive achievements of human groups. They suggest that culture includes artefacts, ideas, traditions and systems.

Mazrui (1986) views culture as a system of interrelated values that may be active enough to influence and condition important aspects of life such as perception, judgment, communication and behaviour in a given society. Hofstede (1980, 1991) from an engineering point of view compares culture to computer software and suggests that culture is the software of the mind. He clarified his view further in 1994 by equating culture to the collective programming of the mind that distinguishes members of one group or a category of people from another.

Culture may also be viewed as a set of the human made objective and subjective elements shared via a common language; that from the past have explained and increased the human's probability of survival and helped them find satisfaction for the participants within an ecological niche (Triandis, 1994). This view relates to shared beliefs, values, attitudes and expectations about appropriate ways to behave held by members of a social group that helps them survive.

All the above perspectives of culture are very important as they clearly point to the critical place of culture in perpetuating and supporting human survival and adaptation within their geographical mapping. Brislin (2000) suggested twelve critical features after considering the many definitions of culture; that possibly should guide any endeavour to understand cultural nuances of any given society or group of people. He suggests that culture firstly consists of assumptions about life consisting of ideals,

values and assumptions about life widely shared that guide specific behaviours. They are largely invisible elements.

Secondly, culture is created by people as a person made part of the environment emphasising on peoples' responses to the environment. Thirdly, it is transmitted from generation to generation based on what is considered socially acceptable. Fourthly, experiences during childhood are important in cultivating culture. Fifthly, culture is not widely discussed because it is based on shared values. Sixthly, well-meaning clashes occur when different cultures meet because of the shared values feature and emotional reaction to its violation or neglect.

Seventhly, culture allows people to fill in the blanks based on their shared knowledge taken for granted, which outsiders may find difficult to comprehend. Eighth, cultural values remain despite mistakes or exceptional issues that may conflict with them. Ninth, people react emotionally when observing violations of the culture and tenth, cultural values experience acceptance and rejection over time in peoples' lives. Eleventh, culture cannot experience a faster change in that; it takes time to change or for people to accept changes and lastly cultures can be summarised in sharp contrasts that differentiate behaviour in one society compared to another like in time, spatial orientation and distinction between high and low contexts.

In trying to understand culture, there is the need to understand both the objective aspects such as the tools that are visible and subjective aspects like norms and values that are invisible (Triandis, 1994). Cultures differ in some cultures that are more complex than others, others have social experiences that are structured around autonomous individuals, while others are organised around one or more collectives like tribe, religious group, tribe or even country. Others impose norms rules and contracts loosely and others tightly based on the cultural syndromes suggested by Triandis (1994).

In relation to why individuals behave the way they do, individual behaviour may be viewed as a product of cultural, biological and ecological factors that intermix depending on the situation in question. Ecology refers to where people live; consisting of objects resources and the geography of the environment and the way one can make a living and survive. Berry (1979) argues that ecology shapes the cultures that emerge and in turn culture shapes particular kinds of behaviours. Human beings like to be in

control of their environment. Triandis (1994) suggests that culture increases human senses of control over the environment. It provides humans with cultural aspects such as firstly, customs that make social environment more predictable. Secondly, myths and magic that give individuals a sense of control over the present and the future. Thirdly, norms that tell individuals what behaviours have worked well in the past, giving them certainty that they will work again in the future. Fourthly, values direct individuals to goals and aspects that they should pay attention to and try to reach. They also serve as a behavioural evaluation tool for individuals within a society.

In order to understand the members of a culture, Georgas (1989) suggests that we need to consider the entire range of influences that impact their culture and behaviour. This ranges from their ecology, social organisation, community, family and personality as well as the behaviour setting. To understand the cultural nuances that may impact HIV/AIDS spreading, management and treatment in Kenya, it is therefore important to explore cultural and contextual nuances of the tribal groups living in the eight former provinces of Kenya. The nuances are viewed as either enablers or barriers. Barriers refer to something that makes it difficult for people to understand each other (Merriam-Webster dictionary, 2016). In this study, barrier refers to issues that make HIV/AIDS related programmes difficult or impossible. While enabler refers to one that enables another to achieve an end from the word enable, that means to make (something) possible, practical or easy (Merriam-Webster dictionary, 2016). In this study, enablers refer to issues that make HIV/AIDS related programmes possible, practical or easy.

## **2.3 Major ethnic groups in Kenya- A cultural perspective**

### **2.3.1 (a) Kikuyus- 15.4%**

The Kikuyu social and economic way of life has been well described by Kershaw (1973) and Berg-Schlosser (1982). The Kikuyu forms the largest ethnic group in Kenya and mainly live in the central province in areas like Kiambu, Muranga, Nyeri, Nyandarua and Kirinyaga. Berg-Schlosser (1982) suggests myths have it that in the past, their women practised polyandry and dominated all Kikuyu families. They however became too domineering and men revolted by making most of them

pregnant. In the weakened state, men overthrew them and domineered and as a result polygyny instead of polyandry became a common form of marriage. This practice of Polygyny may possibly be considered a risky behaviour and significant for the spread of HIV/AIDs. The presence and the nature of a partner's casual or extramarital sexual practices largely determine the risk of HIV transmission (Ahlberg, et al., 1997). Polygyny is a form of cultural license for the Kikuyu men to have as many women as their sexual partners, greatly increasing the HIV infection risk for themselves and their sexual networks.

Land is very central to them and communion with the spirits is through contact with the soil where ancestors are buried. Sons, not daughters or wives, traditionally inherited land. Indeed, brothers to the husband could inherit land, in case a married woman did not have sons. Traditionally, no land was to be passed on to a woman under their strict patriarchal society. This system discriminates against women and may force them to get married to gain access to land to cultivate food crops for themselves and their family. Marriages to philandering husbands heightened women's risk to the HIV virus.

Premarital pregnancy meant that the girl could only be married as a 2<sup>nd</sup>, 3<sup>rd</sup> or nth wife rather than as a first wife, while the boy involved had to pay fines to the girl's parents. Serious cases, where a man violently raped a girl or woman, were punishable by death. Premarital pregnancy to date is viewed with much stigma. It is a cultural licence to unhappy marriage for the girls, as they have to be married to older men who may have experimented with many other women. This greatly encourages cross-generational sex, greatly exposing the young girls to the HIV virus.

After marriage, women were expected to get pregnant and abstain from sex until the child was 2.5 to 3.5 years. The whole idea behind the culturally imposed abstinence was based on the belief that sex was meant for the pleasure of men and only for procreation by women. This belief justified the need for men to marry as many wives in order to satisfy their sexual needs when their other wives were pregnant. It also connoted males' cultural and sexual dominance over females.



Kershaw (1973) explains another interesting practice, where men had the right to give an honoured age mates access to his wives, if the wives consented to the practice. Indeed, the women had very little choice on cultural basis; they were expected to unquestionably obey their husbands. If it is still practiced, it may be seen as a risky behaviour, significant in the spread of HIV/AIDS.

Traditionally, whenever a married man died, his brothers or relatives inherited his wives and any children they begot, belonged to the deceased husband and not the inheritor. The practice of women being inherited was mainly done to give them access to agricultural land, as traditionally they were not allowed to own any. Wife inheritance is still a common practice to date. Barren wealthy widowed could marry other women to bear children for them. Interestingly, the wealthy widow was regarded as the 'husband' of the fertile woman/women. She allowed the 'wife/wives' to have children with males of their choice. Much as it is not common, this practice still exists to date.

Boys were initiated at age 16-22; latest being 25 years when they became '*anake*'. This was done every 4-5 years to form age sets groups. Male circumcision is still very central to the Kikuyus. The practice has however been modernised and instead of the traditional unhygienic ways, many parents prefer the use of sterilised surgical tools and take their boys to hospitals.

An initiated man - '*mwanake*' was traditionally expected to have sexual relations with unmarried girls as he searched for a suitable wife. Men had to pay bride price- '*ruracio*' before marrying any wife. A man without a son was given low status and culturally allowed to marry multiple wives in the hope of siring a son. Sons were highly valued as they inherited their fathers' wealth and took care of them when they became weak due to old age. Interestingly, searching for a son is a common reason given for extra marital sexual relations and gender-related violence.

Sexual perversion like sodomy was regarded as a severe violation of the moral code. Cleanliness '*utheru*' was demanded for good relationship with ancestors and their deity '*Ngai*' hence sodomy was punishable by death. Homosexuality was culturally considered a taboo, however in the modern times, gay men and lesbian women are a lot in numbers among the Kikuyus.

However, due to the stigma attached to such practices, homosexuals operate in secret and many of them, usually, are afraid to even seek medical help for the fear of ridicule and stigma.

Death was accepted as a decision made by ancestors to recall the living soul to the spirit world. Kikuyus believed that the dead person would reincarnate and return to the living in any form such as animals, new-borns or insects or whatever form they chose (Kershaw, 1973). This acceptance of death as the will of ancestors certainly is significant to HIV/AIDS. This ancestral acceptance of death becomes a veil or a shield that hinders appropriate response to behaviour change.

The Kikuyu religion played complete cosmology by explaining man's existence, social order and life after death among other life mysteries. They believed in a single deity '*Ngai*'. They believed that ancestors participated in all aspects of family life and people sought their advice as often as it was necessary via diviners - '*murathi*' and medicinemen - '*mundu-mugo*'. Their religion allowed for polygyny unlike Christianity that advocates for monogamy.

Berg-Schlosser (1982) claims that missionaries found practices like polygyny and female circumcision difficult to deal with, despite many Kikuyus converting to Christianity. As a result, many Kikuyus formed independent churches that were hybrids of their traditional beliefs and Christianity in their quest to preserve their time honoured cultural practices. Indeed, many Christians struggle with the concept of celibacy, monogamy and marital faithfulness, greatly exposing themselves to the HIV virus.

The Kikuyus are considered violent even in ordinary situations and wife battery is common, as a wife disciplining measure. This wife battery emphasises the low status accorded to women and is significant to HIV/AIDS as sexual violence greatly increase women's risk to the HIV virus.

A summary of the key cultural barriers and enablers in as far as HIV/AIDS matters are concerned amongst Kikuyus are highlighted in table 3 below.

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Cultural acceptance of premarital sex among the circumcised boys	Cultural belief that prohibits pre-marital sex for girls
Polygyny- giving males access to many wives and concubines	Cultural belief of punishing rapists severely
Males inheriting property not females due to their patriarchal system	Belief in medicine men that encourages treatment of diseases
Pregnancy related sexual abstinence from 6 months until the child is 2.5 - 3.5 years that perpetuated polygamy	Shift from the traditional religion to Christianity
Sharing of wives with ‘honoured age mates’.	Sterilised male circumcision
In cases of sterility, sharing of wives with different men in the hope of conception.	Age set aligned communication on sensitive matters
Search for the preferred male children with different women.	
Tabooing of sodomy and lesbianism, punishable by death, greatly increasing stigma against homosexuals	
Tabooing of pre-marital pregnancy and condemning the girl to marriage to older men as 2 <sup>nd</sup> , 3 <sup>rd</sup> or nth wife.	
Acceptance of death as ancestors wish	
Violence against women viewed as part of disciplining them	
Belief in witchcraft	
Tabooed discussion on sexual matters	

Culturally accepted extra marital sexual relations
--

**Table 3- Key cultural barriers and enablers in the spread of HIV/AIDS among the Kikuyu's of Kenya**

The bone of contention is, “Do programmers ever consider these critical cultural and contextual enablers and challenges to HIV/AIDS in their programmes at all? Gleaning this information from the programmers is crucial.

### **2.3.2 (b) Luyia- 12.4%**

They are numerically the largest Bantu speakers in Western Province of Kenya compared to other western Bantus like Kisiis and Kurias. Distinctively, they are not as homogeneous as other Kenyan groups in their language cultural beliefs and practices. They mainly live in Bungoma, Busia, Kakamega and many other locations especially, the urban areas in Kenya like Nairobi and Mombasa (Berg-Schlosser (1982). The Western region is quite significant in relation to HIV/AIDs as Nyanza bears the largest share of HIV/AIDS burden in Kenya at 15.1% and Western at 4.7% (NACC 2014).

Their region, being densely populated, certainly means that the land is scarce and people have small portions of land to subsist on. The high poverty levels and lack of land arguably explains their high outmigration to urban areas like Nairobi and Mombasa in search of better lives. Unfortunately, due to the high illiteracy levels compounded by poverty, many of them live in the informal settlements or slums of cities such as Kibera, Korogocho and other slums in cities that are known hotbeds for HIV/AIDS infections.

Similar to other Kenyan ethnic patriarchal groups, land was inherited by male descendants. Traditionally, Luyias had age sets and circumcision was a major rite of passage to adulthood among all their sub groups. Unlike many of the other Kenyan ethnic groups, circumcision was distinctively only for boys and not girls at the age of 18-20 years of full physical and mental maturity. It was mainly done every 3-4 years to sustain the age set system. In sharp contrast to the girls’ expectation of virginity

before marriage, no value was attached to premarital chastity of boys after circumcision. They were culturally allowed to have sexual relations with girls in the girls dormitories or in the bush, as long as it was done in secrecy and did not result in pregnancy, since ruining a girl's chastity in life was frowned upon and punished (Lukalo, 1973). This cultural practice may be important to HIV infections as it points to the gender inequalities and unrealistic virginity expectations placed on the girls and not the boys.

Girls over seven years of age spent nights in elderly couple or widows' houses entrusted with their care and sex education. Customarily, parents were not supposed to instruct children on sexual education during puberty. To date, parents find it difficult to instruct their children on growth, maturity and sexual matters, leaving sex education to chance, greatly disadvantaging their children.

Traditionally, pre-marital sex among girls was highly discouraged as a high bride price was placed on a bride's virginity. After marriage, extramarital sex was not allowed except in cases of suspected sterility, where secretly the husband's brother or cousin could help the woman beget children.

In sharp contrast to many ethnic societies in Kenya, the Maragolis were monogamous and polygyny resulted from necessity like when the first wife failed to have children. This is indeed a cultural positive in relation to HIV/AIDS. Men were culturally not expected to have extramarital relations although it happened secretly. However, if a married man made an unmarried girl pregnant, he was forced to marry her or give a fine. Similarly, women were expected to be faithful and if they got a child outside wedlock, their husbands had the right to reject them and the father of the child was meant to re-marry the woman.

Matters of sex, conception and childbirth were tabooed, not meant for open discussion and were only discussed by closely related individuals, husband and wife or same age group members. Young unmarried men and women could talk about sex privately. Surprisingly, probably due to their strict sexual morals, sodomy was practiced occasionally, although it was highly sanctioned as it caused uncleanness that required ritual cleansing.

While discussing family planning as an innovation among the Maragoli people, Lukalo (1974) asserts that to effectively communicate with them, males should approach males, females approach females and notes that they are good at arguing and criticising. But when they get the point and accept it, they stick to it and defend it. She highlights the key role of teachers in communicating innovation, probably significant to social marketing programmes, as education and educated individuals are highly valued and respected. She emphasises on the role of bush telegraphy as an efficient means of communication due to the power of gossip among them. This bush telegraphy may be a useful social marketing channel that social marketers may explore. Certainly, the Luyias have cultural enablers and barriers that social marketers targeting HIV/AIDs perhaps need to engage with. The extent to which social marketers make use of this cultural knowledge is certainly a bone of contention that needs further gleaning.

A summary of cultural enablers and barriers in as far as HIV/AIDS issues are concerned are summarised in the table 4 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
No value attached to male chastity	Priced female virginity-rewarded with the largest bull in the groom's herd.
Patriarchal belief in male inheritance	Do not practise FGM and old widows huts used for girl's sex education
Cynical view of females refusal to sexual consent (the belief that girls/women mean yes even when they say no)	Cultural strong belief against extra marital sex
Relatives search and approval of a bride	Cultural belief in monogamous marriages except in cases of sterility
Pregnancy related sexual abstinence from 5 <sup>th</sup> month to when the top teeth of the baby	Age set and gender aligned discussions on sex, conception

cut.	and birth related issues.
Tabooed discussion on sex, conception, birth related issues	Belief in medicine men
Attributing and blaming sterility on women	Male circumcision
Strong belief in witchcraft and magic	Respect for education and educated individuals.
High out-migration to urban areas.	Great love for soccer/football.

**Table 4- Key cultural barriers and enablers in the spread of HIV/AIDS among the Luyia's of Kenya.**

### **2.3.3 (c) The Luos- 9.4%**

The Luos are grouped as western Nilotes with more than 30 sub tribes (piny) and mainly occupy the eastern part of Lake Victoria. Their land is not as fertile as the neighbouring Kericho and Kisii land and some areas like Siaya are swampy, infested with tsetse-flies and not suitable for human or animal settlement. The Luos mainly occupy Nyanza province of Kenya in Kisumu and Siaya districts, as well as south Nyanza and Homabay area alongside Bantus like the Kisiis and Kuria. Nyanza province has the highest HIV/AIDs prevalence at 15.1% in Kenya (KAIS, 2014).

Nyanza province is highly populated and often the Luos migrate to urban centres such as Mombasa, Nairobi and other Kenyan towns (Berg-Scholsse, 1982). Nilotes in Kenya mainly pursue a pastoral lifestyle, however due to their proximity to the Lake Victoria waters, many of the Luos are fishermen. Fishing communities are indeed regarded as high-risk group in relation to HIV/AIDS. This is due to their risky and lonely nightly ventures in waters, low status in society and a risky form of exchange where they trade fish for sex with many female fish mongers who fight to get the best fish to sell to earn their living (Kwena, et al., 2010).

The Luos have no clear-cut systems of age grades. Different stages of lifecycle are individuals' and immediate family's matters and not the society's concern. This is unlike most of the other Kenyan ethnic groups that had age sets based on circumcision as a rite of passage from childhood to adulthood. This may be explained

by the fact that the Luos and the Turkanas are among the only Kenyan ethnic groups that culturally did not practise either male or female circumcision.

Polygyny is commonly practised and authority is mainly vested within families and lineages. Fathers are in charge of families and succeeded by their eldest sons or male relative but never the females. Male children are preferred and any man without a son is mainly considered unlucky and unfortunate. It was culturally believed that such men could not take their place among ancestors after death, unless their relatives performed special rituals. Generally, a few daughters were desired for the bride wealth, they brought to the families and their role in assisting in the garden and household chores (Blount, 1973).

Barrenness was mainly blamed on women; as male sterility was alien to Luos. Men were culturally allowed to marry as many wives as they wanted. When women could not bear any children, the husband had to be compensated by returning the bride price paid to the girl's parents. Other times, the younger sister of the wife was forcibly given to the man in compensation. This meant that the women together with their families had the responsibility of ensuring that they became pregnant by whatever means possible, to avoid embarrassing their families.

Among the Luos, adolescent girls slept under the guardianship of an old woman or a widow, with the status of a grandma or older wife in huts known as *siwidhe*. The old lady had a batch of girls under her care. She was responsible for their sex education. Older girls and those who had been married off frequently visited the hut and were a good source of information for the younger girls in the hut. Parents of the girls were anxious about the whereabouts of their daughters, however they were not meant to interfere with the '*siwidhe*' institution. Modernisation means that the '*Siwidhe*' institution has died down.

At the age of 13-14 years' boys had their own huts '*simba*' in their fathers' compound and interestingly premarital sex for boys has never really been sanctioned. It was permitted on condition that it was done discreetly and the girl involved was not a kinsman belonging to the boys' fathers' side, in line with patriarchal lineages to avoid incestuous relations (Blount 1973).



Girls were, however, not culturally allowed to give birth before marriage, and when pregnancy occurred, the girl's parents were required to forcefully take them to the home of the child's father. Interestingly, a girl's virginity was highly priced among the Luos. Customarily, the bridegroom parted with the fattest cow from his father's herd, after appointed family members (married bride's sister/cousin and married groom's brother/cousin) ascertained a bride's virginity on her wedding night (Parkin, 1973).

Culturally, there were no strong sanctions against extra marital sex for the married men as long as they avoided incestuous relations. The Luo men sought extra marital sex from both the married and unmarried women. Surprisingly, extra marital relations did occur between kinsmen as long as caution was taken, like coitus interruption to avoid pregnancy.

Brothers or male relatives of the husband inherited widows after a sexual cleansing ritual. The cleansing ritual involved a cleanser having sex with the widow, before the inheritor could inherit her (Ocholla-Ayayo and Schwarz, 1991). Sexual cleansing was culturally explained as a way of freeing the widowed women from the spirits of their deceased husbands, so that they could fulfil their day-to-day routines (Ayikukwei, et al., 2007). It is important to note that ritual sexual relations are very central to the day-to-day activities among the Luos. A woman cannot cultivate, weed or harvest crops before having sexual relations. The widows' cleansing was therefore important to enable them to get a sexual partner for the continuity of their normal lives (Kenya, et al., 1998).

The women that refused to be cleansed are ostracised, taunted and humiliated by their clans. Culturally, they were not allowed to remarry, get pregnant and give birth to children. They are regarded as being responsible for misfortunes that befall on their immediate and extended families, due to their disobedience to cultural and ancestral dictates thereby attracting their wrath (Keenan et al., 2004). Rituals of sexual cleansing greatly increase the spread of HIV. They encourage indiscriminate unprotected sexual relationships with multiple partners with unknown or known sexual histories and networks.

Luos are well known for holding extravagant funerals. They are also known for their characteristic public emotional displays and hiring of professional wailers/ mourners in honour of the departed souls. Funerals are usually very expensive and involve the travelling of many relatives from urban centres to their rural land. These expensive funerals last for at least seven days.

The Luos usually hold *disco matanga* (funeral discos) that bring many youths and other members of the community together to mourn and pay respect to the deceased before burial. Alcohol is served during these discos and significantly, there are a lot of sexual activities that take place in these overnight *matanga* discos, greatly exposing individuals to the HIV virus. These expensive burial rites and *disco matangas* present challenges and opportunities for social marketers.

In regard to effective communication, Southhall (1973) claims that while communicating family planning, a delicate issue like HIV/AIDS, understanding the culture and language of the Luos is important. He further emphasises the need to discuss such delicate issues with each gender separately. It is also important to consider the ages of the target groups, as age mates were free to discuss intimate sexual issues freely.

Blount (1973) contends that for an innovation to be successful among the Luos, it would need to be introduced by more prestigious and influential men in the community. It should be done based on the age and gender considerations, as women have a low status. He also highlights the need to recognise elders, for any acceptance of the innovation is to take place in the rural set up. Parking (1973) contends that herbalism and ritual therapy do seem to constitute a single important traditional institutional sphere through which new ideas can be introduced. Channels of communication via kins or affines would be more fruitful, as kinship is highly valued among the Luos. It is important to glean and understand from programmers using the social marketing approaches in HIV/AIDS related interventions, how they engage and deal with these key cultural barriers, enablers and challenges in their programme work.

A summary of key cultural barriers and enablers relating to HIV/AIDS among the Luos of Kenya are tabulated in the table 5 shown below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Lack of culturally driven and accepted practice of male circumcision	Girls had the ‘siwidhe’ institution headed by the grandmothers for their sex education
Belief in polygyny	Female virginity highly priced and rewarded
Male kids preference	Belief in medicine men
Male children inheriting their fathers and never daughters	Respect for elders
Strong belief in witchcraft and evil eyes	Respect for prestigious and influential people in regard to effective communication.
Cultural acceptance of premarital sex for boys while demanding virginity for girls.	Strongly knit group along family lines. Family members are quite influential.
Extra marital sex allowed even among kinsmen as long as there is no pregnancy	
Widow inheritance and widow cleansing rituals	
Expensive funerals	
Blaming barrenness on women only	
Low status given to women	
Break down of the ‘siwidhe’ institution while parents were not culturally allowed to give any sexual education to their children.	

**Table 5- Key cultural barriers and enablers in the spread of HIV/AIDS among the Luo's of Kenya.**

#### **2.3.4. (d). The Kalenjins - 11.5%**

The Kalenjins belong to the Nandi Nilotic speaking group and live in the Rift Valley province of Kenya. The Nandis' live in the Elgoyo and Nandi escarpment, while the Tugen, Keiyo, Marakwet and Pokot groups live in the unfertile part of the Rift Valley, although the Keiyos and Marakwets have strips of fertile land.

It is worth noting that the Nandis offered a strong resistance to colonial rule but were eventually subdued, probably explaining their keen interest in the politics of Kenya. Huntingford (1973) asserts that the Kalenjins held hostility towards other ethnic groups including the Kikuyus, Luos and Luyias among other groups. This hostility possibly can be explained by the land tenure system injustices. The Kalenjins had a communal land ownership with tribal reserves of the white highlands of the Transzoia, Uasin Gishu and Laikipia, which were taken over by other ethnic groups after independence under Jomo Kenyatta's (a Kikuyu) regime (Berg-Schlosser, 1982). The Kalenjins were greatly incensed by the foreign occupation of their communal land, explaining the root of ethnic violence in the Rift Valley between the Kalenjins and the Kikuyus groups, which climaxed in post-election violence in 2007. This led to the internally displaced persons living in risky overcrowded camps, prone to sexual violence and exposing them to HIV risk.

Boys- *ngetter* from birth were expected to live with their mothers and later moved on to the unmarried men's hut on the onset of puberty, where they lived with their brothers and other *murenets- worriers*. Boys were secluded for a month after circumcision between the ages 20-30 year, where they were given proper sex education in groups of 4-5 by senior age sets. A distinction was made by the Pokot that circumcised their boys at puberty; however, the initiation into adulthood occurred several years later. After circumcision, they were allowed free-range sexual relations with both circumcised and uncircumcised girls and a special girl- *mureret* of their own.

Young Tugen girls learnt a great deal of sex education from observing animals. They experimented sexually with uncircumcised boys. Although, this was considered inappropriate and when found they were thoroughly beaten (Huntingford, 1973). After puberty, the mother informed her daughter that she was fertile and would get

pregnant if she 'played' around with boys. This introduction to sex education by a mother is significant because unlike other Kenyan ethnic groups, the mother was not supposed to engage in her daughter's sex education. A grandmother would later caution girls if they did not stop sleeping around with boys, following the warning from the mothers.

At puberty, the girls were instructed on sex education, domestic issues and housekeeping by their mothers and grandparents together with members of the mothers' and grandmothers' age groups. These instructions were given to the entire batch of girls being circumcised. Kettel (1973) suggests that many Tugen men refuse to marry girls with whom they have not had sexual relations. Some run through a string of girlfriends before finally settling to marry one and unfortunately they usually reject any children born out of such alliances. This means that culturally, men are given a premarital sexual licence that they selfishly use to exploit young girls sexually, while deceiving them that they may possibly marry them after the sexual experiences. In other cases, hasty circumcisions and marriages were done to avert the awful fate of the girl when they got pregnant.

Sexual relations after marriage were quite complex. Married women were allowed to have sexual relations with their husbands, members of the husbands' age set and their former lovers. When a former lover visited a married woman's hut, he was supposed to stick or 'plant' his spear on the ground outside the woman's hut. The spear was a warning sign, that should any other member of the husband's age set or should the real husband come along, they would know that sexual relations were going on inside the hut and wait outside until the spear had been taken away, before entering the woman's hut. This was indeed an interesting form of hospitality accorded to the fellow age mates and former lovers of the girl. The wife sharing cultural practice and its social acceptance presents a complex sexual network for HIV virus and other STIs to spread.

Child marriages sadly did exist where a poor man could give his young daughter away to an old man to acquire cattle, probably to fetch his son the bride price to get married. The small girl was looked after by the man's other wives until she was circumcised, after which she began sexual relations with her husband. However, if she got pregnant before circumcision, she had to be circumcised immediately (Huntingford, 1973).

A worrying practice noted by Kettel (1973) was that medical decisions among the Tugens were not made until the last minute when a person or child was extremely sick. This was mainly due to the negative attitude held by the medical officers towards Kalenjins. They regarded them as simpletons, uninformed and ignorant about prevention and treatment of diseases. This attitude towards delayed medical intervention possibly presents a social marketing agenda. Their belief in witchcraft and medicine men is consistent with other Kenyan ethnic groups, although it may be considered weaker than that of the Luos and the Luyias groups.

In terms of strategic communication, Huntingford (1973) notes that local knowledge of language is important to explain issues sensitively as well as being sensitive to respect issues in relation to age, position in kinship and age set system. He also contends that Kalenjins regard foreigners as 'slightly mad', hence the need for tact when a foreigner is communicating with them. Kettel (1973) asserts that women should communicate with women while men communicate with men. A woman communicating with men would not be taken seriously and instead would receive sexual advances from the audience. The extent to which social marketers targeting HIV/AIDs among the Kalenjins engage with these cultural realities warrants further gleaning.

A summary of the possible cultural enablers and barriers in relation to HIV/AIDS among the Kalenjins is summarised in table 6 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Cultural license to premarital sex in the Muranet-mureret institution and free range sex for boys after circumcision	Male circumcision when done using sterilised tools

Female circumcision	Sex education for the girls was given by the mother and later the grandmothers
Culturally allowed early childhood marriages for girls even before circumcision to old men for bride price.	Communication on sensitive issues mainly based on gender and age set considerations
Violence targeted at women/girls popular among the Tugens if women became unfaithful	
Culturally licensed extra marital sexual affairs after marriage with the husbands age set members and former lovers of the girl in the 'spear planting' culture	
Culturally imposed sexual abstinence periods following pregnancy and birth.	
Killing of children born as a result of premarital sex before the girl was circumcised	
Male children inheriting their fathers wealth	
Low status of the women	
Polygyny	
Belief in witchcraft	
Falsehoods and myths surrounding sexuality and conception.	

**Table 6- Key cultural barriers and enablers in the spread of HIV/AIDS among the Kalenjin's of Kenya.**

### 2.3.5 (e). Kambas 9.05%

They are Eastern Bantus speakers, mainly occupying Machakos and Kitui districts of the Eastern Province of Kenya. Machakos is relatively fertile while Kitui is quite dry with inadequate rainfall for agriculture and prone to famine.

They are also well known for their craftsmanship in wood as well as soap mask carvings and sculptures. Unlike the Kikuyu ethnic group that staged a fierce resistance to colonial rule, the Kambas were friendly to the British. This explains their high numbers in the armed forces and police force in Kenya to date.

The Kambas are patrilineal just like other Kenyan tribes. They, however, differ in that when a family head died, wives could and can inherit land and later pass it on to their sons. Traditionally, any sonless family could easily adopt a son or wealthy women could marry other younger women to bear sons for them. The fact that women could inherit resources from their husbands meant that unlike in many other Kenyan ethnic groups, the status of a woman among the Kambas is not too low.

They circumcised their small boys at the age of 5-6 years in what they called the small circumcision- '*nzaiko ila nini*' every year during the dry season. After puberty, the young boys were ritually initiated into adulthood in the big circumcision- '*nzaiko ila nene*'. Circumcision of boys was and still is very important, as uncircumcised boys were not allowed to marry, get kids, participate in any rituals or inherit any property. They also practiced female circumcisions although it is dwindling with time.

Pre-marital sex for boys was allowed, although it was not expected to result in pregnancy. Pre-marital pregnancy brought shame on the girls' families, however in sharp contrast to other Kenyan ethnic groups, the girl was eventually accepted by the family with her baby and had no trouble in finding a husband or getting married even as a first wife, as her fertility had already been proven (Mbiti, 1973).

Religion was very important to the Kambas and affected every sphere of their lives. They believed in *Ngai*, their supreme deity that lived in *Ituni* -heaven, mountains and certain trees. He was not expected to be bothered unless in times of crisis. The males/sons of the departed living dead give them food and poured out libations. This explains the preference for sons in every family to pour libations for their fathers



upon their demise (Mbiti, 1973). The *aimus*-spirits had to be well taken care of to prevent them from bringing misfortunes to the living. Protection from sorcerers was sought from *mundu mue* who gave anti magical devices and charms that individuals wore around the neck and wrists.

Sex was restricted to the circumcised and married individuals, however circumcised boys and girls often engaged in dance (*mbathi*) and experimented sexually during the dances intermission (*mulinga*) as suggested by Ndeti (1973). Any pregnancies that arose as a result of these intermissions were taken as the will of God, although such kids carried stigma and the mother was not well respected. In cases of sterility, medicine men were consulted and if the consultation was not successful, practical measures were taken. A husband's brother or close relative (*musina*) - translated as the 'burner' could impregnate the wife to sire children for the sterile brother in secrecy, to avoid sterility shame on the brother. This led to the popular belief that men were never barren.

After marriage, sex was stopped around the fifth month of pregnancy until the birth and was also expected to cease with the onset of menopause (Ueda, 1973). Culturally allowed polygyny took care of such culturally imposed abstinence periods as the men had access to other wives and girlfriends.

Kamba men and women are known for their great innovation in sexual matters, thereby referred to as the sex kings and queens of Kenya. This title means that other ethnic groups are keen to experience their sexual expertise, significantly exposing themselves and other communities to the HIV virus.

Ndeti (1973) underscores the need to communicate to both the men and women separately, and the need to involve extended family such as grandparents and other close kinships in crucial health discussions to avoid social pressure. She further explains the need for a good understanding of a subject by the educator to clearly educate people and knowledgeably deal with their questions, to avoid any cynicism that may be attributed to the inadequate knowledge evidenced by the educator.

In relation to communication, Kambas took the help of intermediaries who acted on their behalf when delivering important messages. They mainly took the help of elder-*mutumia*, individuals, well known for diplomacy and shrewd character (Ndeti, 1973).

Kambas and other Kenyan ethnic groups commonly use euphemism to convey sexual images. For instance, when wooing a woman for sex, a man may ask the woman to help him with some ‘tobacco snuff’ since sexual matters were not freely discussed to avoid sounding vulgar. The extent to which social marketers use this cultural knowledge in their programme work is an interesting area to explore.

A summary of key cultural barriers and enablers relating to HIV/AIDS among the Kambas are summarised in table 7 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Cultural acceptance of premarital sex among boys and girls.	Wives inherited their dead husbands’ property and later passed them on to their sons.
Strong belief in witchcraft	Relatively higher status accorded to women compared to other Kenyan tribal groups.
In case of sterility- the use of ‘musina’ to help the sterile men’s wives conceive	Male circumcision
Practice of polygyny	Sex education for the girls given by the mother and the grandmothers
Culturally prescribed Pregnancy and lactation related sexual abstinence periods	Premarital pregnancy taken positively as a prove of fertility rather than a life condemnation- girls could still find suitable suitors
Tabooed discussions of sexual matters- mainly use euphemism	Communication respected along gender and age set lines
Elder wealthy women marrying younger women to bear children for them by the help of different lovers.	Culturally accepted use of intermediaries in communication and negotiations

Marrying of the ghosts of the deceased young unmarried man to perpetuate their lineages	Respected medicine men institution
Preference for male children and the vigorous search for them	

**Table 7- Key cultural barriers and enablers in the spread of HIV/AIDs among the Kamba's of Kenya.**

### **2.3.6 (f). Merus - (3.9%)**

The Meru people are Bantu speakers of Eastern province and mainly live in the agriculturally rich Eastern slopes of Mount Kenya. They grow a variety of subsistence and cash crops that include coffee, tea, cotton and Khat-Miraa (a controversial stimulant plant banned within the Eurozone).

Merus believed in their deity- *Murungu* and spirits (*nkoma* or *irundu*). Medicine men (*araguri*) were greatly respected because of their knowledge of natural herbs and medicine. Their divination knowledge was also associated with exorcising of evil spirits (*nkoma*), believed to cause misfortunes.

Boys between ages 5-7 years, usually slept with other small boys in a hut up to senior boyhood. They were circumcised at the age of 20, and then secluded as they healed their wounds. During this seclusion period, they were educated informally on important life issues and sex education. After seclusion, the circumcised boys were culturally expected to engage in pre-marital sex to 'sharpen their swords' and keep them 'sharp' all the time by ensuring that they were sexually active. Their 'sponsors' and older men, in the name of instilling discipline, meted lots of violence on initiated boys while in seclusion, and sadly, many of them died from their injuries.

Surprisingly, part of their sex education included the emphasis on the inferior position of women and the need to be a real man 'cocks' and the need to physically beat women if they disobeyed their orders (Mwambia, 1973). Indeed, the Meru men are known for their high tempers and violent tendencies and well known for wife battering and violence against women as a way of disciplining them. Male circumcision to date is a very important rite of passage among them. However, when not carried out with sterile instruments, it may increase the boys' risk to the HIV virus.

Girls were also circumcised and the rationale of female circumcision was to reduce or tame their libido. The practice was also believed to help women during delivery, contrary to scientific based evidence that it complicates delivery due to scarring involved as the mutilated parts heal. Uncircumcised girls were expected to abstain from sex and when a mother discovered that her daughter was pregnant, aborting assistants' *aruti ba mau* forced the foetus out by squeezing the baby out forcibly, a factor that was largely responsible for many women's barrenness. Abortions were common as culturally no illegitimate children were accepted within the Meru society. Girls who got pregnant before marriage brought shame to themselves and their families and it was very difficult for them to find a husband

The Meru married women were meant to practice long sexual abstinence period. This abstinence started from the fifth month of pregnancy, continued after birth until the child lost its milk teeth between the ages of 4-7 years. They also were culturally allowed to visit wives of their age mates, as long as the husbands and wives consented, under the institution of *bankiro or barwimbo* (lovers). Men were also allowed to visit the wives of other men that were abstaining from sexual relations for cultural reasons, such as those serving in the council of elders (*njuri ncheke*).

The '*Bankiro*' institution was restricted only to married people belonging to married men's age set. It was socially and legally accepted and not regarded as adultery, although sexual relations had to take place within the husbands' homesteads to avoid ritual uncleanness (Mwambia, 1973).

The Merus were patrilineal and had a clear preference for male children, as boys were regarded as security for parent in the old age. Girls usually married off and were considered as belonging to their matrimonial families. It was believed that a man's lineage or their ancestral lineage came to an end when no sons were born to them. Men were, therefore, keen to marry as many wives as possible to ensure that they begot sons. This preference of males could explain the gap between the educated boys and girls amongst the Merus. Parents clearly favour investing on and educating boys for their own security, rather than girls who usually got married off to other families.

The Merus did not believe in a marriage without children. Barren women were mainly chased away from their marital homes and greatly feared by fertile women. On the contrary, it was believed that there were no sterile men. A sterile man, like in many

other Kenyan tribal groups, was culturally allowed to invite an age mate to secretly help his wives get children. The only men that did not find admirers were the mentally retarded and the physically deformed.

The attitude of the Merus towards the disabled was culturally negative. After birth, disabled children including the albinos were thrown away into the forests and bushes to be exposed to wild animals and natural elements, sometimes even without the knowledge of the mother. This explains the shame and stigma attached to disabled children and the efforts parents make in hiding them from the public. Probably, this is an opportunity for social marketers to sell acceptance for disabled children among the Meru people, as disability does not equate to inability.

While introducing innovations, Mwambia (1973) explains that it is vital to win men first before women, due to their inferior status. It is also advisable to speak to each gender separately, as many women do not share much with their husbands due to their inferior position. She suggests communicating with women at their points of services such as the maternity and child welfare clinics and churches and women groups. She further highlights that the issue of age and gender needs to be well considered in the communication strategy. Age mates and close friends, traditionally, discussed sexual matters freely, just as grandmothers and mother-in-laws with their daughter-in-laws.

Merus are quite cynical, thereby, informers must be well versed in their subjects. Use of role models, blending with traditions, being firm with men, careful selection of words as sex matters are delicate, are all important communication issues that should be considered while communicating with them (Mwambia, 1973). It is important to explore how social marketers targeting the Meru group engage with these cultural barriers and enablers in their programme work targeting HIV/AIDS pandemic

Key cultural issues that may probably be fuelling HIV/AIDS among the Merus are summarised in the table 8 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Cultural acceptance of premarital sex among the circumcised boys to 'sharpen their swords'	Male circumcision using sterilised instruments
Tabooing of sexual related discussions explaining the silence on sexuality matters.	Belief in chastity of girls before marriage apart from the Igoji group
The <i>Bankiro/Barwimbo</i> institution among the married men- a cultural licence to extra marital sexual relations	Communication along gender, age set lines
Pregnancy related abstinence from 5 months to between 4-7 years	Belief in medicine men
Wife disciplining via beating and gender related violence	
Belief in witchcraft	
Blaming sterility on women	
Getting male friends to help wives sire in case of male sterility	
Boys inherited their fathers preferred to girls	
Search for preferred male child	
Female circumcision	
Culturally allowed polygyny	

**Table 8- Key cultural barriers and enablers in the spread of HIV/AIDs among the Meru's of Kenya.**

### **2.3.7. (g). Kisii/Gusii- 5.13%**

Kisii, the home of the Gusii people is an area of adequate rainfall and soil fertility. They have the highest rural population density in Kenya, with over 90% of dwellers as native Kisiis (LeVine, 1962; Raikes, 1994). Children were traditionally viewed as an economic asset just like cattle, therefore the more children a man had, the wealthier he was perceived (Mayer, 1973). They also have a low outward migration unlike the Luos and Luyia tribes. They are agriculturists growing cash crops such as coffee, tea, pyrethrum and many other subsistence crops. They are known for their soapstone carvings, pottery and basketry.

The Kisiis are an isolated bantu-speaking group surrounded by different Nilotic language speakers such as the Luos to the north and west, Kipsigis and Maasai to the east and south. They are separated from other Bantus mainly found in the central and eastern provinces of Kenya. Their geographical isolation meant that relations with their neighbours were violent, as the Kipsigis (Kalenjins) and Maasais often raided them for their cattle.

They are patriarchal, however, their men practised ultra-maleness characterised by exaggerated male aggression and anomic violence against women (LeVines, 1979; Raikes, 1994). The Meru group, considered as distant cousins of the Kisii people, shared in this male aggression and gender related violence. It can, however, perhaps, be argued that their dense population, patchy land and unfriendly neighbours possibly aggravated their male aggression. This was, unfortunately, often expressed in gender violence characterised by wife battering and rape case. Raikes (1994) suggests that the Kisiis have the highest rates of wife battering and rape cases in comparison to the neighbouring ethnic groups like the Kipsigis, Luyia, Maasais and Luos.

Gusii girls were circumcised between 13-15 years and Mayer (1973) explains the rationale for girls' circumcision was to reduce their sexual desire and make them marriageable. Raikes (1994) explained that girls desired circumcision, firstly, to avoid crude sexual harassment from young uncircumcised boys, as they were severely punished when found making advances at circumcised girls and secondly, to attain young adults' status. They were expected to learn from their grandmothers and not their parents. They stayed in an old woman's hut for sex and life education during the

initiation period. Interestingly, after circumcisions, they were allowed to have sexual relationships with circumcised boys and if they got pregnant, it was not a problem although elders discouraged it. Positively among the Kisiis, pregnancy before marriage was not a barrier to respectable marriage even as a first wife. A 'good girl' stayed home until cattle were paid for her bride price, regardless of what she did behind the bushes. Circumcision was indeed a cultural licence for the girl's free-range sex until she found a suitor. Having sexual intercourse or bearing a child was a small fault like a child pinching food (Mayer, 1973).

Girls and women had a very low social status. A father and/or a brother could pressure a girl to accept a man against her will, in exchange of cattle to repay debt or fetch bride price to be used by her brothers for marriage. Women were also never expected to object to polygyny or widow concubinage, meant to expand the family *egesaku* (Mayer, 1973). Polygyny expands sexual networks and increases exposure to the HIV virus. Much as the practice has subsided, extra marital relations are still popular, an area social marketer may like to target.

Gusii boys were circumcised between the age of 8-12 years. They were required to undergo the procedure without any pain relievers and under the taunts of drunken adults. They were not expected to flinch in pain as any flinching resulted in scorn and threats of being branded as a failure for life. Circumcision marked the transition from boyhood to manhood and the pain and courageous displays were key to this transition. Actually, the fear of pain by the Luo men meant that the Kisiis referred to Luo adults as grown 'children' and viewed them both as cowards and as an inferior ethnic group (LeVine, 1962; Raikes, 1994). A distinction existed between the circumcision of girls and boys, where girls were held while being cut, while boys had to stand-alone without flinching. Boys were later subjected to painful hazing as girls played and teased them by touching their raw cut exposed genitals (Raikes, 1994), possibly further explaining their male ultra-maleness and gender violence related tendencies, in revenge for the painful hazing.

Male children were preferred to girls as they were meant to maintain the lineages of their aging parents, through the immortalisation process of naming the grandchildren after the aged ones. The boys were also preferred because they did inherit their fathers' property unlike the girls who were married off (Raikes, 1992). Infertility was



associated with witchcraft and greatly stigmatised. Upon the death of a childless woman, a thorn was struck on her nipple symbolising her absent child (Mayer, 1973). The diviner *omuragori* was sought to diagnose the cause of infertility that may have ranged from: curses (*emuma*), witches, breaking of taboos by the girls, like eating the meat from the head of any animal among other culturally fuelled causes.

Gusii men were known for disciplining their women by beating them. Raike (1994) contends that wife beating is both common and serious enough to be reported by primary health workers, as one of the more common causes of women seeking treatment. Unfortunately, LeVine (1966) explains that the Gusii women respond to the male violence by venting their anger on the children. Child rearing takes a hard approach characterised by slapping, caning, forced weaning and threats of being locked out in the dark to be eaten up by hyenas. Indeed, the period between 18 months and 3 years is one of severe punishment. This hard approach to children rearing is strikingly similar to that shared by Kisii cousins- the Meru group. Possibly, this hard approach to rearing children may further explain why the boys grow to be very aggressive towards the women.

In communicating innovation among the Kisiis, it is important to consider the use of local administrators, leaders, hospitals, clinics, churches local committees, elites like teachers, entrepreneurs as well as local communication networks like women's and men's networks (Mayer, 1972). It is necessary to explore the extent to which social marketers targeting HIV/AIDs among the Kisiis engage with these cultural barriers and challenges.

A summary of the cultural barriers and enablers among the Kisiis are summarised in the table 9 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Female circumcision, still quite common to date	Male circumcision if done with sterilised instruments
Ultra-maleness - exaggerated male aggression and violence against women	Belief in medicine men
High incidences of culturally accepted rape cases	Grandmothers responsibility of girls' sex education
Free range culturally allowed pre-marital sex after the circumcision of girls and boys	Positive attitude towards premarital pregnancy- girls could even marry as first wives
Pregnancy abstinence from 6 months to 2 years	Communication inclined along gender and age set lines
Cynical view of girls/women refusal to sexual demands culminating in culturally accepted rape cases	
Culturally allowed marital raping- women fined and divorced for not accepting sexual demands from their husbands	
Strong belief in witchcraft	
Polygyny	
Very low social status accorded to girls/women	

**Table 9- Key cultural barriers and enablers in the spread of HIV/AIDs among the Kisii's of Kenya.**

The seven ethnic groups discussed above literally form 67% of the Kenyan population. However, it is important to note that the Coastal and Northern Kenya provinces are not represented and discussed, as they are not traditional homes of the seven major ethnic groups. It is therefore important to discuss two other ethnic groups from the minor ethnic groups namely Mijikenda's from the coast region and Somalis from Northern Kenya, to ensure regional cultural mapping of the Kenyan tribal groups. The Maasais also cannot be left out because they are arguably an outstanding ethnic group that are well known all over the world for their interesting culture.

#### **2.3.8 (h). The Mijikenda- 4.6%**

They live in the coastal area of Kenya alongside other coastal dwellers that include the Taita, Pokomo, Taveta, Boni, Swahili, Arabs and Asians. The Kenyan coast is a key tourists' attraction area due to the beautiful beaches along the Indian Ocean. The area attracts both local and foreign tourists; however, poverty is endemic among the local natives. Due to the impoverished natives and many arguably wealthy tourists, prostitution by both males and females is common as well as other vices such as sex trafficking, illegal drugs trafficking and misuse and child prostitution. All these vices are risk factors that drive HIV, STIs and other infections.

The Mijikenda consist of nine groups hence the Swahili name Mijikenda. Their settlements were referred to as *Makaya* (plural), *Kaya* (singular) mainly on hilltops or ridges within the forest (Tinga, 2004). They mainly inhabit Kwale and Kilifi districts of the Coastal province and are mainly agriculturist with some livestock rearing. Fishing is common among the Digos, due to their proximity to Indian Ocean waters. Giriamas also do some games trapping. Generally, the Mijikenda people are well known for their coconut trees, which take little effort to grow but represent life abundance (Berg-Schlosser, 1982).

Senior elders were culturally, greatly respected and even in the modern times, elders are still used to witness transactions of land and property. The importance and respect accorded to elders may be area social marketers targeting HIV among the Mijikendas may need to consider incorporating in their projects, as they are credible, respected and well listened to by their people.

They believed in a single deity *Mulungu* and believed in immediate ancestors (*komas*) and impersonal spirits (*mzimu mzuka*) with malevolent behaviour. They offered ancestors food in shrines (Kayas) and also performed traditional funeral rites in the same Kayas. Sickness, death, and childlessness among other misfortunes were mainly associated with sorcery, malevolent neighbours or relatives and as a result, individuals mainly consulted diviners for such issues. In stark contrast to other Kenyan ethnic groups, their women were not normally associated with the power of sorcery or witchcraft. It was surprisingly, mainly, the men that accused one another of witchcraft (Monica and Parkin, 1972).

The Digos are mainly Muslims while the other Mijikenda groups have few Muslims and mainly practice Christianity. The Digos have a hybrid culture of Digo and Islam due to the influence by Arabs and Swahili culture. Possibly, there may be a need to appreciate the Arab and Swahili cultures, if, social marketers targeting the Mijikenda have to clearly understand the Digo group.

Generally, many Arabs and Swahilis ascribe to Islam faith. This makes religion possibly important to social marketers in the Coastal province. Indeed, Sheikhs and imams as leaders may play a crucial role as HIV/AIDS related communicators.

The Mijikendas just like the Luos did not circumcise their girls and they married them off at between 12-15 years, leaving little chances for premarital pregnancy. Child betrothal was common and the girls were mainly given off for marriage after their breasts developed. Mijikenda women were never known to inherit anything and had a low status just like women in other Kenyan ethnic groups. They also have high illiteracy levels. In contrast, the Swahili and Digo women were self-styled and enjoyed considerable independence status both sexually and economically as they were literate. Indeed, Digo women were and are still well-famed for their sexual innovations and expertise (Berg-Schlosser, 1982). This fact is well appreciated by other Kenyan ethnic groups as well as foreigners who like to experiment with these sexual experts. Their sexual prowess and the curiosity of local and foreign tourists to experiment may be factors that may possibly be contributing to the rising HIV infections in the coastal province.

Just like the Kisiis, children born before marriage were well received and they inherited maternal granddad, unless bride wealth was paid to the father of the girl for

marriage. Interestingly, they had a belief that if a woman committed adultery while pregnant, after birth or while lactating, the foetus would die from *kirwa* (a wasting disease), a belief that commands marital faithfulness by the wives but not the husbands. In sharp contrast, the men practice polygyny that allows them to have as many wives and extra marital relations as they can. Upon the death of a husband, his relative or an appointed heir inherited his widows.

Mijikenda women, unfortunately, had a low fertility rate mainly attributed to their poor diet and also the several stillbirths. This may be explained by their forceful traditional methods of delivery, where traditional birth attendants forcefully pulled children out of the womb, before a woman's cervix was fully dilated. This practice made their women to greatly fear childbirth, as it was greatly distressing, painful and led to many injuries including the incapacity to carry foetuses and still births. Indeed, many Mijikenda women preferred delivering in mission hospitals. Although traditionally, no other western medicine or medical practice was accepted (Monica and Parkin, 1972).

In communicating with the Mijikendas, especially, Giriamas, Monika and Parkin (1973) emphasise the role of traditional medicine and argue that attacking traditional medicine and therapy is bound to cause resentment.

A summary of the cultural barriers and enablers among the Mijikenda people relating to HIV/AIDS are summarised in table 10 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Males inherited their fathers, women inherited nothing	Male circumcision
Low status of women	Belief in medicine men
Early girl's marriage-12-15 years mainly based on child betrothal	
Culturally imposed pregnancy sexual abstinence periods	Positive attitude towards children born from pre-marital sexual relations

High dependence on coconut trees- 'minazi' for their subsistence	Painful forceful traditional births push women to desire and plan for hospital deliveries- great chance for HIV/AIDS targeted messages during antenatal care and birth.
Polygyny	Communication along gender lines- male to males.
Widow inheritance by husband relatives or appointed heirs	Did not practice female circumcision
Belief and practice of witchcraft by the men	
Digo women known for their sexual innovations and given the title sexual queens, arguably not a brilliant title to take in relation to HIV/AIDS	
High illiteracy rates especially among girls.	
Coast attracts many tourists with accompanying vices such as prostitution, drug trafficking and child prostitution	

**Table 10- Key cultural barriers and enablers in the spread of HIV/AIDs among the Mijikenda's of Kenya.**

### **2.3.9 (i). Somalis- 5.54%**

The Somalis mainly live in the North-Eastern Province of Kenya neighbouring Somaliland, with Garissa as the main town. The area is semiarid and hot, with nomadic pastoralism as the main economic activity in the region. Clans are the basic point for cultural and political identity (Schlee, 1994) and they are mainly patrilineal, with strong preference for male children just as among other Kenyan tribal groups.

The Somalis are mainly nomadic pastoralist and value camels as the most desired form of wealth, although they also keep cattle and goats. Men herd the highly valued camels while women take care of the less valued goats and sheep, in line with their culturally inferior position.

Their land is very dry and they struggle to find water and pastures for their animals. They traditionally lived in mobile huts and their traditional diet was mainly milk and dairy products. They are well known for their chewing of *Miraa* (khat) grown in Meru. This is a mild stimulant mainly used to stay alert while tending their camels. Religiously they are mainly Muslims with very few Christians. Their culture is greatly influenced by their Islam faith. They practice polygyny and divorce is extremely common. Their bride wealth (*yarad*) is mainly in the form of camels, money and may also consist of firearms. Unlike the other Kenyan tribes, where the bridegrooms' families mainly fund and provide for weddings, the bride's family provides for future children in terms of camels, marriage tent materials and may also give sheep to the newlywed couple.

Somali boys are mainly circumcised after birth in line with the Islamic religious beliefs, while others may be circumcised around puberty in readiness for marriage. Traditionally boys from the ages of 7-8 years usually accompanied their fathers while they searched for pastures and wells to tend their camels. The tough pastoral culture engendered masculine values in the boys as they spent much time away from home with their fathers and other men away from females. They were taught male roles of tending and defending camels, a role that women could never be allowed to do as they were considered weak to handle camels (Lewis, 1973). Premarital sex among the boys was limited to flirting with girls or prostitutes in town centres and markets that they passed through, in their search for camel pastures. However, full sexual experiences were constrained until marriage. Interestingly, men regarded sex drive as a scarce resource, meant to be carefully conserved and not wasted, due to the low subsistence nomads lived on, especially, during the dry seasons. Men could risk adultery but any adultery by their wives formed a firm ground for divorce and compensation (Lewis, 1973).

Somali girls continue till now, to be circumcised anywhere between the ages of 5 to 13 years. The Somalis literally practice infibulations, which is the most extensive form of female circumcision or female genital cutting. It involves the partial or total removal of the clitoris, labia minora and labia majora. The labia majora are scraped or cut on the inside before the two sides are joined together by sutures or thorns. A seal of skin and scar tissues covers the clitoral area, the urethra and most of the vaginal opening. At the lower end, an orifice less than one centimetre in diameter is left for

the passage of urine and menstrual blood (McCaffrey, 1995; Johansen, 2002). After the operation the girl's legs are tied together to enable the healing of the wound and the tying is gradually reduced to allow the girl some movement. The healing process takes around seven weeks. Infections, painful menstruations and passing of urine, emotional trauma and sense of loss accompany this practice; however, more pain is experienced after marriage, during sex and childbirth.

At marriage, a circumciser or an experienced woman had to be sought for defibulation. The infibulations had to be partially reopened to make sexual intercourse possible and the couple usually have penetrative sex through open wounds, making it extremely painful for the newlywed girl (Johansen, 2002). Some clans, especially, from Southern Somali demand that defibulation be done through male penetration after the marriage ceremony, where the girl is pinned down for the man to defibulate her, causing painful wounds and tears around the vaginal opening. Interestingly, men also described penetration at marriage as painful to themselves and some of them report wounds and scars on their manhood (Dirie and Lindmark, 1991; Almroth, 2000). Many men also experience trauma related to the pain they cause their wives during sex (Abdalla, 1982; Talle, 1987; Almroth, 2000; Rye, 2002).

During delivery, women need further defibulation and extensive episiotomy due to the reduced elasticity in the scar tissues. The combination of labour pain and complications related to the infibulations intensify the experience of pain at delivery (Johansen, 2001b; Vangen, et al., 2001). The reasons for inflicting such cultural pain are arguably insignificant as they range from symbolic affirmation of patrilineal clan affiliations, construction of a feminine body and identity, a proof of virginity, sign of courage and stamina as preparation for baby pain and something to be endured resulting in the positive transformation of the individual (Talle, 1993; Walley, 1997; Ahmad, 2000). Lewis (1973) suggests that the object of this extensive circumcision is to accentuate and even to make trophy of the future bride's virginity and to safeguard it until her marriage, which it actually does. This gives men a reason to boast, when they succeeded unaided in penetrating this formidable barrier on their wedding night, while others boast that surgical help may be required for sexual intercourse to be successful.



Female infibulation is important to HIV/AIDS, mainly because it predisposes women to tears during intercourse that may provide portals for the HIV viruses to enter the woman or man's system. Hardy (1987) and Brady (1999) suggest that female genital cutting also may increase a woman's risk of HIV infection by elevating her risk of physical trauma. More severely cut women may experience greater trauma during coitus that may cause injuries to and ulcerations in the vaginal surface area that enhance transmission of the HIV virus.

The Somali men practiced polygyny and interestingly although the first wife had authority, kept the moneybox and managed other junior wives; her sexual position was undermined, as their husbands prefer the younger wives. Social marketers could possibly target the uptake of protection because of their polygamous practice.

In communicating innovation to the Somalis, Lewis (1973) asserts the need to consider traditional institutions like the Ballard singers and professional bands that may be used to reach the nomads effectively. Popular songs on a key theme may also help. Radios are also common in local language that could have discussions and debates as well as the use of influential religious leaders like sheikhs and *wadads*. He advises on the need to speak to each gender separately and consider using older people that are taken more seriously and listened to than the younger ones. Packaging the message in convincing oratory, use of appropriate proverbs and using well-known stories and passages of Koran, may also help position the message to the targeted audience due to their strong Islamic faith. It is however important to explore the extent to which social marketers targeting HIV/AIDS among Somalis engage with these cultural realities.

A summary of the key cultural barriers and enablers relating to HIV/AIDS among the Somalis is given in table 11 below:

<b>Key cultural barriers to programmes targeting HIV/AIDS</b>	<b>Key cultural enablers to programmes targeting HIV/AIDS</b>
Low status of women	Culturally discouraged pre-marital sex among both girls and boys
Males inherit their fathers not females	Culturally discouraged extra marital sex- among the women as this gave grounds for divorce and compensation
Severe female infibulations and unnecessary de-fibulations	Gender lines and age considerations for communication
Polygyny	Elder people taken more seriously than younger people in relation to communicating important messages
Nomadic lifestyle makes settling difficult	Use of oratory- proverbs, stories, and Koran due to the influence of the Islam faith

**Table 11- Key cultural barriers and enablers in the spread of HIV/AIDs among the Somali's of Kenya.**

#### **2.3.10. (j). Maasais- 2%**

The Maasais are Eastern Nilotic speakers. They traditionally pursued a purely nomadic pastoral way of life. They mainly live in Narok, Kajiado and Laikipia districts of the Rift Valley province. Their neighbours such as the Kisiis, Kalenjins, Turkana, Kikuyus and Kambas held them in fearful respect, as they violently raided them and stole their cattle. Krapf and Ravenstein (1968) describe the Maasais as truculent savages that were dreaded as warriors, mainly using fire and sword so that the weaker tribes did not venture to resist them in the open field and he further claims

that they were mainly held with a war like image. Thompson (1968) described them as pastoral nomads that recognise only two things as worthy of their care and interest namely cattle and warfare.

Although part of their land is quite arid with the hottest point in Kenya at Lake Magadi in Narok (where soda ash-sodium bicarbonate is produced), other parts are quite fertile like the Kajiado area, making their preference for pure pastoral life, a matter of choice and cultural preference as opposed to a matter of necessity (Berg-Schlosser, 1982). Their nomadic lifestyle that involved moving from one place to another in search of pasture and water meant that hygienic lifestyle, formal education and proper medical care systems were difficult to maintain and this led to the popular perception of the Maasais as dirty, uneducated and unhygienic people.

Being nomadic pastoralists, they believe that they are superior as they are their deity's -*Enkai's* chosen people, and he exclusively gave them custody of all cattle. Consequently, they waged serious raids on neighbours to claim their cattle back. Interestingly, the Kalenjins, a neighbouring ethnic group also held this belief and as a result violent war like cattle raids and counter-raids were common among them and their neighbouring tribes. They indeed enjoyed uncontested economic, political and military dominance in the years before colonialism. When the British colonised Kenya, they imposed *paxi Britannica*, outlawing cattle raids and terming the act as theft punishable under the law. The British administrators further viewed the *ilmuranis* war like instincts as an obstacle to the peaceful development of the more industrious agricultural neighbouring tribes (Lugard, 1960). They ambitiously tried to forcibly abolish it in 1921 by prohibiting the *ilmuran* visible symbols that included the carrying of spears and shields, wearing of pigtails, constructing of *imanyattas* and the eating of meat at *ilpuli* meat feasting sites, all perceived as their source of belligerence. Unfortunately, the British administrators' effort did not work and by the 1930s and 1940s, the 'ilmurani' symbols were visible together with their characteristic neighbourhood raids for cattle.

Maasais had very few Christians converted by the early missionaries and indeed the missionaries concluded that most of the 'grapes' in the Maasai vineyard of the Lord were quite sour. The few, who were Christianised, abandoned their traditional pastoral way of life and became farmers, meaning that Christianity meant a complete

change of culture and lifestyle, explaining their low conversion rates. The Christian doctrine on monogamy was also an alien concept to their culture.

They practiced tribal initiation (*emurata*) for the boys between the ages 14-20, for transition from boys to junior warriors. This was done in batches on strictly regulated periods for cooperate age sets. The *olmurrani* -circumcised boys lived in seclusion for 6-7 years separated from ordinary family lives. The seclusion was marked by their prescribed meat, blood and daily products diet. Their preference for a mainly raw carnivorous diet and cattle warfare led to their various descriptions that include savage, primitive and beasts like natural people (Eliot, 1966; Gurdon 1912). While in seclusion, they were not allowed to marry, reproduce, associate with circumcised married women nor consume meat seen by the women (Talle, 2007).

Traditionally the Maasais had a more formalised education structure in the *manyattas*, where junior warriors were taught by their elders on matters of warfare, social politics and sex education. They had a popular cliché that he, who had not been to a '*manyatta*', knew nothing at all, as they lived in the Manyattas for a considerable time, ranging from several months to between five to seven years, learning about their traditional way of life. Indeed, the *manyatta* education systems did clash with the modern school systems and they had to choose where their boys were to spend part of their formative years. The Maasais held and to date, some of them believe that those children that went/or go to school, were/are lost to the Maasai way of life. They describe schooling as an unbearable loss similar to death or enslavement of children as they are lost to the *manyatta*'s cultural societal knowledge (Knowles and Collett, 1989).

The Maasais, unlike, all other Kenyan tribal groups do not believe in the existence of ancestral spirits or other supernatural and superstitious mystical powers. They are quite sceptical about witchcraft and other superstitions held dearly by their neighbours (Berg-Schlosser, 1982). They, however, believe in *Enkai* or *Ngai* that lived in the skies and creates rain and was regularly prayed to by the women but not the men.

The Maasai's sexual culture allows for pre-menarche sexual debut that permits young males to have sex with physically immature girls and also allows for extra-marital sex. The sexual interaction between unmarried people is commonly labelled as *enkigurun* (play) (Talle, 2007). The initiated males have a high partner frequency

ranging from 0 to 45 partners (Morley, 1991). It is normal for women and men to have two to three permanent lovers (*e-osindani*) in addition to occasional lovers (*engare engeene*), with the standard being between 7-10 sexual partners. Attractive partners may have as many as 10-20 lovers and extremely popular women may entertain up to 30 lovers and are sometimes referred to as prostitutes (*emalaai*), although the term does not allude to monetary transactions but to promiscuity (Talle, 1995, 2007; Coast 2000).

This high sexual partner frequency can be explained by the age set systems, as age mates can share sexual partners and the associated prestige of being sexually attractive. It is indeed shameful for a man to be without lovers, as they would not wear the typical Maasai beaded jewellery that distinguishes Maasai men. Interestingly, the women make the beaded jewellery as presents for lovers and tokens of intimate relationships, adding an erotic dimension to beaded ornaments worn by the men. Bright beads of red, white, dark blue and black sewn on strings are worn on wrists, arms, ankles, legs, neck, head and waist, making young men and women attractive to one another. Talle (2007) suggests that a Maasai man without these bodily embellishments stands forth as a social anomaly. He further suggests that to the Maasais, being sexually active is a sign of prosperity and good health, as it is believed that sexual inactivity causes accumulation of semen (*olkirati*), associated with ill health symptoms such as back stiffness, aching joints, backache and breaking of the back.

Unlike many other Kenyan ethnic groups, virginity had no cultural importance or place among the Maasais. A virgin bride was traditionally looked upon as an embarrassment to the family, as she did not have a gate (*meata kishomo*), as a gate is a symbol of maturity and independence (Talle, 1987). The rationale for women's early sexual debut was that the semen of the *ilmurannis* that helped girls develop their breasts and hips, key signs of girls' female maturity, making the young *ilmuranis* key in engendering of girls.

Traditionally a virgin bride was sent back to her own family and her father had to compensate the son in law with a heifer, for the offence of undermining age-set roles. Indeed, it was considered inappropriate for the Maasai men past *ilmurani* stage to have sex with 'children' (referring to the virgins). The role of ensuring that girls were

not virgins was well assigned to the junior warriors, rightfully the circumcised *ilmuranis* before they got married. Elders' sexual relations with virgins were perceived as reversing their age-set seniority and polluting themselves with another age-set's role (Ortner, 1996).

Culturally, the *illmurranis* could play with girls sexually from ten years to puberty. Talle (2007) describes this important *emurano* period of youthful beauty and playfulness, as a time when the young girls and *olmurannis* met to dance, sing and play sexually. These plays took place in special huts within homesteads that were specially assigned for this purpose or in bushes. He also suggests that brutality and violence often accompanied such sexual plays. The girls readily accepted and complied with these sexual plays, as it was believed that these plays were a part of their natural progression to social adulthood.

The Maasai girls were circumcised at puberty. The practice was the last and painful step in attaining maturity. By removing the outer flesh, the genitals are given an open look as a cultural inscription of adult femininity, transforming them from girls to women in readiness for marriage to a man 10-15 years older than them (Talle, 2007). Girls who died uncircumcised were considered physically and morally immature. During circumcision, the girl's father arranged marriage and the girl was taken to her husband's home soon after her circumcision wounds healed. Marriage of the girl marked the end of freely mixing and sexual relations *esoto* games with the junior warriors (*ilmurannis*). It, however, marked the beginning of sexual relations with the girl's senior husband and the members of his age group that were 10-15 years older than the young bride. Some of the women continued to associate with their earlier *ilmurani* lovers to rebel their senior husband's authority. Female circumcision is still very dear to the Maasais and increases the risk of HIV via unsterilised instruments, not forgetting the physical, mental trauma suffered by female initiates.

Certainly, with so much of the sexual sharing culture, it was difficult to determine the paternity of the children women bore. Indeed, paternity was traditionally not significant and the Maasai men regarded any children begot by their wives as their own. Homosexuality, was however, culturally detested and considered deeply inappropriate for circumcised males (Talle, 2007). Pregnant women were strictly prohibited from sexual activity from the third or fourth months of pregnancy because it was feared that the semen could choke the child in the womb (Talle, 1988).

Nursing mothers were also prohibited from sex until the child was weaned to avoid the semen weakening the child. Semen and mother's milk were considered as incongruent fluids that were culturally not allowed to mix. Talle (1987) contends that from a cultural point of view, the Maasais are unwilling to use the condom technology. This is based on the belief that that semen will enter the man's body again, making him a useless man just like the impotent men. Culturally, semen had to be ejaculated into a woman and nowhere else.

In terms of communication Jacobs (1973) describes several important features to note when communicating innovations with the Maasais. Traditionally Maasais engaged in lengthy discussions to solve group decisions. This was due to the belief that one head cannot contain all knowledge and a popular belief that you cannot come into conclusion before lengthy discussions. In matters beyond their control, the Maasais take a fatalistic attitude founded on a popular belief that a spear does not miss a man fated to die.

Sexual matters are freely discussed in their age sets not in mixed gender groups. Girls learnt their sex education from their mothers and old women (*kooko*) as well as from their age mates. The *Kookos* had special rights in their society in that they were culturally allowed to share sexual jokes with young girls and the junior warriors; however, their parents were forbidden from such jokes.

A summary of cultural barriers and enablers relating to HIV/AIDS among the Maasais are summarised in the table 12 below:

Key cultural barriers to programmes targeting HIV/AIDS	Key cultural enablers to programmes targeting HIV/AIDS
Pre-menarche sexual debut of girls from as early as 10 years	Male circumcision when done using sterilised instruments
Free range sex by the circumcised 'ilmuranis' with uncircumcised girls from 10 years in the <i>esoto</i> plays cultural institution	Communication of sexual matters along gender and age sets groups
Low status of women	Girls sex education done by mothers and grandmothers and age mates
Culturally accepted gender violence like raping by the <i>ilmurannis</i> in the <i>esoto</i> play.	Men gladly accepted children without questioning their paternity
Female circumcision, quite severe form of infibulations	
Pre-arranged forced marriages of girls after circumcision to men 10-15 years their senior	
Culturally allowed extra marital sexual affairs between wives and the husbands' age set group as well as with their former <i>ilmuranni</i> lovers	
High sexual partner frequency – 0-20 partners	
Fertility delegates- olamal where women slept with any one with the hope of conceiving	



Polygyny
Pastoral lifestyle
Culturally imposed pregnancy related abstinence until weaning of the baby

**Table 12 - Cultural barriers and enablers in the spread of HIV/AIDs among the Maasai's of Kenya.**

## **2.4 Chapter summary**

The Kenya HIV/AIDS burden differs significantly in relation to geographical mapping of the country. Some regions such as Nyanza, Nairobi, Mombasa and Rift Valley have high HIV/AIDS prevalence as compared to others such as North Eastern Kenya. Indeed, ethnicity in relation to tribes of origin in Kenya has been associated with risky sexual behaviour (Akwara, et al., 2003), although cultural and contextual factors have not been deeply investigated.

Social marketing programmes targeting HIV/AIDS have been hailed as greatly contributing to the awareness, testing and uptake of treatment in relation to HIV/AIDS. However, these programmes are mainly Western, European and American funded, and the extent to which these programmes incorporate local cultural knowledge in their programmes, rather than donor's culture has not been investigated, necessitating the need for this study.

Kenya prides is a rich cultural heritage due to its forty-one (41) tribal groups. These tribes may be divided into major and minor groups that have their settlements in different parts of the country. The major tribes include the Kikuyus of Central province, Luyias of the Western Province, Luo of the Nyanza province, Kalenjins of the Rift Valley province, Kambas of the Eastern Province, Merus of the Eastern province and the Gusii/Kisii of the Nyanza province. Some of the minor groups include Mijikenda of the coastal province, Somalis of the Northern Eastern province, Maasais of the Rift Valley among other smaller groups and foreigners found in Kenya.

Common cultural beliefs and practices that cut across different Kenyan tribal groups that may be considered as HIV/AIDS risk factors groups include polygyny, sexual related violence, wife inheritance, low social economic status of women, belief and

practice of witchcraft, cultural acceptance of death, free range sex practised by age set members of some tribal groups and belief in medicine men. Others include cultural silence on sexual matters adopted by parents towards sex education for their children, culturally licensed premarital and post marital sexual relations, female infibulations, widow inheritance, search and preference for male children and the diminishing role of grandparents in the youth's sex education. Social marketers may probably need to identify and engage with these cultural barriers and enablers tactfully in their programmes targeting HIV/AIDS, for more effective programme work.

Cultural enabler that social marketers may also engage within their programme work include: monogamy culturally encouraged among the Luyias, male circumcision-practised by most of the ethnic groups apart from the Luos, high valued girl virginity among some ethnic group such as: the Luos of South Nyanza, Meru groups with an exception of the Igoji sub- groups and Somalis of Kenya. Much as tribal groups may share common cultural barriers and enablers, they each have their unique beliefs and practices probably that may need the attention of social marketers in their programme work targeting HIV/AIDS.

After an explicit discussion of cultural and contextual realities of the Kenyan tribal groups, it is only logical to focus on culture as a concept in order to understand it deeply, how it is engaged with other disciplines, its link to health and HIV/AIDS and how social marketers may engage with it for successful interventions.

## **Chapter 3: Culture and Health: Exploring the Link.**

### **3.0 Chapter Introduction**

This chapter explores the concept of culture. It looks at how the broad and complex concept of culture is conceptualised, classified, its various elements and how these elements interact to affect health issues and HIV/AIDS. It explores various models used by marketers and health programmers to engage culture and lastly suggest a composite model that may guide social marketing programmers in aligning key programme activities such as planning, designing, implementing and evaluating interventions to cultural and contextual realities of their target audiences.

### **3.1 Defining the concept of culture**

The concept of culture is broad and complex because it involves virtually every part of an individual's life and touches all human needs both psychological and physical (Jain, 2001). Taylor (1871) views it as a complex whole that includes aspects such as: knowledge, beliefs, art, morals, law, custom and any other capabilities and habits acquired by individuals as members of society. Kluckhohn and Kroeber (1952) suggest that culture is to society what memory is to the individual. Hofstede (1991) views it as the collective programming of the mind that distinguishes the members of one group or category from others (Hofstede, 1991, p.5). Triandis (1972) suggests that it is the shared perception of the social environment. Terpstra and David (1991, p.6) posit that culture is a set of symbols that are learned, shared, compelling and interrelated, whose meanings provide a set of orientations for members of society that provide solutions to problems that all societies must solve if they are to remain viable.

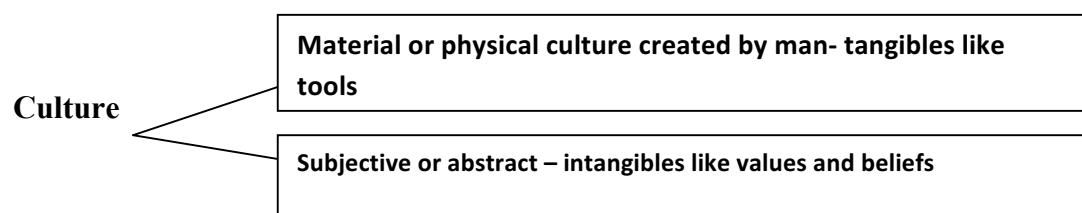
Certainly, no consensus exist in defining culture however key truth about culture is that it is not genetically transmitted but learned via various social agents of society such as family, peer groups, schools among others and it has many interrelated parts making it a complex puzzle that has to be shared by a group of people.

Allen (1992) distinguished seven different perspectives of viewing culture. Firstly, the generic perspective that refers to the learned as opposed to the instinctive behaviour. Secondly, the expressive perspective, based on the artistic expression by a group of people. Thirdly, the hierarchical view that implies the superiority of a group

in relation to another. Fourthly, super organic view, based on the context of everyday behaviour rather than the trivial details. Fifthly, holistic perspective, based on interconnected aspects of life in a society like gender, religion, economics among other aspects. Sixthly, pluralistic view, based on coexistence of multiple cultures in the same setting and lastly, hegemonic perspective, based on cultural groups and power distribution. These perspectives are interesting and certainly vital in understanding culture and critical in carrying out cultural analysis.

### 3.2 Classification of culture

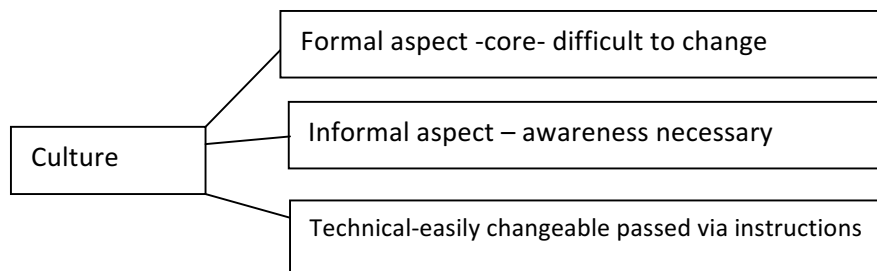
Kluckhohn and Strodtbeck (1961) argue that mankind faces universal problems that emanate from relationships with fellow beings, time, activities and nature and suggest that cultures differ in their solutions for each problem situations. Murdock (1945) classifies culture in two broad groups: material culture or physical culture created by human likes clothing and tools and secondly the non-material/subjective/abstract culture with intangibles as religion, perception, attitudes, beliefs and values. He identified cultural universals common to all groups of people including sports, body adornments, cooking, courtship, dancing, decorative art, education, ethics, etiquette, family feasting, food taboos, language, marriage, mealtime, medicine, mourning, music, property rights, religious rituals, residence rules, status differentiations and trade that are vital in understanding different groups of people.



**Figure 4 - Classification culture-adopted from Murdock (1945)**

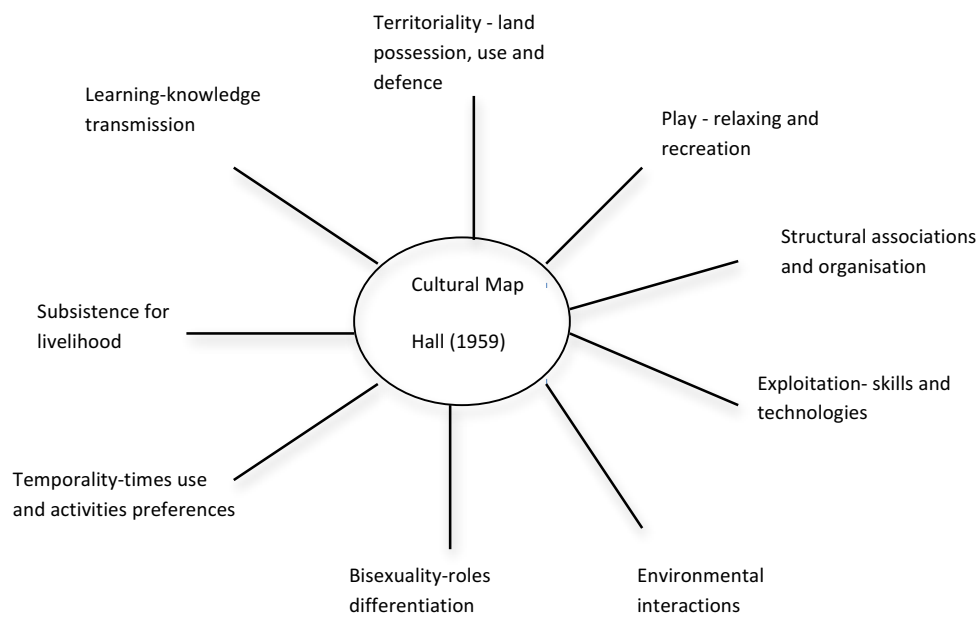
Hofstede (1992) suggests geographic elements of culture based on: national borders, cross-national borders and based on subcultures within the borders. Hall (1959) classified cultural aspects into: formal, informal and technical. He suggests that formal aspects are the cores of a deep-rooted culture and it's extremely difficult to change, mainly taught as absolute rights and wrong and non-observance cannot be forgiven. Informal aspects relate to those aspects that are learnt by being a member of society and everyone is supposed to be aware of them. Violating these informal

aspects may cause concern, however other societal members may accommodate offenders. Technical aspects are passed via instructions. Change may be easy on technical aspects based on logical explanation, in contrast to the formal cores. The bone of contention, however, lies in the fact that the definitions and classifications of formal, informal and technical, cultural aspects vary from culture to culture necessitating a deep understanding of individual cultures in order to understand their classification systems rather than assuming universal classification systems.



**Figure 5- Cultural classification adopted from Hall (1959).**

Hall (1959) further describes a cultural map necessary to understand a group of people. The map consists of: interactions with the environment, associations based on structure and how a society organises itself, subsistence in relation to how individuals live and derive their livelihood, bisexuality necessary to understand differentiation of roles and functions along sex line, territoriality that deals with the possession use and defence of land and territory, temporality in relation to the use of time and activities engaged in, learning in reference to patterns of transmitting knowledge, play that relate to relaxing, recreation and how individuals enjoy themselves and lastly exploitation in reference to skills and technologies used to change natural resources to suit societal members' needs.



**Figure 6 - Cultural map adapted from Hall (1959)**

Hall (1976) made a further distinction between high context and low context cultures. In high context cultures, cues are used to interpret messages with little emphasis being made on explicitly explaining messages. Contextual cues like gender, age, balance of power, time, venue and body language among others ought to be interpreted to clearly get the messages. A good example is the African collectivists where context and non-verbal cues mean more than the spoken words.

Low context cultures depend on clear communication lines that are explicit. What is meant is simply said and the context does not really matter. This is mainly found in western countries where individuals are meant to clearly explain themselves in words in order to be understood. High context and low context cultures are critical in relation to communication styles and content. Explicit messages are vital in individualistic cultures found in the Euro America while content and context related cues are critical in African and Asian cultures. This denotes a difference in the methods and content considerations in relation to communication planning and styles targeting different cultures for effective communication to take place.

Hofstede (1995) also classified cultures based on cultural dimensions such as: power distance- degree to which inequality among people is viewed as being acceptable. High power distance, societies tolerate with high social inequalities and status

symbol, plays a vital role. Ideal bosses are viewed as benevolent dictators or good patriarchs. Kenya, certainly, rates high in power distance due to the prevalent accepted social inequalities. In low power distance countries, the rich and powerful try to look less powerful and status symbols are frowned upon with the ideal boss being a resourceful democrat.

Uncertainty avoidance is another element referring to the extent to which people feel threatened by uncertainty and how they cope with it. In weak uncertainty avoidance cultures, people are more easy-going, innovative and entrepreneurial, while in high uncertainty avoidance cultures, people prefer to be conservative by sticking to what they know such as rules and avoiding ambiguous situations. Many Kenyan tribal groups are quite conservative, sticking to their traditions and preferring their cultural way of life to lifestyle changes.

Individualism is another dimension that refers to the degree to which people act as individuals rather than groups. In high individualism countries, people focus on their interests and those of their immediate family while in collectivist society's interests of the group take centre stage. The in-group is vital as it offers protection and in return individuals are loyal to the group. Collectivism in Kenya is high in rural areas while in urban areas, individualism is rife. Masculinity dimension refers to the importance of male values like assertiveness, status competitiveness among others while femininity refers to the importance of female values like solidarity, quality of life and people orientation. In Kenya, masculinity is valued and femininity is mainly valued within family set ups. Long term versus short-term orientation denote individuals' perspective on time in their lives. Short-term orientation relates to satisfying needs here and now mainly found in western cultures whereas long term orientation stresses persistence and is prevalent in Eastern cultures. Kenyans are mainly long-term oriented preferring to plan and sacrifice for future generations especially within the family set up.

All these cultural classifications point to a very important aspect of culture, there is no universal way of dealing and managing people and those cultures are different, shaped by the way how individuals respond to their contextual challenges. This strongly suggests the need to understand and adapt to local, social and cultural profiles rather than engaging in cultural impositions, based on the assumption that one culture is more superior or inferior to another.

The dimension, mainly cited, is the collectivism versus individualism dimension that possibly surrounds other dimensions (Triandis 1995). In individualistic cultures, the individuals view themselves as being independent of others; pursue personal goals, making it easy to get in and out of groups when costs exceed benefits (Singelis, et al., 1995). This certainly results in less cohesive groups and decision making centred on the individual self.

Collectivists construct the self-aspect as being interdependent with others and consider relationships as essential, maintaining them even if the costs may be greater than benefits, resulting in cohesive groups like families and workgroups (Markus and Kitayama, 1991). This suggests that individuals from individualistic cultures are programmed differently to those from collectivist cultures, suggesting a need for cultural understanding before decisions and actions are made in all spheres of life including the health context.

### **3.3 Elements and layers of culture**

Knowledge of a culture can be gained by probing its various elements. The iceberg's analogy of culture depicts the visible parts and the larger invisible parts of cultures (Hall, 1959). The external or conscious part of culture relates to what we see while the internal/subconscious part relates to what we cannot see. Onion layers have also been used to represent key elements of culture. Hofstede (1991) depicts values at the core of his onion as they are deeply hidden.



Next layer are the visible rituals, then the heroes and lastly, the symbols. Across all these layers are practices that permeate the other onion layers. Trompenaars and Hampden-Turner (1998, p.21) describe their outer layer of onion of culture as the explicit observable reality of language, food, buildings, houses, monuments, agriculture, shrines, markets, fashions and art that only symbolise a deeper level of culture. The next layer is norms that represent a group's sense of right from wrong guiding how individuals ought to behave, and their inner most layer are the values that represent the good and bad choice criterion of how individuals desire to behave.

Schein (2004) posits three layers of culture: the outer one- artefacts and behaviour relating to visible aspects, then the espoused values and at the core layer are the assumptions. In all the onion representations of layers of cultures, the observables are based on cultural universals (Murdock, 1945). However, the intricacies of what may constitute the visible and invisible cultural aspects differ among the theorists, depending on the disciplines, they belong to.

Terpstra and David (1991) and Albaum, Strandkov and Duerr (2002) suggest that elements of social cultural environment relevant to business and marketing decisions include: firstly, language in relation to the spoken, written, official, linguistic pluralism, language hierarchy, mass media and international language. Secondly, religion that includes sacred objects, philosophical systems, beliefs and norms, prayers, taboos, holidays and rituals. Thirdly, values and attitudes toward time, achievement, work, wealth, change, scientific method and risk taking.

Fourthly, law based on the use of common law, code law, foreign law, home country laws and regulations. Fifthly, education ranging from formal, vocational, primary, secondary, higher education, literacy levels and human resource planning. Sixthly, politics considering aspects of nationalism, sovereignty, imperialism, power, ideologies and political risk. Seventhly, technology and material culture that cover transportation, energy systems, tools and objects, communications, urbanisation, science and inventions. And eighthly, social organisation that relates to kinship, social institutions, interest groups, social mobility, and status systems. On the other hand, Ganon (1994, p.3-18) suggests that cultural elements relevant to marketers include material life, social interactions, language, aesthetics, religion, pride and prejudice, ethics, etc.

Kotabe and Helsen (2011) suggest seven cultural elements relevant to particularly international marketers as: material life, language, social interactions, aesthetics, religion, education, and value systems. Instead, Cateora and Graham (2005) emphasis on five key elements of vital culture when designing the marketing mix: values, rituals, symbols, beliefs and thought process. The elements of culture suggested by marketers seem to point to the need to centralise culture and use cultural knowledge to guide marketing related tools and decisions. Cultural knowledge should be central in examining various business environments. Cultural complexities permeate, intermix and impact on all other aspects of the internal, operating and macro environments of business (Cateora and Graham, 2005; Albaum, Strandkov and Duerr, 2002; Katobe and Helsen, 2011).

In order to understand the culture of a target audience, it is critical to understand the target audiences' various elements of culture and how they interplay to influence their choices, decisions and behaviour. This information may guide marketing strategy and the choice of various marketing tools and concepts for successful marketing programmes. Having highlighted cultural variables relevant to commercial marketers, it is critical to explore the link and relationship between health and culture as well as HIV/AIDS and culture, in order to understand how culture impacts social marketing interventions targeting the HIV pandemic.

### **3.4. Culture and health related models**

World Health Organisation-WHO, (2003) defined health as a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity in individuals. Durch, et al. (1997) suggests that health not only involves the physical, mental and social well-being, but also encompasses the social and personal resources, ability to participate in everyday activities in family, community and work and being able to command the personal and social resources necessary in order to adapt to changing circumstances. His assertion suggests a link among individual, social, economical and contextual elements that all impact the well-being of an individual.

To understand the various factors that affect health, Winkelman (2009, p.36) distinguishes between malady, illness, sickness and diseases. He suggests that biomedicine views malady as an umbrella of different unwanted health conditions.

These conditions may be classed as: firstly, diseases referring to the biological problems involving abnormality in the body's structure chemistry or functions. Secondly, illness referring to a patient's experience of something wrong as a sense of disruption in well-being that may be as a result of disease or that may be caused by cultural beliefs and thirdly, sickness focuses on social responses to a person with an illness or disease. Concepts of disease, illness and sickness reflect differences among medical, personal and social realities of health wellbeing that perhaps necessitate further investigation to understand cross cultural constructions of maladies. This interesting distinction, however, clearly points to the fact that cultural issues may impact on illness and sickness, impacting on diseases and how they are managed.

The biomedicine perspective of health is also referred to as allopathic, Western and scientific medicine. It views maladies, primarily, as diseases understood as biological abnormalities in the body's structure, chemistry or functions (Eisenberg, 1977; Kleinman, 1980). Its conceptions of diseases are based mainly on a universally valid system of classification and belief that each disease originates from specific physical causes, and the belief that medical practice is culture free and scientifically neutral and objective, in line with quantitative methodology research paradigm. It is, however, limited in that it gives a narrow definition of health and reflects cultural superiority of the Euro-American thinking and command of medicine. In contrast, every society has its health reality, based on their accepted beliefs, norms and practices that are ignored, side-lined or viewed as barriers to Euro-American biomedical practices (MacLachlan, 2006; Winkelman, 2009), bringing in issues of cultural hegemony and discrimination.

Various perspectives and models suggest the link between culture and health. Engel (1980) challenged the biomedical perspective that indicates diseases as being caused by physiological conditions. He suggested a bio-psycho-social model that calls for the need to look into the biological, psychological, social, cultural and physical environment that may affect health. Winkelman (2009) however, argues that this model calls attention to the individual psychosocial determinants while neglecting the broader social factors that may be fundamental causes and warrant prevention effort. The model, however, does not vigorously deal with cultural issues, in relation to what really ought to be examined under cultural environment.

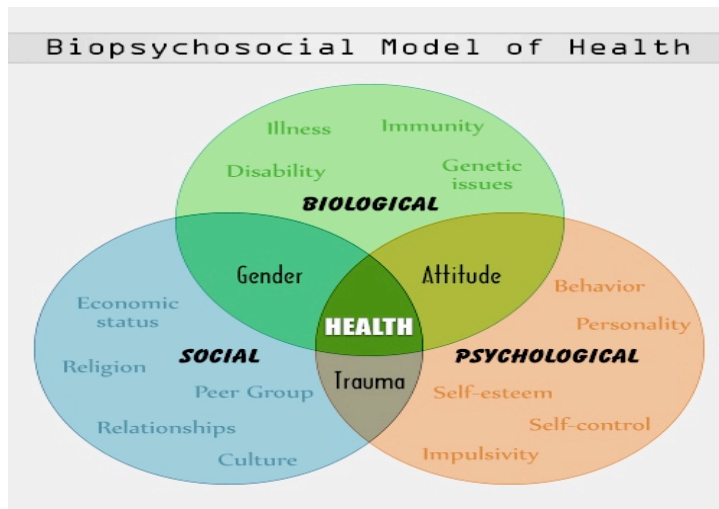


Figure 7 - Biopsychosocial model of health by Engel (1980)

diagram from: <http://www.buzzle.com/articles/general-overview-of-the-biopsychosocial-model.html> (2015)

The environment of health or force-field paradigm (Blum, 1983) views health as a product of the relationship among many subsystems that affect one another. At the core of the model, there are the three basic areas of health: psycho, somatic and social areas. The three areas are influenced by four main elements. The largest influence is the environmental system consisting of the: foetal, physical (natural and manmade), socio-cultural environments, education, employment and means. The second main influencer is the health care services that consist of prevention/cure and rehabilitation services. Thirdly, he suggests behaviours of individuals and lastly heredity issues.

The outer layer of the model consists of five elements. Firstly, natural resources, secondly ecological balance, thirdly, population in relation to size distribution, growth rate and gene pool. Fourthly, cultural systems and fifthly, mental health in relation to emotional satisfaction, intellectual efficiency and adaptability. The model contributes to the factors that influence human health. However, cultural system should really have been represented probably second to the environmental influences. It has not been given the emphasis it deserves as it interacts and influences all the other environments. Besides, cultural systems have not been explained in depth as to what they really entail or constitute.

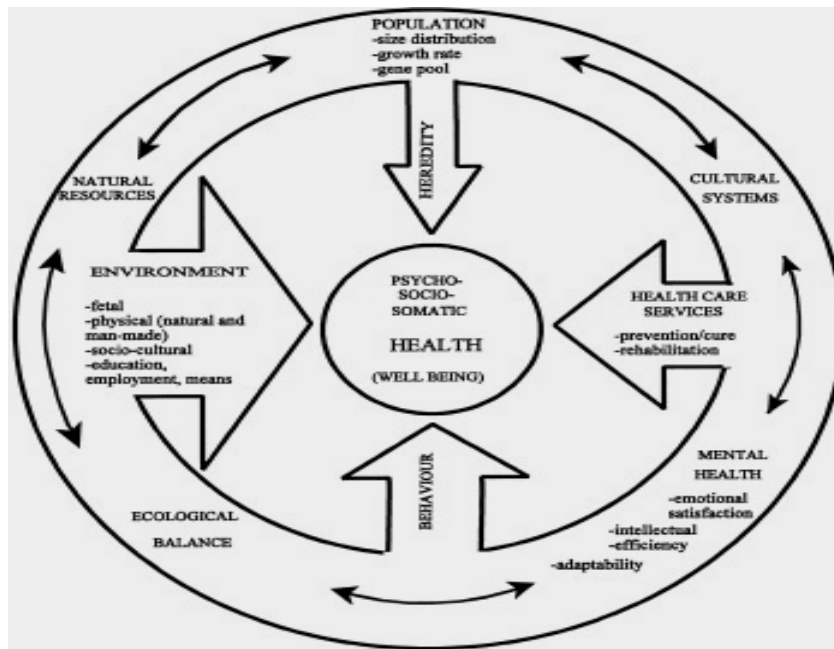
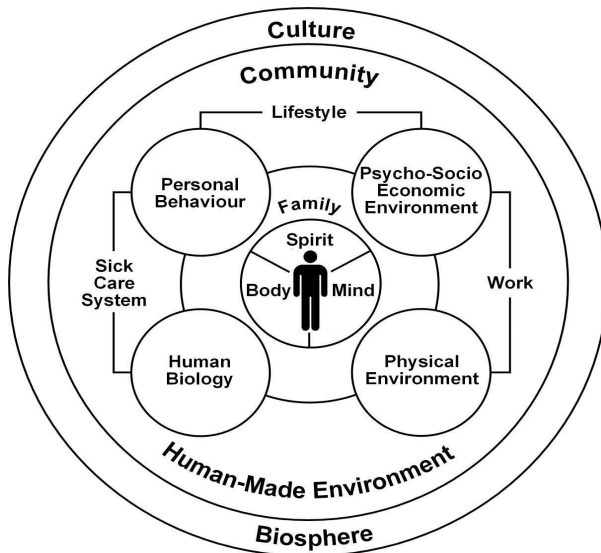


Figure 8- Force field paradigm (Blum 1974; 1983)

figure from:

[http://www.researchgate.net/publication/227664188\\_Evolving\\_Models\\_of\\_Human\\_Health\\_Toward\\_an\\_Ecosystem\\_Context](http://www.researchgate.net/publication/227664188_Evolving_Models_of_Human_Health_Toward_an_Ecosystem_Context) [accessed Oct 29, 2015]

The ecological or in the ecosystem perspective of health (O'Conner and Lubin, 1984) suggests that a person's behaviour is strongly influenced by their surroundings such as the community and culture with which they identify with, not just their internal attributes as: intelligence, personality and attitudes. Examining the ecological factors that relate to health is important as changes in the physical environment can nudge individuals towards a healthier lifestyle. However, the concept of culture is again quite generic in this model.



**Figure 9 - Mandala of health by Hancock and Perkins (1985)**

[http://www.researchgate.net/publication/227664188\\_Evolving\\_Models\\_of\\_Human\\_Health\\_Toward\\_an\\_Ecosystem\\_Context](http://www.researchgate.net/publication/227664188_Evolving_Models_of_Human_Health_Toward_an_Ecosystem_Context) [accessed Oct 29, 2015]

Hancock and Perkins (1985) posit the health Mandala that depicts some determinants of an individual's health in layers or nestled form. At the core they cite spirit, body and mind status that relates to the physical, spiritual and psychological aspects of an individual. Any injuries to the physical body or imbalances may affect health negatively. Spiritual disharmony and psychological problems may also contribute to unhealthy individuals. The second layer consists of family relations to an individual. Cordial family relations support health while unhealthy ones impede an individual's health wellbeing. The third layer consists of the human made environment and community. It has three major elements: lifestyle, work and sick care systems.

These three elements are influenced by the psychosocial economic environment, physical environment, human biology and personal behaviours. Indeed, healthy personal choices such as avoiding risky sexual behaviours may impact on an individual's reproductive health by lowering chances of venereal diseases. However, psychosocial economic environment characterised by poverty, may push young girls and single mothers to prostitution, greatly exposing them to the risk of the HIV virus. Unhealthy and deprived physical environments such as slums could expose children and young girls to crime and vices such as prostitution, drugs and illicit brews again exposing them to the HIV virus. Accessible sick care systems may support sickly individuals, help with early diagnosis, provide timely treatments, greatly averting

early deaths. Under developed and out of pocket payment sick care systems that may be out of reach for ordinary poor people like the Kenyan medical system, may explain many unnecessary early deaths and the poor health well-being of the majority of poor Kenyans.

Lack of job opportunities for majority of young people and the relatively low wages paid to the individuals in Kenya, may affect their lifestyle choices, impacting their health and well-being, and access to the unaffordable sick care system. Healthy work environments also may impact positively on health wellbeing, while unhealthy work environment may contribute to poor health outcomes. Healthy communities may encourage healthy lifestyles and avail sick care systems to their citizens, while unhealthy communities may be economically deprived leading to underdeveloped sick care systems and low economic activities.

The final layer of the Mandala of health model consists of biosphere and culture. Biosphere relates to the living organisms and their environments or the part of the world in which life can exist. The ecosystem balances may impact positively or negatively on health. Quality of life in slums may mean that the air and water is polluted exposing the residents to air and water borne diseases. Unfertile soils and inadequate rainfall could mean inadequate food supply negatively affecting the health being of humans and animals.

Extremely hostile climate conditions as found in Northern Kenya could mean that farming could be difficult again, explaining food insecurities that characterise these areas. Lastly, healthy cultures could encourage healthy lifestyles, while some cultures may encourage practices that may impede on health and well-being of its people. For instance, female genital mutilation encouraged by some cultures in Kenya as the Somalis, bring many health complications to the girls. It causes extreme pain, may lead to infections, causes painful sexual experiences and complications during childbirth. Simply stopping the practices may prevent these problems; however, changing this culture is not easy.

Although the model is not prescriptive, MacLachlan (2006) suggests that it can serve as a guide to a comprehensive understanding of the human ecosystem and some of the factors that determine the well-being of individuals that may need addressing to healthier individuals. Indeed, it is the first model that represents a nested hierarchy of

influences on individual health such as: family, community, culture and biosphere recognising their influence on health. The model, however, does not give much attention to socio economic and biophysical environmental structures and processes that influence health (Vanleeuwen, et al., 1999) and certainly it does not give culture, the requisite attention as well.

On a positive note, all these models and perspectives of health suggest that cultural environment influences health and point to the need for culturally informed approaches to health interventions. They are problematic for not detailing what they mean by culture, or in other words, the parameters of culture that should be investigated or explored in relation to health. The need for considering culture in health was well emphasised by the World Health Organisation (WHO) in the Alma Ata declaration of 1978; which emphasised on the need to focus on the social dimensions of health. They suggested the need to focus on primary healthcare and the importance of community participation and ownership of healthcare. They reiterated the need to incorporate and integrate community and cultural values into healthcare for successful primary healthcare and community participation.

Indeed, culture provides the core conceptual framework for understanding all of human behaviour including health. Culture infiltrates most aspects of human life. They shape biological needs like reproduction, diet, elimination and how individuals interact with their environments and certainly these factors affect the wellbeing of the members of a particular culture (Winkelman, 2009). It affects health by enhancing or reducing both the risk factors and conditions associated with an increased likelihood of diseases. Culture may also provide protective factors that may reduce the risk of a disease. It is indeed central to health assessment as culture affects how individuals interpret their experiences. It also informs the criteria used for judging and defining normalcy and abnormality and further provides definitions of social expectations regarding quality of life.

MacLachlan (2006) suggests that culture influences health concepts such as concepts of desirable physical abilities, views of ideals, normal and problematic bodily conditions, preferred psychological dynamics, emotional states, social relations, illness concepts, perception of symptoms, spiritual or metaphysical conditions and relations. Culture affects health behaviour in many ways. Firstly, it affects how



individuals conceptualise health maladies. Secondly, it impacts the distribution of causes of diseases and illnesses by motivating risk behaviours and disease exposing practices. Thirdly, it informs symptom recognition and care seeking behaviour and fourthly, influences how health providers are created and how their structures and institutions respond to health care needs. Indeed, culture shapes how individuals and groups utilise three key healthcare systems of the popular, folk and professional sectors of health care. Fourthly, it determines the emotional and psychodynamic influences on health and wellbeing and provides psychodynamic, symbolic and social mechanisms of healing relationship (Airhenbuwa, 1995; Helman, 2007; Winkelman, 2009).

Cultural dimensions are significant to health. Collectivist cultures mainly promote harmony within small supportive groups and consequently have lower disease levels compared to individualistic cultures (Triandis, et al., 1988; Bond, 1991). The collectivism notion and philosophy of *umunthu* (a person is a person through other persons), popular in African cultures is very different to individualism enshrined in Descartes' *cogito ergo sum* (I think therefore I am) found in Western thinking (Bandawe, 2005). Social support found in many collectivist cultures may influence health positively. High levels of social support have been arguably associated with less stress, increased disease resistance, better adherence to treatment, easier labour and childbirth, less severe bereavement reactions and even reduced death rates (Ornstein and Sobel, 1987). Culture may, however, influence health negatively by perpetuating ill-health practices such as forced female circumcision that impacts negatively on the reproductive health of girls by predisposing girls to associated bleeding, infections and increase in child birth complications (Elchalal, et al., 1999). It is therefore necessary to investigate and understand the aspects of culture that may impact positively or negatively the well-being of individuals especially within the Kenyan context.

### **3.5. Cultural elements in relation to Health and HIV/AIDS**

Airhenbuwa (1995) suggests that the future of health promotion and disease prevention strategies lies in the ability to centralise the discourse on culture and context and placing them at the core of programmes. He further suggests that the philosophy of health programmes should be grounded on cultural codes at both micro and macro levels of society with target audiences as collaborators so that programmes can meet their needs.

Breidlid (2009) contends that the failure by modernist interventions to achieve health behavioural change means that we urgently need to explore the extent to which traditional processes, practices, dynamics, structures and networks within communities are under-reported and under-utilised as resources to support or facilitate behavioural change. These arguments strongly point to the need for cultural and contextual understanding to unearth relevant beliefs, attitudes, values pertaining to practices surrounding health and HIV/AIDS and the need to engage with them sensitively to possibly nudge behaviour change. A critical review into some of the important cultural elements and how they impact on health and HIV/AIDs is therefore crucial.

#### **3.5.1. (a). Beliefs, attitudes, values and their impact on health and HIV/AIDS**

The triad of beliefs, attitudes and values relate to Harris (1980) super structural aspects of culture that exemplifies its abstract essence. They are characterised by mental and symbolic forms such as beliefs, ideologies and meanings that guide behaviour. The superstructure guides behaviour at the infrastructure and structural levels of culture.

Wright (2006) suggests that beliefs relate to organised patterns of knowledge that an individual may hold to be true or real about the world. They relate to the opinions or convictions that we hold about different realities of the world. What may be construed as truth or false may be based on facts, falsehoods, universals and most importantly, may vary from culture to culture. Beliefs are social constructs that are learnt or acquired from various sources and vary in their strength, from weakly to strongly held ones and also vary in the importance we attach to them. There are various sources of

beliefs. They include: the media, reasoning based on discussing or arguments, institutionally taught like education related ones, work, political parties, marketers and sales people, experiences based on perceptions, travel, religion from sacred book, imitation of parents and may also be learned from friends and other reference groups (Wright 2006). Belief can develop into an attitude according to the strength of feeling involved, the stronger the belief the stronger becomes the attitude and the more likely it may affect behaviour positively or negatively. A cluster of inter-related beliefs form attitudes.

An attitude is a learned tendency to respond in a consistent way to a given object or entity. They are favourable or unfavourable evaluations of an object (Eagly and Chaiken, 1993). They play a key role of helping us explore and navigate our complex environments and may help predict and explain human behaviour (Olson and Kendrick, 2008). They summarise how we feel about pretty much everything and this summary nature makes them efficient, flexible and adaptive (Eagly and Chaiken, 1993; Fazio, 1995). They have three key domains, the affective domain that deals with our emotions or feelings, the cognitive domain that deals with our reasoning or rational aspect and the behavioural domain that deals with our actions, referred to as the ABC's of attitude or the tripartite model that explains how attitudes are formed (Zanna and Rempel, 1988).

Attitudes may be formed through implicit or unconscious processes and explicit or conscious ones (Rudman, 2004). Tesser (1993) controversially suggests that attitudes do have the inherited or unlearned component, questioning the nature versus nurture debate on attitudes. Buss (1989) posits that there may be a possibility that some of our attitudes may be a product of human's evolutionary past. Attitudes as a social construct are learned from socialising agents such as parents, peers, learning institutions, nation, among other sources perhaps strengthening the nurture rather than nature debate.

Appealing to the elements of the tripartite model may change attitudes. Cognitive approaches that rely on how people think about an object may be used via persuasive communication to introduce conflict or dissonance between the varying strengths of beliefs (Festinger, 1957). Marketers use information that is convincingly presented to create the cognitive uncomfortable state of dissonance that has to be resolved by

altering, denying or rationalising our beliefs. They mainly use research to unearth attitudes held about specific products. They then creatively present information that position their positive beliefs to motivate cognitive dissonance and offer advice on how to resolve the dissonance by directing consumers to purchase their products. Behavioural approaches rely on reinforcements and punishments.

Consciously rewarding positive attitudes helps strengthen the stimulus response bond while punishing may help to weaken the bond (Skinner, 1968). Marketers use free samples, lower introductory prices and discounts, to induce or nudge and reward customers for directing their attitudes and behaviour in line with the marketer's view. Social approaches are based on Banduras (1986) social learning, where he suggests that we learn by imitating individuals we admire within our desired reference groups. It is based on the need to belong and be accepted by our preferred group/s by conforming to their beliefs and attitudes. Marketers make use of role models in their adverts to associate their products to the positively held attitude towards the models in their adverts.

Attitudes may be measured via various scaling methods including Likert scale evaluating how strongly people agree or disagree with favourable and unfavourable statements about an attitude object and also via semantic differentials that rates attitudes on bipolar adjectives among other methods. In differentiating attitudes and values, Kristiansen and Zanna (1991) link values to attitudes by suggesting that attitudes can either express values or influence the perception of values. However differences exist between the two; in that, values are more central to personhood as compared to attitudes (Erickson, 1995; Hitlin, 2003) and are more durable over time as compared to attitudes (Konty and Dunham, 1997).

Kluckhohn (1951, p.395) defines values as a conception explicit or implicit distinctive of an individual or characteristic of a group of the desirables, which influence the selection from available modes means and ends of actions. They are centrally held enduring beliefs, which guides actions and judgments across specific situations and beyond immediate goals to more ultimate end states of existence (Rokeach, 1968, p.161). Posner and Schmidt (1996) describe values as lying at the core of personality thereby influencing choices individuals make. Schwartz and Bilsky (1987) argue that values are enduring beliefs or concepts about desirable goals and modes of action.

They are trans-situational, influence behaviour and provide relative ordering of competing beliefs modes of action and behaviour. Values determine our definition of good and bad, and reflects the ideals shared by a group of people (Trompenaars and Hampden-Turner, 1998). Ideal behaviours give us a feeling of how we aspire or desire to behave by providing a yardstick of desirable versus undesirable behaviour to choose from. They predict or at least act as antecedents of actual behaviour (Connor and Becker, 1994; Stackman, et al., 2000). They moderate behaviour in a way that they specify modes of conduct that are socially desirable, in the face of threats or social sanctions such as punishment and shame and thereby induce individuals to conform to dominant social values in their actions (Kluckhohn, 1951).

Values are ideals that carry inherent positivity unlike attitudes that carry both positive and negative valences (Hitlin and Piliavin, 2004). They are not simply abstract conceptions of the desirable but are motivational in regard to social behaviour explaining the link between values and behaviours (Feather, 1995). However, the question of what is defined as positive or negative behaviours may vary from group to group based on dictates of socialising agents. Values are the ones that guide the choices of universal values like freedom, happiness, and pleasure, which may differ among others; how they are construed across cultures and may further be moderated by inherited individual traits and characteristics. This is because individuals incorporate socially shared values into their self-concept. Although there may be individual interpretations of these shared values (Smith, 1991).

Values may be researched via ranking approach (Rokeach, 1968). The rationale for ranking is that values are perceived as always being in competition with one another. They are also measured via rating system (Schwartz, 1994), which considers most and least important values. Marketers are interested in values because they motivate individual and group consumer behaviour by influencing concepts of self and group identity, perceptions towards products and ultimately motivations to consume or not to consume the products (Kahle, 1996). Marketers are, however, aware that they have the potential of changing values by acting as change agents via persuasive communication and behavioural changes strategies of classical and operant conditioning, mainly by going back to key strategies of changing beliefs and attitudes that eventually translate to value change (Ball-Rokeach, et al., 1984).

In relation to health, different cultures have varying beliefs, attitudes and values that guide their understanding of maladies, explanations of their sufferings and choices of treatments offered. A universal folk concept of health is the classification of origin of illness as either natural or unnatural. Natural illnesses are attributed to either not following laws of nature or maintaining harmony in an individual's life (Giger and Davidhizar, 1991). Native Americans and many African societies believe that nature is powerful and touching and or eating certain animals and being insensitive to the environment may invoke illness (Carmody and Carmody, 1993; Huttlinger and Turner, 1994; Wing and Thompson, 1995). Imbalances of the Chi energy are believed to cause natural illnesses among the south-eastern Asians (Lin, et al., 1992). Defying laws of nature is attributed to natural illnesses by the Afro-Caribbean (Schwartz, 1985). Unnatural illnesses, on the other hand, are mainly attributed to black magicians among Afro-Caribbean and witches among central and South American. They are also associated with angry spirits punishing people and the evil eyes in Mediterranean, parts of Africa, Central and South America, and South East (Pasquale, 1984; Campinha-Bacote, 1992; Uba, 1992; Wing and Thompson, 1995).

In Latin America, the concept of hot and cold body balance explains cultural understanding where some illnesses are referred to as cold deserving hot foods, and others, hot deserving cold foods. The Chinese hold a similar body balance based on the concept of *Yin* and *Yang*. *Yin* has the attributes of darkness and femininity while *yang* is bright, hot and masculine. The imbalance of yin and yang causes illness and hence the need for curative systems such as acupuncture to help restore such balance that is based on sticking needles at specific body points (Wing, 1998).

Murdock (1980) distinguishes between natural and supernatural beliefs in relation to illnesses. He claims that theories of natural causation of illness like infections, stress, accidents and human aggressions among others were outnumbered by theories of supernatural causations. He divides supernatural causations into three categories. Firstly, mystical causes based on illness caused by acts or experiences of a person such as ill luck, astrological influences, contagions, violating of taboos and ominous sensations like sights and dreams. Secondly, illnesses caused by personalised supernatural beings such as spirits, ghosts and gods like spirits' aggression and thirdly, illnesses related to use of magic maliciously by the use of witchcraft motivated by envy.

The beliefs held about the causes of maladies influence the curative approaches undertaken. For instance, considering the Kenyan context, the Digo of Kenyan Coast attributes disease causes to God, ancestral spirits, possession by evil spirits (*shaitani*), sorcery, broken taboos and disharmony with the supernatural beings, especially failure to adhere to Islamic rites. To cure various diseases, they mainly use herbal medicines, koranic medicines, charms and amulets worn on various body parts, foods, strict observance of taboos and performance of required rites after consulting diviners, and as a last alternative consulting western medicine believed to be watered down and ineffective (Read, 1966). The Samburu of Kenya, relatives to the Maasais consider diseases as poison that must be expelled by purgatives mainly from plants and trees to keep the body system clear. They further believe that an individual must avoid contact with any forms of excrement as they consider them to be the most unclean. They regard eggs as hens' excrement and avoid them as well as foods like fish and pigs culturally considered unclean. Interestingly, this belief extends to as far as avoiding marrying women from tribes that eat unclean foods. The Somalis of Kenya consult the *wadads* considered as local practitioner that may prescribe treatments ranging from foods, cauterisation and bleeding.

In relation to HIV/AIDS, cultural differences and blame games in beliefs and attitudes are seen right from the debate regarding the origin of the HIV virus. The virus was first believed to originate from Haiti to the USA and later the African hypothesis emerged. It is suggested that monkeys from Congo in Africa had transmitted AIDS like virus to humans via practices such as injecting monkey blood as a sexual stimulant, use of dead monkeys as pets, eating of monkeys' meat or from monkey bites and bizarrely when humans had sex with monkeys. The HIV/AIDS origin debate clearly evidences cultural beliefs and attitude blame games. Chirimuuta and Chirimuuta (1989) contend that the African hypothesis is based on a racist stereotyping of black people as dirty, disease carrying and sexually promiscuous and that racism and not science motivated the search for the origin of AIDS.

Belief in witchcraft have led to narratives that HIV positive individuals are bewitched, rather than accepting to take a confirmatory test and managing the infection. This has mainly led to PLWAS wasting much valuable time and family resources with witchdoctors trying to cure them. This ultimately results in weaker immune systems and unnecessary deaths, while they should have really followed the allopathic route and taken anti-retroviral medicine that may strengthen their immunity systems, giving them a longer quality of life without many opportunistic infections.

Others consult herbalists that give them endless concoctions that do not really help them, resulting in untimely deaths and unnecessary suffering. Beliefs in polygamy, extra marital affairs, values attached to searching for the preferred boy children and female circumcision, low value accorded to women may all be risk factors that may be fuelling the HIV spread.

Traditional forms of healing are, perhaps, the only health system that is accessible to everyone in Africa and many traditional societies of the world and some 80% of Africans use traditional healing methods (Bannerman, et al., 1983). The traditional healing system has been in existence over years, mainly because it is based on cultural values and norms that are passed from generation to generation, is readily and locally available and arguably affordable. The problem, however, is that African cultural evolution has been misrepresented and it is no surprise that its healing modalities have been victims of allopathic hegemony (Airhihenbuwa, 1995). This is mainly because the medical beliefs and practices of most of the non-European people were considered primitive, savage and barbaric. They were not perceived as credible curative systems but regarded as magic, religion and witchcraft and consequently, laws were enacted to criminalise traditional medicine mainly by colonialists (Seijas, 1975).



Ignoring traditional medicine is tantamount to ignoring the cultural impact of health and disease, as traditional medicine is an important health care sector in many African counties (Airhihenbuwa, 1995). Interestingly, Chinweizu, et al. (1983) claims that it is a commonly and easily observed fact that even the most detribalised and modernised Christians, scholars, scientists, politicians and entrepreneurs among the African bourgeoisie still consult African divinities, diviners and healers when their health or other affairs are in serious trouble. This is based on the belief that western medicine and the Christian God have their place but when the going gets tough, one runs back to their roots and ancestral ways.

Key to the integration of traditional and allopathic medicine is an understanding of ethno-medicine, mainly concerned with understanding the interplay of cultural beliefs, experiences of suffering and curative methods. From this perspective, Kleinman (1980) suggests that found in all societies and based on perceived beliefs, attitudes and values of health, exist three overlapping key health care systems. The first is the popular sector where suffering is first experienced and explained. It is made up of friends, family and colleagues that determine the choice of any of the other two routes of health care namely folk and professional systems. MacLachlan (1996) argues that for health promotion to be successful, it needs to address and counteract anti-health promotion ideas that are a huge part of the popular sector.

The second health care system is the professional sector. It is based on Europe and North America professional health sector, mainly driven by biological reductionism and the necessity for scientific logical and consistent explanations. This belief makes them dismiss other alternative health care systems, although inconsistent explanations of illness and diseases characterise their practice. They overlook the fact that other societies too have their alternative systems and ignore the fact that all health care systems have their positives and negatives, necessitating tolerance and a pluralistic view of health (Vincent and Furhnam, 1996). The last health sector is the folk system that includes sacred and secular healers like faith healers, witchdoctors, mediums, fortune-tellers and herbalists and also includes alternative medicines like acupuncture, hypnosis among others. The popular and the folk sector vary from culture to culture and arguably, the professional sector although universal may also take a cultural context interpretation.

The differences in the beliefs, attitudes and values of different groups' ethno medicine and American-Euro-medicine have created a cultural gap that may, perhaps, explain the cultural noise existing in many societies, considered traditional by the developed countries. This is based on a view that culture is an exotic collection believed to exist only in Africa, Asia, Latin America and in their descendants in the Diaspora, a belief that may render many American-Euro led programmes ineffective in other countries and continent contexts. There is, therefore, the need to address this cultural noise for the sake of the well-being of the individuals in these geographic areas and their descendants in the Diaspora (Airhihenbuwa, Makinwa and Obregon, 2000).

Cultural blame games arguably do not solve much as HIV/AIDs is now a worldwide scourge. Importantly, prevalence rates differ across ethnic groups and countries depending on their cultural beliefs and practices. This means that an understanding of socio-cultural symbolism is inevitable as well as a commitment to multiculturalism and cultural tolerance approach, in order to understand how different people understand their health and suffering (MacLachlan, 1996). Carr (2002) suggests the need for glocality describing the need to understand interaction between local beliefs and global systems as each interaction produces a distinctive local resolution to the HIV problem. The bone of contention, however is, could the lack of integration between traditional and allopathic medicine explain the low uptake of HIV testing, medication and unnecessary deaths in Kenya? Could the failure to integrate cultural beliefs, attitudes and values in health and HIV programmes also explain the lack of behaviour change and the high HIV prevalence among women and girls compared to the men in Kenya? Gleaning on how beliefs, attitudes and values impact on HIV/AIDS targeted programmes is necessary to understand how programmers deal with them in their programme work.

### **3.5.2 (b). Language and its impact on health and HIV/AIDS**

Symbols refer to objects and processes that carry a meaning unique to a particular group of people Geertz (1973, p.89). Language is a significant symbol because it is a means of communication that facilitates social interaction and fosters shared values and norms. Communication involves a complex and multi-layered dynamic process through which meaning is exchanged (Adler, 1991; Albaum, et al., 2005) and

includes any behaviour that another person perceives and interprets. Language consists of spoken words, non-spoken ones and symbols of times, space, things, friendships and agreements (Hall, 1976) that vary from culture to culture.

The spoken language mainly mirrors culture because it is a cultural construct. However, even when similar languages are spoken, the vocabulary, idioms, grammar, and cultural reference usage are all usually different due to cultural differences. Marketers are aware that language, whether written or spoken, is an embodiment of culture and a means people use to communicate with people from their own cultures or other cultures. It affects strategy and the marketing mix choices as in writing of contracts, negotiations, advertising, labelling of products and branding among other marketing aspects. Mishaps in language use may be costly and can interfere with achieving of marketing objectives. Marketers are keen to avoid mistranslations of product labels, advertising slogans and other language blunders that may occur when language analysis is assumed or not done at all.

In low context cultures, communication is clear and straight to the point. Whereas, in high context cultures, it goes unsaid and depends on the interpretation of the non-verbal language and the context. Ambiguity is the norm and directness is avoided (Hall, 1982). Language is significant as it may foster unity in a society as exemplified in Kenya's use of Kiswahili as the national language and use of English as the official language in key social structures such as schools, media and press. On the other hand, it may also cause division as seen in the use of tribal languages that promote ethnic differences and help fuel tribal hatred, clashes and wars amongst Kenyan tribal groups.

Low context cultures are mainly individualistic cultures found in the developed west and North America whereas high context cultures are mainly collectivist that are mainly found in Africa, Asia and South American countries. This again suggests the differences in communication styles that are mainly cultural, between the individualistic and the collectivist cultures.

Soola (1991) argues that when dealing with traditional societies, it is important to understand how to communicate and arguably, these societies value segmentation of audiences, channels, messages and the use of different channels that may be different from those used in the west. Cultural dynamics are significant in language use such as in communication codes, meaning and context between the story teller/communicator and listener/target audience that may serve to promote or hinder knowledge production and acquisition.

Oral traditional cultures found in many African countries, traditionally instructed their members orally. The choice of the listening style by the listeners mainly depended on who the speaker was, speakers' knowledge of the subject matter and age, the way the words were said and in what context, all suggesting the need for ethical and cultural congruence before assuming the role of a story teller or information source. It has been demonstrated that in several African countries, person-to-person communication like home visits, has been more effective in changing negative health behaviours, than when messages are distributed through the mass media and written communication. This is because oral tradition is the customary bedrock for the production and acquisition of knowledge and construction of reality in African cultures (Airhihenbuwa, 1995).

Many health prevention and promotion programmes in Africa are mainly western led and use written communication as exemplified by the use of posters, flyers and other pictorial learning tools in health promotion and communication programmes. These visual elements albeit useful, perhaps may have little or no impact on individuals in these oral cultures. Could this explain the cultural gap prevalent in effective health communication strategies? Could there be the need for developing culturally appropriate methods of communicating for meaningful health related learning? This is indeed worth investigating.

In relation to sexual matters communication, Kambas and many other Kenyan ethnic groups mainly used euphemism to convey sexual information. For example, the Kamba men asked women for 'tobacco snuff' referring to a sexual experience to avoid sounding vulgar. Grandparents could be explicit in their usage of language. However, parents were not expected to use sexually explicit terms for their children (Ueda, 1973). Among the Nilotic groups like the Luos of Kenya, girls traditionally

received sex education from grandparents in special huts – *siwidhe* (Cohen and Atieno-Odhiambo, 1989). The Kalenjin girls again received instructions mainly from mothers and grandparents while the boys were taught by their fathers and other males (Huntingford, 1973). Among the Maasais, another Nilotic group, age mates, mothers and old women-*kooko* were responsible for girls' sex education (Hinde and Hinde, 1901). Generally, in most Kenyan tribal groups, discussion on sexual matters were not supposed to be done freely but were restricted on grounds of gender, age sets and mainly grandparents were believed to be repositories of wisdom and knowledge, and were expected to socialise boys and girls into adulthood. Older men and women were well respected on the grounds of their life experiences and again they mainly used songs, proverbs, stories, riddles and puzzles to instruct others society members orally.

The bone of contention, however is, could the failure by the western funded and directed programmers to engage with culturally preferred and relevant communication models explain lack of effective communication and cultural communication noise and gap? Could this noise be responsible for the failure of behaviour change in spite of the many information and awareness programmes especially regarding HIV/AIDs by the programmers? This communication gap possibly needs further investigation to understand it better.

### **3.5.3. (c). Education**

The education system featured among African tribal groups before the invasion of Europeans was an education that prepared them for their adulthood responsibilities in their homes, villages and tribes (Scanlon, 1964). The education of girls was differentiated from that of the boys in accordance to the roles each gender was expected to play in their adult lives (Kenyatta, 1965). Education devices were mainly folk tales, proverbs, riddles and songs all used not only to amuse but teach ideal behaviours, morality and to pass culture from one generation to another (Ociti, 1973).

Children and young adults learned by listening to elders and imitating them. Children were educated to know and internalise roles that were appropriate to their age. Key instructors during childhood were the mothers and the extended family. The age groups become important as circumcision approached and during and after circumcision. Older members of the community used orature based on dances, myths,

and proverbs to prepare the youth for adulthood. The African indigenous education was therefore quite adequate as far as it met the requirements of the society and it had its objectives, scope and methods that reflected cultural realities of the people (Ociti, 1973).

A lot changed when the West invaded and brought formal school systems. The new school system represented education for cultural change, individuality, diplomas and degrees that were a means to social prestige, economic and political power (Ibid). The west equates literacy with education and stages of development and uses literacy levels to classify countries as developed or underdeveloped (Anderson, 1966). Indigenous African education indeed had its positives and negatives and many of its holistic aspects remain arguably admirable. Boateng (1983) argues that a total rejection of the African heritage will leave African societies in a vacuum that can only be filled with confusion, loss of identity and a total breakdown in intergenerational communication.

Different Kenyan tribal groups had their distinct indigenous education. Among the Maasais, from birth boys were instructed by their mothers and fathers and were initiated around the ages of 14-20 years in batches, after which they became junior warriors. They had their formalised education structure in the *manyattas*, where elders taught them the matters of warfare, social, political and sex education. They lived in *Manyattas* for most of their formative years. After the British introduced western education, the Maasais found it difficult to choose between the 'manyatta' and formal western education. Many Maasais despised the western education and described schooling as an unbearable loss similar to death or enslavement of children, as they are considered to be lost forever to their cultural way of life (Knowles and Collett, 1989). Many of them choose their cultural way of life; a factor that may explain their current low literacy rates.

Traditionally many Kenyan ethnic groups instructed their children based on their cultural attitudes and values. Grandparents were the key source of knowledge for the children, although age mates and parents had some instructional roles. Methods of instruction were mainly oral-media mainly using riddles, puzzles, saying, songs, stories, proverbs and modelling. Figurative language was used in stories and imagination was important in learning.

The instructional methods were certainly in line with Hall (1976) low context culture, where much is left to be interpreted based on verbal and non-verbal cues rather than explicit use of words.

When the British introduced western formal education, certainly much of the informal cultural learning was interrupted and western-based instructional methods were used. Literacy rates among the Kenyan tribal rates, unfortunately, correlated with their alignment to the colonialist. For instance, the Luos did not put up a fierce resistance to the British rule which were rewarded with formal education privileges, explaining their high current literacy rates, unlike the Kikuyus that did put up a fierce '*maumau*' rebellion explaining their post-independence low literacy rate (Berg-Schlosser, 1984).

Another source of disparity in literacy rates is the preference of educating boys based on cultural attitudes and values of preferring boys to girls. This is mainly because culturally, boys inherited land and perpetuated patriarchal family lines while girls were expected to be married off to perpetuate the husband's lineage. Since western education requires resources such as money for fees, books and uniform, many families preferred to educate the boys rather the girls. Unfortunately, western education became key to blue collar jobs, better income and drivers to modernisation unlike the traditional informal education that was associated with illiteracy by the west. Many of the formally educated individuals in Kenya prefer living in urban areas while a large population living in the rural set up mainly have low levels of western education attainments.

Illiteracy and low literacy attainments in Kenya mean that individuals may experience unemployment and where they are lucky to find jobs, they get low income or get casual jobs, explaining the high poverty levels. Unfortunately, poverty is highly linked to risky behaviour that may predispose individual to HIV/AIDs. For instance, uneducated women cannot seek professional jobs and depend on men, or are forced by poverty to engage in transactional sex as commercial sex workers that may increase their exposure to the HIV virus. Verheij (1996) suggests that variation in HIV/AIDS mortality between urban and rural set up in Kenya results from differences in life styles, ecological situations, access to social and health services and unequal distribution of income and resources.

Income plays a big role in accessing medical care, as healthcare is not free in Kenya. It may also influence healthy eating lifestyle, access to appropriate housing and other social amenities and participation in pro-social behaviour required in a collectivist culture like Kenya. At least, higher education attainments might increase chances of a reasonably paying job that may sustain a healthy and decent lifestyle. Unfortunately, unemployment rate of university graduates in Kenya is peaking, forcing even the educated into poverty and risky behaviour. However, the bone of contention is, to what extent traditional methods of instructions and education, choice of educators, venues for education, high illiteracy rates among rural folks amongst other realities of education in Kenya, are incorporated in programme work by programmers targeted HIV/AIDS amongst different tribal groups of Kenya. A gleaning of this reality is necessary to understand how education impacts on HIV/AIDS related programmes.

#### **3.5.4 (d). Aesthetics**

Perception of beauty is multi-dimensional; it may refer to physical, intellectual, moral or verbal aspects (Johnson, 1982). Aesthetic concept is, however, socially and culturally constructed as culture shapes notions of beauty, philosophy and values on which aesthetics are determined and presented (Harrison, 1982). African aesthetics were mainly learned through socialisation and participation in the daily life aspects of the people. It permeated orature based on what was said in songs, poems, drama, proverbs, riddles, chanting and sayings (Thiong'o, 1986). It also included folklores that comprise of traditional ways of cooking, architecture, dressing, religion, art, music and dance, all representing a lifestyle of a tribal group. African aesthetics appeal to appreciating nature and symbolically represent man's relationship with God, nature, spirits, ancestors, plants, animals, seen and unseen terrestrial and celestial forces. It captures the tripartite essence of man comprising of soul, spirit and body and is embedded in traditional and cultural values and beliefs that have a functional and communicative role (Onyewuenyi, 1999).

Considering the tribal groups of Kenya, culturally, different groups had their symbolic aesthetic symbols. For instance, among the Luyia of Kenya, girls had their lower front teeth removed and tattoos on the abdomen and back, soon as they got their first menstrual period to signify entrance to womanhood. Beauty and courage were



symbolised by markings on the face, piercing of lower lip and ear lobes and girls that avoided these practices were regarded as cowards (Lukalo, 1973). The Luos of Kenya are stereotyped as being fond of bright colours and being pompous, proud and having a taste for the finest things money can buy (BergSchlosser, 1982).

The Maasai group of Kenya is well known for their beadwork that has a sexual connotation. Traditionally, the Maasai girls exchanged tokens of beads with their lovers in the form of beadwork, money and songs. Culturally, it was shameful for a young Maasai man to be without female lovers, as they would not wear the typical beaded jewellery that culturally distinguishes them. Bright coloured beads of red, white, dark blue and black sewn on strings are worn on wrists, arms, ankles, legs, neck, head and waist making young men and women attractive to one another. A Maasai man without these bodily embellishments stands forth as a social anomaly. Being sexually active among the Maasai's was considered a sign of prosperity and good health because of the traditional belief that sexual inactivity causes accumulation of semen that causes discomforts and ill health such as stiffness, aching joints, backache and breaking of the back (Talle, 2007).

Different Kenyan ethnic groups, to date, have their distinct cultural songs, dances and costumes. The Kambas are known for their beautiful rhythmic drumming and vigorous shoulder shaking dances, the Swahilis of Mombasa for their '*chakacha*' – a slow motion seductive hip moving dance. The Kikuyus for the '*mwoboko*' dance that is similar to waltz, the Maasais dances showcase their beadwork and high jumping skills. Aesthetics may also be seen in individual's choices related to marriage partners, as individuals are mainly attracted to the physical appearance and other forms of aesthetic. Traditionally, strong well-fed individuals were preferred to feeble looking ones that are mainly regarded as sick. It is however important to glean this concept in order to understand how aesthetics as a cultural element impact on programmes targeting HIV/AIDS in Kenya and how programmers deal with this cultural concept.

### **3.5.5 (e). Social organisation**

Social organisation relates to groups and subgroups and how they interact in a society. It refers to the structural aspect of culture (Harris, 1988), partly based on the social organisations at the domestic level that includes family, gender roles, and division of labour. It also includes the political sphere characterised by division of labour, class systems and political structures. The family is the basic unit that may provide individuals of a society with their genetic characteristics and the initial socialisation into the society. Initial beliefs, attitudes, values and behaviour are learned within the family and later within other structures of socialisation like among peers, community, schools, and nations among others. Indigenous African societies were structured along with age, gender, and roles.

Possibly significant to health and HIV/AIDS, the question may be of gender that refers to the social construction of roles, responsibilities and obligations associated with being a man or woman. Helman (2007) suggests four elements of gender: genetic gender at birth, somatic gender based on phenotype, physical appearance and secondary sex characteristics, psychological gender based on self-perception and social gender based on cultural definitions that dictate perception and behaviour. The sex role theory by Connel (1987) suggests that men and women play roles decided in part by their sex and societal roles expectations based on the idea of role learning, socialising and internalising.

A similar theory is the script theory. It posits that sexuality is learned and internalised through social processes, learnt from an early stage, is based on acceptable norms for where, when and with whom individuals can relate to in relation to their physical sexuality. It perceives sexuality as a socialisation process that explains the difference within and between countries, communities and cultures at differing historical periods (Simon and Gagnon, 1987; Gagnon and Parker, 1995). Scripts characterise ways in which gender, sexuality and relationships are negotiated at three interrelated levels: cultural, interpersonal and individual levels (Laumann and Gagnon, 1995).

Sexuality is acquired through learning processes in which the individual learns scripts for sexual behaviour in accordance with what is acceptable in specific localities based on the social and cultural context (Gagnon and Simon, 2005). Individual choices are eventually as a result of the complex interaction between the individual's wishes, desires and the social and cultural practices into which the person is socialised. An understanding of how sexual scripts are constructed at cultural, interpersonal and individual level among target audiences is crucial, in order to understand how sexual scripts, family, gender roles, political structures and division of labour impact on programmes targeting HIV/AIDS amongst different tribal groups of Kenya.

#### **3.5.6 (f). Religion and health**

Durkheim defines religion as a unified system of beliefs and practices relative to sacred things, things set apart and surrounded by prohibitions, beliefs and practices that unite its adherents in a single moral community (Durkheim, Cosman and Cladis, 2001, pp.46). He defines two spheres of religion. Firstly, the sacred sphere that includes rituals, symbols and places of worship that impact the physical and moral aspects of people's lives. Secondly, the profane sphere that refers to anything else that does not hold religious significance.

Religious leaders and traditional healers are influential in most societies and are looked upon as role models because they act as the moral conscience of society, specifying norms to which societies should adhere (Ahmed, 1999). They hold authoritative positions in societies mainly because they are associated with divine or supreme beings. They give advice on ethical, moral and behavioural issues affecting societies and may use holy books and divinations to provide guidance. In relation to illness and diseases, they may offer healing through prayer or traditional medicine. Religious leaders have the ability to influence individuals and societies, as it is believed that they are in direct communication with their communities and have the knowledge of complexities of daily life compared to other types of leaders (Hewson, 1998).

Conversely, the insignificance of religion was highlighted by Freud (1989). He dismissed religion as merely neurosis exhibited at the cultural level. On a negative side, religion may create fundamentalists whose interpretations may hold prejudiced and bigoted opinions towards out groups causing conflict. The caste system among the Indian Hindus is an example of the use of religion to isolate and discriminate individuals. The *Brahmins*- priests and teachers are considered pure, depicted as from the head of their creators, the *Kshatriyas* - warriors and rulers from the arms, the *Vaishyas* - traders and merchants from the lower limbs, the *Shudras* - the lowest caste from the feet that must serve the other castes as labourers and artisans and lastly, the untouchables considered impure and polluting and usually, excluded from the society (Thekaekara, 2005a). She argues that Hindu fundamentalism in the west has led to increased segregation, discrimination and stigma among castes.

Souad (2004) describes being doused in petrol and being set alight for the crime of getting pregnant at seventeen against her Islamic teachings as a Palestinian girl on the West Bank thereby bringing shame to her family. This suggests further, the extent individuals may be ready to go to like in 'honour' killings, based on their religious and cultural beliefs without questioning the human rights of other individuals. The deaths and atrocities by jihadist belonging to the Islamic extremist groups all over the world cannot be logically explained.

The benefits of religious beliefs may relate to a high degree of optimism, spiritual well-being and marital happiness. George, Ellison and Larson (2002) suggest that religious involvement is associated with better physical and mental health, and longer survival. It does this through psychosocial mechanisms such as positive health practices, greater social support through social networks, better psychosocial resources like self-esteem and self-efficacy and presence of belief structures that help create coherence and bring meaning to living.

Religion further helps make life more manageable and predictable. Ilola (1990), reviewing Seventh Day Adventists, suggests that numerous studies from different countries have shown that followers of Seventh Day Adventist religion live longer and are healthier than their county men, mainly because their diet is based on biblical principles based on eating unrefined foods, grains, vegetable protein, fruits and vegetables. Describing a USA survey of 40,000 followers, half of them were

vegetarians, 90% did not consume alcohol, 99% did not smoke and consequently, had a lower incident of cancers and for those who develop cancer, had better survival rates. This suggests that adherence to religious beliefs, attitudes and values may lower health risk factors and serious disease incidences and may also help in management of health and diseases by prescribing healthy options and proscribing unhealthy lifestyles.

In another study to investigate the association between religion and health, Philips, Ruth and Wagner (1993) focussed on the belief in Chinese astrology. The Chinese believe that the year of birth influences an individual's fate. The Chinese that believed in astrology got a disease associated with their year of birth and their response to the disease was that of helplessness and hopelessness. They were more likely to die significantly earlier as compared to those in the control group, suggesting that faith may work for or against an individual's health. Kenya has many religious sects ranging from Catholics, Protestants, Muslims, Hindus, Sikhs, and traditionalists that vary in their beliefs and practices. It would however be important to investigate how the various sects and religion present in multi-cultural Kenyan environment impact the programmes targeting HIV/AIDS.

### **3.5.7 (g). Material life**

Material life as a cultural element refers to the infrastructural aspect that forms the interface between culture and the physical environment (Harris, 1988). It comprises of two key domains; firstly, the material production of culture based on technologies used for energy source and sustenance. Secondly, the economic activities domain that individual engages in for survival. Material production refers to technologies used to produce, distribute and consume goods and services within society (Jain, 2001). Technologies, available, mainly shape the adoption of products to suit target audiences and may range from traditional to industrialised ones.

Distribution relates to the delivery of products based on the available infrastructure. If it is poor or non-existent, innovation and improvising may be necessary to achieve marketing objectives (Kotabe and Helsen, 2011). Other aspects of material life include transportation, energy systems, tools and objects, communication, urbanisation, science and inventions in the technology and material culture

description (Terpstra and David, 1978). Reproduction and how a population replicates itself, in relation to its ecological dynamics, have also been suggested as a domain of material culture by Harris (1988), an aspect that describes and explain demographic patterns and trends.

Infrastructural or material culture aspects have impact on health. These may relate to issues such as industrial pollution, work related risks and hazards, demographic characteristics like high population leading to overcrowding and hazardous living conditions, what is eaten and why it is eaten, attitudes towards sex, conception and pregnancy, among other factors that all affect human health and are arguably relevant to HIV/AIDs programmes. Different tribal groups of Kenya engage in different types of economic activities depending on their ecological characteristics. Those in fertile areas farm, those near water masses fish, those in arid areas prefer nomadic lifestyles and many in urban areas prefer white-collar jobs. Risky economic activities such as prostitution, brewing of illicit brews, peddling drugs also exist that may negatively impact the health and well-being of the individuals. It is however necessary to glean how important material culture's aspects such as consumption, urbanisation, technology, science and inventions impact the programmes targeting HIV/AIDs in Kenya, and how programmers engage with these cultural and contextual realities in their programme work.

### **3.6. Can culture be blamed for all health maladies?**

The elements of culture, certainly, are relevant to health and HIV/AIDS and their interventions. Culture however does not account for all diseases, as some diseases are genetically determined. For instance, the sickle-cell anaemia that affects oxygen supply to vital body organs, mainly found in individuals from West Africa, South India, Saudi Arabia, Persian Gulf and North Coast of the Mediterranean (Williams, Lavisso-Mourey and Warren, 1994; Giger and Davidhizar, 1999) and some Kenyan tribes like the Luo of Kenya, is genetically passed on from parents to children. Lactase deficiency is also genetic related conditions that make individuals intolerant to milk based products. Although genetics may explain these diseases, cultural practice may perpetuate them such as marrying of cousins among Asian Muslims due to genetic interactions.

Some nutrition and vitamin related diseases like rickets are more prevalent in some cultures; for instance, some Asian children, again linking cultural customs to these diseases. Black (1989) discusses factors associated with rickets such as strict vegetarian diets, maternal deficiency of vitamin D, feeding infants on cow's milk that has little vitamin D and inadequate exposure to sunlight. Some cultural practices may also be unhealthy and lead to negative health outcomes such as female circumcision that may cause distress during child birth, infections due to un-sterilised objects, complications in menstrual process and passing of urine, as well as sex performance related complications such as tears, abrasions and bleeding highly risking HIV infections (Kun, 1997; Dirie and Landmark, 1991; Lightfoot-Klein, 1989).

In regard to HIV/AIDs, cultural factors could perpetuate the spreading of the virus through many beliefs, attitudes, values and practices of target audiences. This further suggests the need to understand cultural and contextual implications that may be surrounding many of diseases viewed as genetic or caused by microorganism, and possibly engage culture in dealing with them. If culture greatly impacts health and HIV, the next questions should really be how we can engage it to inform health and HIV interventions.

### **3.7. How can programmers possibly engage with culture?**

HIV/AIDs awareness is high in most of the countries especially Kenya as information, education and communication (IEC) strategies have mainly focussed on imparting knowledge and not on behaviour change. Educational programmes have, however, increasingly recognised that information alone is insufficient to reduce risk behaviours for HIV/AIDS (Asthana and Oostvogels, 1996). Indeed, knowledge change reported by most health and HIV interventions is relatively easy to influence and measure (Kirby, Obasi and Laris, 2006). However, changing other factors such as skills, vulnerability, actual risky behaviours and complex affective factors that influence them is challenging and less clear (Gregson, et al., 2004). The main challenge remains that even when people have the relevant knowledge, their efficacy and autonomy to act may be constrained by cultural norms (Howard-Grabman and Snetro, 2003; UNAIDS, 1999). Therefore, without engaging in cultural and contextual realities, it could arguably be difficult to translate educational programmes to behaviour change.

Supra bodies like UNAIDS and UNESCO have suggested the need to take a more culturally explicit approach to encourage behaviour change. They suggest the need to consider the population's characteristics such as beliefs and lifestyles and using them as essential reference for the creation of an action plan. They further attribute ineffective HIV/AIDS programmes to cultural realities such as a lack of openness in many societies regarding sexuality, male-female relationships, illness and deaths. They also blame taboos rooted in cultures and emphasise on the need to understand what motivates behaviours by considering culture to develop programmes addressing HIV/AIDS attitude and behaviour change (UNESCO, 2001). They suggest that culture ought to be engaged with in three main respects - firstly, context in relation to the environmental realities of the people as the subjects. Secondly, the content based on values and resources that can ensure culturally appropriate content and thirdly, in method by embedding prevention and care in local cultural contexts in a stimulating and accessible way. They further recommend a five point criteria for ensuring culturally effective HIV/AIDS projects, firstly, cultural appropriateness; secondly, fully respectful of human rights; thirdly, gender responsiveness; fourthly, age responsiveness and lastly involvement of people living with HIV/AIDS at every stage of the projects. The criteria are quite commendable; however, cultural appropriateness is ambiguous, as it really does not expound on what specific parameters denote or exemplify cultural appropriateness.

To gain a clear understanding of culture, MacLachlan (2006) discusses taxonomies of culture relevant to understanding health and cultural interaction. Firstly, cultural colonialism that began from the 19<sup>th</sup> century where the colonial masters exploited their inferior subjects to further European interests. This, consequently, created culture bound syndromes that till now have a social function within the cultural context of former colonies. Secondly, cultural sensitivity that mainly focuses on the need to include minority groups in health. Thirdly, cultural migration issue, that considers whether migration is voluntary or forced and the accompanying acculturation problems. Fourthly, cultural alternativism that relates to the interplay among the professional sectors, popular and folk-ways of seeking healing.



Fifthly, cultural empowerment that connects individuals to their cultural heritage. It also provides a medium for intervention based on the cultural group's sense of value and meaning of their world. Sixthly, cultural globalisation that is western led and uneven in its consequences on health (Giddens, 1999) and lastly, cultural evolution where values, attitudes and customs within the same social systems change over time creating problems with adaptation and identity.

In terms of cultural colonialism within the Kenyan context, land inequalities and tribal clashes can be traced back to the work of the early British settlers that pushed the owners away, marginalised and segregated them. After independence, the ruling tribe - Kikuyus were settled in many of these former white settlers' highlands greatly incensing the locals. This land question contributes greatly to the tribal clashes that to date account for human suffering, such as internally displaced persons settled in camps.

The camps are rife with poverty, rape cases, inhuman living conditions that greatly compound HIV/AIDS spreading and complicates management and prevention efforts. Western missionaries and where they settled would also be relevant. For instance, the Western Luyia Kenyan tribal group are mainly Seventh Day Adventist followers while the Merus tribal group are mainly Methodists and Catholics based on religious beliefs and values taught by the missionary groups that settled in their geographic areas. Seventh Day Adventists are quite keen on healthy diets while Catholics are keen on avoiding modern family planning methods including the use of condoms and contraception that have a huge bearing on protection against HIV/AIDS.

Cultural sensitivity would entail, perhaps, focussing on each distinct group rather than blanketing messages and interventions. For instance, the Somalis in the North of Kenya is greatly marginalised in all spheres of life and development, especially in education and health related issues. Developing basic health infrastructure would be necessary as well as promoting economic activities in such arid regions. Cultural migration may refer to the need to understand target groups settlement patterns, such as the outward migration of Luos to urban areas especially in Nairobi and Mombasa city and specifically targeting them rather than blanketing messages to all urban dwellers.

In Kenya, cultural migration again may be explained by the borders imposed by the British colonial rulers as well as urban rural migration push and pull factors. The overpopulated slums in Nairobi such as *Kibera, Kangemi and Mukuru kwa Jenga* are hot beds for HIV/AIDS and certainly requires attention to the plight of the extremely poor slums dwellers living in squalid conditions. Cultural alternativism based on the interaction among the professional, folk and popular health sectors may be paramount mainly because the folk first is used to understand suffering, then the popular and lastly the professional sector (Kleinman, 1980). This may explain the late presentation of health problems to health professionals' characteristic among many Kenyan tribal groups. This is mainly attributed to the fact that many first seek treatment from the local medicine men, witchdoctors and spiritual healers as their first point of call; lastly, the professional medication as a last resort. This impacts any meaningful intervention that may be considered in managing complications like HIV/AIDS related ones, as valuable time is lost while the immunity system is ravaged by the virus.

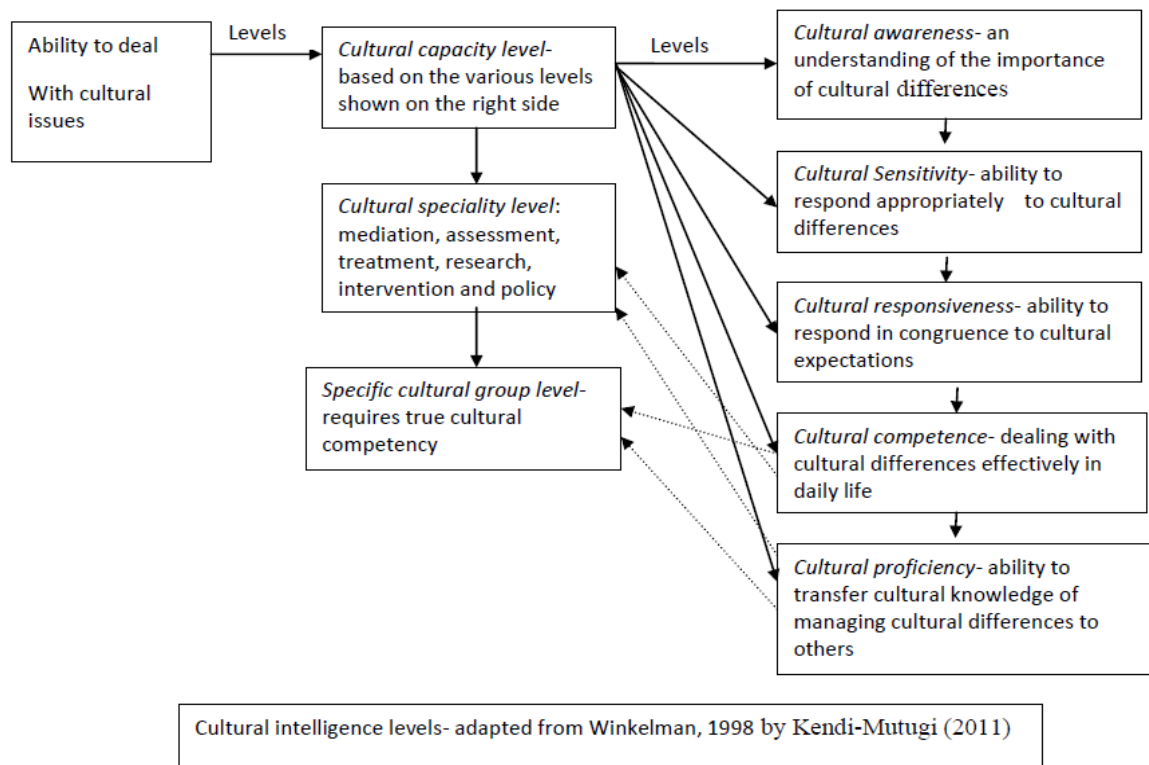
Cultural empowerment is based on connecting individuals with their cultural heritage, probably by engaging the folk and popular health sector, and possibly considering the need to deal with cultural disempowerment to de-market risky cultures in the context of HIV/AIDS such as wife inheritance and lack of male circumcision. Cultural globalisation may relate to advancing the health infrastructure to reflect global trends in both the rural and urban areas while cultural evolution may explain identity crisis especially faced by the Kenyan youth in choosing between cultural dictates or modern trends of sexuality creating cultural dilemmas and conflict.

The seven taxonomies of culture are arguably critical in understanding cultural contextual realities of people, especially in guiding cultural research to inform appropriate health interventions however they still do not explicate the cultural contextual realities in details for programmers to critically engage within their programme work.

Castro (1998) suggests that the ability to deal with cultural issues can be conceptualised as an interaction of three major levels: capacity level, specialty area and specific cultural group level. There exists a range of cultural capacities such as awareness, sensitivity and competence levels. Specialty areas may range from

mediation, assessment, treatment, research, communication, intervention, and policy formation. Specific cultural competencies refer to abilities relating to particular cultures. They require longer time to develop and are mainly beyond the reach of programmers, unless they are perhaps native members of a culture or participate in a culture for a long time to develop true cultural competence.

A distinction has been made in the various levels of cultural capacities by Winkelman (2009). He suggests that at a basic level is the cultural awareness that involves an understanding of the importance of cultural differences. Cultural sensitivity goes beyond awareness, to provide an appropriate response to cultural differences; cultural competence refers to having further capabilities to deal with cultural differences effectively in everyday life, whereas cultural responsiveness falls between sensitivity and competence, referring to the ability to respond to needs in a manner that is congruent with the cultural expectations. Top of the level is the cultural proficiency involves the ability to transfer cultural knowledge and skills to others by providing others with the skills to effectively manage cultural differences.



**Figure 10 - Cultural intelligence levels adapted from Winkelman (1998)**

Much as programmers should be culturally competent rather than merely operating at the cultural awareness level for effective programme work, it could perhaps be argued that cultural competence is an assumption rather than a reality amongst health programmers. Financiers, programme directors and managers of many social marketing programmes are mainly from Europe and Americas, subscribing to individualistic cultures rather than collectivists' cultures. Depending on their cultural capacities, they could be prone to cultural myopia that may render many programmes ineffective.

There may be, therefore, the need to engage culture vigorously, especially at the research level, prior to programmes formulation to ensure that programmes are culturally congruent with the target audiences to avoid programme failure (Castrol, 1998; Skiffs, et al., 2002). The bone of contention is how programmers, financiers and other related stakeholders engage or could engage robustly with culture. This gap clearly needs explication.

### **3.8. Models of engaging culture in health**

Culturally congruent interventions are key to effective health intervention programmes. Castro, et al. (2004) suggests the need for cultural adaptation in health intervention to ensure programmes are responsive to the needs of local communities. He underscores the need to avoid cultural blindness as it naturally disengages participation, affecting programme outcomes negatively. Cultural adaptation involves programmes that are culturally sensitive and tailored to a cultural group's world-view (Kumpfer, et al., 2002). It does not just involve the surface engagement but deep structure engagement by addressing the core values, beliefs, norms and relevant aspects of a cultural group's lifestyle and worldview (Resnikow, et al., 2000). Key dimensions that should be considered in adaptation as suggested by Castro, et al. (2004) includes firstly, cognitive information processing characteristics such as language and developmental levels. Secondly, affective and motivation characteristics like the gender, ethnic, religious backgrounds, social economic status and thirdly, the environmental characteristics that include the ecological aspects of a local community.

Another insightful model of engaging culture in health that focuses on cultural appropriateness is suggested by Airhihenbuwa (1995). He posits a PEN-3 model that encourages intercultural diversity and challenges health workers to addresses issues at the macro-policy, government, societal and international level as well as the traditional micro level of health programme intervention. It consists of three categories each with three dimensions. First dimension is health education with three categories of person, extended family and neighbourhood. He argues that there is a need to empower individuals to make informed health decisions appropriate to their roles in families and communities. The extended family focuses on the nuclear, extended and family lineage while the neighbourhood reflects the need to involve community members and leaders for culturally appropriate health programmes.

The second dimension of the model is the educational diagnosis of health behaviour, reflecting determinants that influence individuals, family and community actions based on dimensions of perceptions, enablers and nurturer. Perception relates to knowledge, attitudes, values and beliefs within a culture that may facilitate or hinder personal, family and community motivation to change. Enablers are cultural

systematic societal or structural influences that may enhance or be barriers to change such as resources, services available, skills and accessibility among others. Nurturers refer to the extent to which health beliefs, attitudes and actions are influenced and mediated or nurtured by extended family, friends and community.

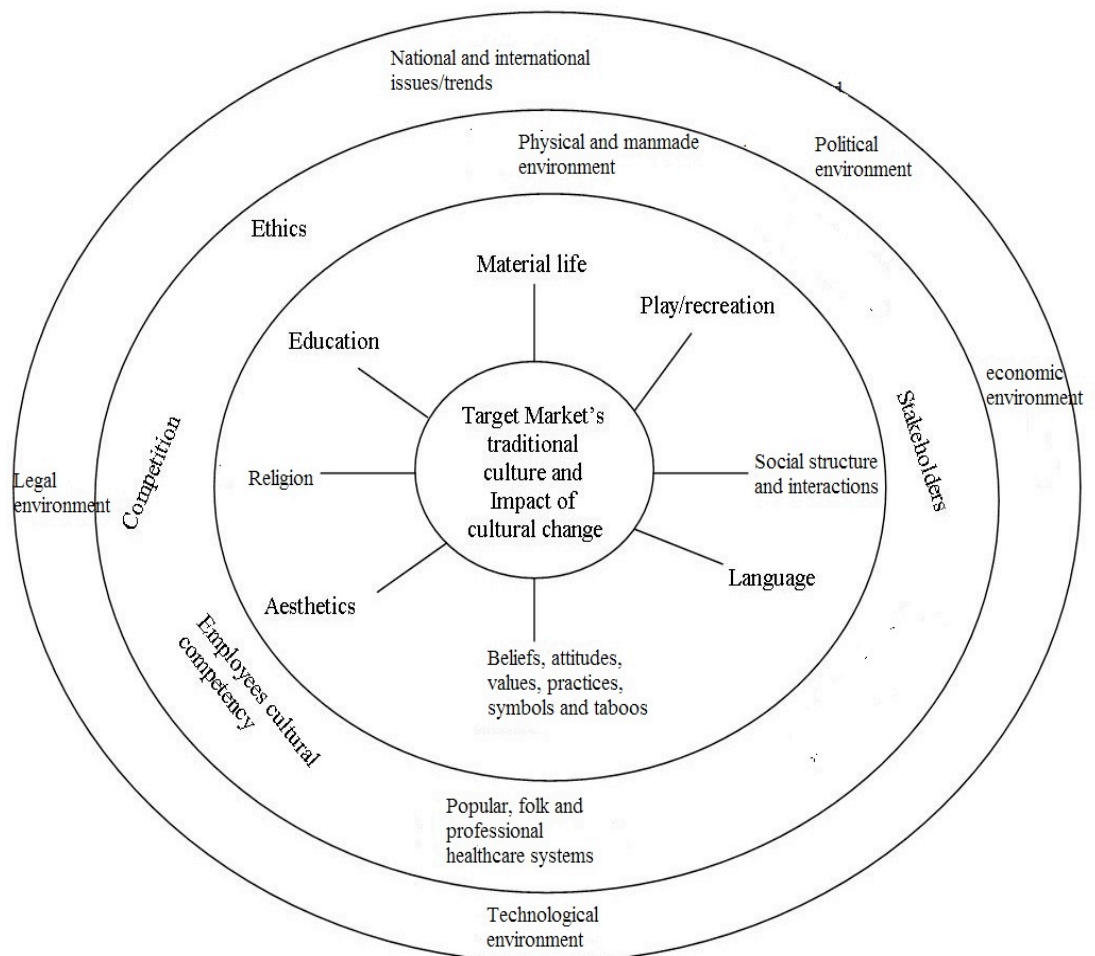
The last dimension of the model is the cultural appropriateness of health behaviour pivotal to culturally sensitive health education programmes. It relates to the individual, family and community behaviour and also relates to perception, enablers and nurturers. It has three domains, positive behaviour based on beliefs and actions known to be beneficial that ought to be encouraged that may relate to individual, families and neighbourhood. Affirming these beliefs and behaviours is critical for programme success and sustainability.

Existential behaviour refers to those beliefs, practices and behaviours indigenous to a people with no harmful health consequences. These need not be targeted for change and blame for programme failure, just because they are not well understood especially by foreign programmers. Negative behaviours are based on health beliefs known to be harmful to health. They should be understood within their cultural, historical and political context before attempting to change them. In the Pen-3 model, the Es: extended family, enablers and existential behaviours are the most powerful influences for cultural production. Enablers relate to power, politics and history, existential relate to affirmation of humanity and cultural empowerment, while extended family relate to positive traditions and influence production of knowledge, meaning and interpretation.

This is a useful model in researching, planning and implementation of health programmes. It recognises the roles of individuals/ persons, extended family and neighbourhood in health education acknowledging the nature of collectivist group, as extended families and neighbours do influence behaviour. It also acknowledges the positives, existential and negative behaviours that may be inherent in a culture, which programmers need to focus on for effective programme work. It, however, does not engage much with cultural elements, neither does it point to specific cultural elements that need to be examined as enhancers, nurturers, or barriers to health intervention.

Marketing, however, offers a more robust approach to engaging with culture. Commercial marketing especially international marketing are keen on cross cultural research to inform marketing tools such as segmentation, positioning, strategies and the marketing mix. They know that engaging with culture is key to their success in foreign and home markets. Cultural elements such as material life, language, social interactions, value systems, aesthetics, religion, and education suggested by (Katobe and Helsen, 2011) in international marketing are critical to informing marketing concepts. However, in relation to health and HIV/AIDS, these aspects of culture are not the only relevant issues. Elements of play, based on the use of leisure and recreation (Hall, 1959) is critical as HIV/AIDS is mainly spread via sexual means, sharing of sharp objects and through mother to the unborn child.

Other realities that certainly impact HIV/AIDs will relate to the issues highlighted by theorists such as the Force Field paradigm (Blum, 1983; Evans and Stoddart, 1994). They consist of physical environment, social environment, medical care system and genetic/biological factors. These are very similar to Engel's (1977) bio psychosocial model that relates to the psychological, social, cultural, biological and physical environments that resonate well with the marketing PESTEL (political, environmental, social, technological, economic and legal) factors (Humprey, 1960; Kotler, 1998). The medical care systems resonate well with Kleinman (1980) popular, folk and professional health care systems, which also impact the management and care of HIV/AIDs. Airhihenbuwa (1995) concepts of enablers, nurturers, positives, existentials and negative behaviours are also quite relevant to HIV/AIDS issues. All these useful cultural frameworks point to the need for a composite framework/model that incorporates and blends these health and cultural aspects into a super model, which would probably assist social marketers in understanding the contextual and cultural realities of their target audiences. After careful consideration of other relevant frameworks/models, the researcher suggests the composite model below:



Cultural-context assessment model (2013) adapted from: Hall (1959); Humprey 1960; Kleinman 1980; Airhenbuwa 1995 and Katobe and Helnsen 2011.

**Figure 11 - Cultural-context composite assessment model (2013), adapted from: Hall (1959); Humprey (1960); Kleinman (1980); Airhihenbuwa (1995) and Katobe and Helnsen (2011).**



### **3.9 A discussion of the formulated composite model**

In the model shown above, cultural elements are centralised and shown at the core, emphasising their importance in research, in order to understand the target market. The objective is to understand the traditional aspects and changes that have occurred as a result of cultural evolution and changes in relation to the eight core elements of culture of the target market group such as the:

#### **3.9.1. Beliefs, attitudes, values, norms, practices, symbols, taboos**

These relates to the abstract essence of culture and the mental and symbolic forms that provide meaning and guide behaviour. Beliefs, attitudes and values are well discussed in section 3.5.1. The three cut across all the other elements of cultural micro and macro environments to guide norms, practices, symbols and taboos. They should therefore be gleaned and understood well enough to inform interventions, the use of marketing strategies and tools in programmes targeting HIV/AIDS.

#### **3.9.2. Material life**

This element is well explained in 3.5.7 and involves assessing the technologies, knowledge, methods, tools and processes (Jain, 2001) related to or surrounding the products or behaviours of interest to the programmer. It also relates to how the product/behaviour in question is distributed and consumed by the target markets. The objective is to glean and understand meaningful ways of engaging the social marketing tools, as well as understanding tactful ways of dealing with the target markets for more effective and efficient interventions. Relevant to HIV programmes, would be the HIV/AIDS knowledge, methods and tools of preventions, processes involved such as mother to child transmission, injecting drug use, heterosexual and homosexuality related transmission of the HIV virus, ARV treatment among other pertinent issues.

### **3.9.3. Language**

This element is well explained in 3.5.2 and relates to the cultural nuances of the spoken, written, official, linguistic pluralism, language hierarchy, mass media, international languages and the non verbal communication (Hall, 1997; Albaum, et al., 2002), and how they relate to the product or behaviour in question and their interplay with the marketing strategy tools and mix. Communication elements of sender, message encoding, channel, decoding by the receiver, feedback and cultural noise that may occur at any point need to be well considered and understood in the light of traditional, current and changes that may be relevant to intervention. Communication plays an important role in HIV/AIDS related programmes and the languages, mode, channels of communication used are crucial to the success of interventions due to the effectiveness/ineffectiveness of information passed on to the target audiences.

### **3.9.4. Aesthetics**

This element is well explained in 3.5.4 and encapsulates the concept of taste, beauty and what is perceived as pleasant and desirable. Physical, intellectual, moral or literary aspects of beauty (Johnson, 1982) should be analysed and engaged with. Within collectivist groups, orature is relevant based on what may or should be said in songs, poems, drama, proverbs, riddles, chanting and sayings (Thiong'o, 1993). Folklores based on what is done that include ways of cooking, architecture, dressing, religion, art, music and dance that all represent a lifestyle of people, (Nandwa and Bukenya, 1983). They should be engaged with, to inform the use of marketing strategies, tools and mix in interventions. In relation to HIV/AIDS programmes, concepts of suitable sexual partners, beautiful bodies, attractive people, and healthy eating may all be critical for interventions.

### **3.9.5. Education**

Education element is well explained under 3.5.3. Education methods and tools need to be explored such as folk tales, proverbs, riddles and songs, all traditionally used not only to amuse but teach ideal behaviours and morality and to pass on the culture from one generation to another (Ngugi 1993). Modern ways of educating markets also need to be analysed for their strengths and weaknesses. Traditional and modern perceptions of methods and modes of learning, curriculum content, the need to segment learners by age groups, gender and use of social events, need to be explored. Other critical issues include the concepts of culturally suitable and socially acceptable instructors and places of learning, as well as the literacy levels of learners are all needed to be explored to maximise the learning experiences.

### **3.9.6. Social Structure and Organisation**

This element is well explained in 3.5.5 and is based on levels of organisation that includes family, gender roles and division of labour. It also includes the structural sphere that is characterised by division of labour, class systems and political structures (Harris, 1988). Social construction of roles, responsibilities and obligations associated with being a man or woman, aspects of sexual scripts, gender inequalities, economic dependence and gender related discrimination are all needed to be explored to inform interventions. Critical to HIV programmes may, culturally, engender female discrimination and the accompanying sexual violence.

### **3.9.7. Religion**

This element is explained in 3.5.6 and involves exploring and understanding a market's traditional, modern and hybrid beliefs in supernatural agents, explanations of the unknown, religious structures and rituals and the moral rules that define good and bad behaviour (Diamond, 2002). Costs and benefits of religion need to be explored (Pargament, 2002) as well as the impact of the closed moralist versus open religious views held by religious leaders and followers to inform interventions appropriately. The extent to which, religion of target audiences impacts the interventions, also need to be analysed and engaged with.

### **3.9.8. Play/recreation**

Leisure contributes to a sense of well-being as it affords a context for self-validation and expression (Caldwell, 2005). It provides times for relaxing and recuperating (Warner-Smith and Brown, 2002). However, some leisure activities and avenues/places may expose individuals to risky behaviours that may expose them to health risks such as pubs, bars, discos, nightclubs and other alcohol and unlawful drug taking and sex venues. Alcohol drinking environments serve as recreational, and social avenues and provide opportunities to meet sex partners especially in gay bars (Nardone, Frankis and Dodds, 2001). Commercial sex workers represent a risky group that also frequent alcohol serving bars. Alcohol elevates sexual risks via intoxication that may inhibit decision making, protective actions, and enhance risk taking characteristics (Cook and Clark, 2005). The problem is compounded by the fact that alcohol establishments may also serve as sex venues where back rooms and adjacent building may offer avenues for rest and sex (Morojele, Kachieng'a, and Makoko, 2006). There is clearly the need to engage in play and recreation activities in programme work.

The second layer of the model comprises of the operating environment in which culture may exist. It comprises of:

### **3.9.9. The physical and manmade environment**

The natural geographical realities such as the local topography, climate, air and water supplies as well as the man-made environment such as building, roads, parks, hospitals, schools among others are all relevant for interventions. Perceived environmental aesthetics or beauty and the convenience of access to facilities may encourage physical exercises and health seeking behaviours in individuals, while a lack of health related facilities and the perceived inconveniences of accessing them, may be a barrier to health seeking behaviours (Ball, et al., 2001; Bauman, et al., 2002). An analysis of the strengths, weaknesses, opportunities and threats provided by both the natural and manmade neighbourhood realities may possibly inform and shape interventions.

### **3.9.10. Cultural competency/incompetency of the programmers**

Lack of cultural competency among the programmers is arguably the foundation of ineffective interventions. This is because of the ethnocentric, stereotyped, biased, and prejudiced perceptions that may be held and exhibited by social marketing stakeholders, that may be used to inform the strategies and decisions taken in interventions, perhaps rendering them futile and a waste of resources (Lee, 1966; Chrisman and Zimmer, 2000; Winkelman, 2009;). Cultural training may, perhaps, not only be relevant to the programmers but also to donors, policy makers and all the stakeholders involved in interventions.

### **3.9.11. Health care systems available**

Three types of health care systems operate in all societies: folk, popular and professional systems (Kleinman, 1980). The three health care systems, arguably, should be understood and creatively, engaged with as they each play different roles and have different value hierarchies attached to them. Ignoring any of the three systems may be counteractive. Traditional healing is, perhaps, the only health system that is accessible to everyone in Africa and some 80% of the Africans use traditional healing methods (Bannerman, et al., 1983). Professional health care is unequally distributed in developing countries and is mainly found in urban areas. This leaves the rural populace to traditional healing systems. The three systems may need to be effectively engaged with, to inform effective interventions.

### **3.9.12. Competition**

This is a dynamic situation where several actors in a market, struggle for scarce resources and produce very similar products or services that satisfy same customer needs (Hunt, 2007). Competitors to programme work may be from numerous sources, commercial marketing, cultural elements such as beliefs, attitudes and practices, factors in any of the macro, operating and micro environment among others or arising from other stakeholder and organisations. It is a challenging area that may offer threats and opportunities. Commercial marketers are keen on competition analysis for instance based on models like: porter's five (1985) analysis that focuses on the

bargaining power of buyers, entry barriers, rivalry, substitutes, and the bargaining power of the suppliers and other tools like PESTEL and SWOT analysis to inform strategies and their marketing tools choices. It leads them to interesting decisions such as forming of strategic alliances with their competitors, product divesting or even development, market diversification or self-destruction and creation, all meant to enhance their competitive position. Programmes may benefit from competition analysis based on these business models to inform their interventions just as commercial marketers adjust their strategies based on competition analysis.

### **3.9.13. Ethics**

Deals with nuances of what is perceived and judged as right or wrong. It differs from one society to another, making it a social construct. Culture plays an important role in influencing ethical decision-making (Ferrel and Gresham, 1985; Vitell, Rallapalli and Singhapakdi, 1993). Individuals respond to ethical situations with varying levels of moral intensity. High moral intensity issues are generally recognised as ethical issues that lead to risky ethical decisions compared to those with low moral intensity.

Ethics as a social construct, suggest the importance of cultural competence and the need to culturally analyse ethical dilemmas related to health interventions, as they are all based on the perceptions, mainly informed by cultural contextual realities of markets/people. Indeed, ethics ought to guide all aspects of an intervention from the research undertaken, intervention planning and design, implementation and evaluation of social marketing interventions.

### **3.9.14. National and international trends**

Migration and globalisation trends have presented challenges to many social and health related issues. Demands and supply of health care and other social issues now transcend beyond the neighbourhoods to national and international boundaries. This, certainly, impacts on health and social systems migration destination areas as resources such as workforce, hospitals and financial may be stretched and unable to cope with the influx of migrants (Ramirez De Arellano, 2007; Bookman and Bookman, 2007; Helble, 2010). This suggests the need for cooperation, coalitions, policy and strategy coherence, national and international agreements in tackling

public health and other social challenges (Kickbusch, Silberschmidt and Buss, 2007). Supra national organisations like World Health Organisation (WHO) recognise health issues as global challenges and are keen to share learning and best practices among countries. Individuals, involved in health interventions, may need to understand health challenges and responses beyond their immediate contexts. This may enable valuable learning and understanding of health challenges to take place. It may perhaps help them understand what they may borrow and adapt to their local contextual realities, based on what has worked in different environments.

### **3.9.15. Stakeholders**

This relates to individuals and groups who can affect or are affected by strategic outcomes of an organisation (Jones and Wicks, 1999). Managing stakeholders may lead to benefits such as competitive advantage via exchanging of goods and services, information, sharing technology, sharing talent and other resources (Freeman, 1984). Caution ought to be exercised in managing stakeholders to avoid opportunism, by using cost benefit analysis to analyse relationships to ensure a win-win situation rather than loose win situations (Harrison, Bosse and Phillips, 2010). Programmers may need to analyse stakeholders involved in the behaviour of interest and related products and strategically work with them to achieve their objectives, whilst avoiding parasitic relationships.

Suppliers of related goals and services may provide synergistic relationships. This may help in avoiding the re-inventing and duplication of already present structures and processes and misuse of scarce resources. Synergy may be achieved by sharing of resources, knowledge, products and marketing efforts (Singh and Montgomery, 1987; Seth, 1990). Mutual relationships may be explored while symbiotic ones need to be identified while parasitic ones should be strategically avoided (Sirower, 1997).

The outer layer consists of the macro environment that basically consists of the macro forces that culminates in a PESTEL/SLEPT analysis (Kotler, 1998). Key issues include:

### **3.9.16. Legal environment**

Commercial marketers know that they exist within many regulations such as manufacturing standards, competition, advertising pricing standards and regulations and therefore realise the need to manipulate the legal environment to their advantage. They, usually, entertain legislators, opinion leaders such as the media and policy makers and actively lobbying for legislations that favour their marketing activities (Kotler, 1980).

In relation to social marketing, law is an intervention tool that may be used to achieve goals based on legal powers, duties and restraints that may help structure the objectives of publics and shape how these objectives are carried out (Gostin, 2008). Social marketers and other health interventionists must learn the techniques to manipulate the legal environment to achieve their objectives just as commercial marketers do in upstream social marketing (Donovan, 2011).

Challenging public health and social issues arising from especially the HIV/AIDs pandemic, involve reproductive and sexual health rights and legalities. These may relate to areas such as access to sexual and reproductive health services, prevention of sexual violence, sex work and anti-discrimination issues, respecting and enforcing human rights such as rights to health (Gable, Gostin and Hodge, 2008). Unearthing these reproductive health challenges require an analysis of the legal environment in relation to the behaviour or product in question to identify the relevant legal enablers and barriers in order to, meaningfully, engage them.

### **3.9.17. Technological environment**

Digital divide relates to the concept of unequal access to information and communication technologies at global and local levels (Wyatt, et al., 2005). In the developed west, the Internet has become an indispensable part of every day's life and there is no aspect of daily life that has not been transformed by the Internet including health and social issues (Rice, 2006; Park, Chung and Hoo, 2009). The same cannot be said for third world countries like Kenya. The digital divide is compounded by issues such as poverty, which translates to affordability of computers or mobile phones that are significant in accessing the Internet. Other issues include lack of



electricity to power relevant gadgets, lack of skills to use computers and internet as public primary and secondary schools cannot afford the luxury of computers even for their basic administration work, costs associated with use of cybercafés for those that have the knowledge of computers and internet speeds among other digital divide related challenges.

In the west, due to ease of access to internet, searching and retrieving health information, participating in support groups and online communities and communication with health care providers is common (Cline and Hayes, 2001; Dolan, 2007).

Technologies found in hospitals and other health and social centres typify the digital divide. In developing countries like Kenya, health providers lack current and up to date health technologies and knowledge, making health care provision arguably outdated in comparison to the developed countries. There is, arguably, a need to engage with the contextual realities of the digital divide in interventions. There is a need to creatively look for effective avenues for health related information sharing and means of technology transfer to the developing countries.

### **3.9.18. Economic environment**

This relates to the economic realities such as employment and incomes, wealth, demand and supply factors as well as government controlled factors like interest rates, inflations issues that may affect the relevant product or behaviour of interest to social marketers. United Nations Joint Programme on HIV/AIDS (UNAIDS 2001) suggested that poverty, underdevelopment, lack of choices and inability to determine one's own destiny fuel the HIV epidemic. Fenton (2004) suggest that poverty leads individuals to high-risk behaviours and reducing poverty may be the only viable long-term response to the epidemic.

Parkhurst (2010), however, challenges the assumption that wealth and poverty are correlated with HIV prevalence. He argues that structural factors can affect HIV risk in different ways in different contexts. Poor people, in some settings, may undertake particular risky practices like earlier sexual debut, transactional sex among others. However, the wealthy individuals may also engage in other risky practices such as

participation in broader social and sexual networks or casual sex with higher numbers of partners and other risky behaviours related to their wealth. He argues that the risky behaviours associated with either the rich or the poor is highly context specific. This is because the wealthy and educated individuals are likely to take greater medical attention and care of themselves after the knowledge of their HIV status, while the poor and less educated may not have the resources to effectively look after themselves after the HIV infection. This suggests the need to consider economic aspects of target audiences in HIV/AIDS related interventions and engage with them appropriately.

### **3.9.19. Political environment**

This relates to the governance, power bases procedures and elections to government offices. It also includes philosophies such as democracy versus totalitarianism and political structures like the legislature that enacts laws, executive that implements and judiciary that interprets the laws and settles disputes. Central governments and local governments of the day have key responsibilities of promoting and protecting the health and well-being of its population. These roles range from: legislation, information, fiscal strategy, targeting audience's setting, enforcement of justice, enabling and empowerment of individuals (Chelson, 2005). They also have responsibilities in areas such as providing financial and material resources relating to health, health workforce issues and implementing pro-equity health policies. The government's spending and policies on sectors such as education, housing, infrastructure, healthcare, information technology, agriculture and food securities, national security, policies to reduce regional inequalities and pollution, all play a multi-sectoral role in the health and well-being of its people.

Dynamics of politics may, indeed, provide opportunities or barriers to health issues. Government attitudes towards health issues such as HIV/AIDS may affect the decisions and actions taken in response to the pandemic. This is well exemplified by the denial, scepticism and slow response witnessed in Kenya in the early 80s and the drastic actions and resources mobilised after the government declared HIV/AIDS a national pandemic (Kwena, 2004). Other political dynamics like tribal clashes and ethnic wars that led to internally displaced refugees in Kenya following post election skirmishes after President Kibaki elections in 2008, again destabilised many families

and interrupted their access to HIV related care and medication and led to further social ills like rapes within crowded refugee camps, compounding the HIV situation further (Pyne-Mercier, et al., 2011). Political stability is arguably an important platform for public health interventions.

Perhaps, by considering this robust model, social marketers and other stakeholders involved in health and social programmes may be able to have a better contextual and cultural understanding of their target markets. This knowledge may be valuable in the choice and engagement of relevant marketing tools such as segmentation, positioning, and the use of the marketing Ps such as: products, pricing, place, promotion, people, processes and physical evidence for more effective and efficient programme: planning, designing, implementing and evaluating.

Applying this model within a culturally rich context as Kenya is the next natural step. This testing helps to understand; how robust the model may be in gleaning the cultural and contextual reality of target audiences/markets in order to inform social marketing initiatives. Perhaps, testing the model would also provide insights into its strengths and weaknesses and point to, how the model may be improved and refined. However, before the model is applied and tested, there is a need to explore the social marketing concept and practices in order to understand, how the discipline engages with cultural and contextual realities of the target audiences.

### **3.10 Chapter summary**

Culture is a broad and complex concept as it virtually involves every part of an individual's life and touches on all human needs, both psychological and physical (Jain, 2001). Culture affects health by enhancing or reducing both the risk factors and conditions associated with an increased likelihood of diseases. It may also provide protective factors that reduce disease risks. It affects how individuals conceptualise health maladies and impacts the distribution of causes of diseases and illnesses, by motivating risk behaviours and disease exposing practices. It also informs the preferred curative and healing methods. It may, perhaps, be important to engage cultural and contextual realities to inform all health programme related decisions.

Critical elements that they may not be overlooked may include cultural elements that may impact the health positively or negatively. Elements such as beliefs, attitudes values, practices and taboos may expose individuals to health complications and HIV/AIDS acts as a protection against ill health. Language too may impact the health communication. Education methods, content, and instructors affect health knowledge acquisition and understanding. Aesthetics may shape choices related to marriage partners, foods eaten, environments lived, all impacting the health of the individuals. Social organisations may promote gender discrimination and practices that may impede or promote health. Religion may positively impact on mental and social health, although, extremism may also lead to ill health. Material life in the form of technologies used may promote preventive and curative methods, although it may conversely lead to more health hazards. Production, consumption and distribution methods and patterns may also affect health positively or negatively.

Programmes' operating environments are critical to health and HIV/AIDS intervention programmes. Natural, manmade, health sector's popular, folk and professional health sectors, cultural competence of stakeholders, ethics and stakeholders may all impact the programme work positively or negatively.

The macro environmental factors such as political, economic, technological, legal, national and international trends may present barriers or enablers to health and programmers need to look into all these issues to inform their health and HIV/AIDS related social marketing programmes.

The next chapter explores the social marketing concept and practice, in order to understand how it presently engages the cultural and contextual realities of target audiences in health and HIV/AIDS targeted interventions and understand any gaps that may exist.

## **4. Chapter Four- Social Marketing Theory and Practice**

### **4.0 Chapter introduction**

This chapter explores social marketing theory and practice. It explores its genesis, from when Wiebe (1952) posed the challenge of why brotherhood cannot be sold like soap, to its current use and challenges especially in countering commercial marketing efforts. It explores the various debates and arguments of what social marketing entails, how its understanding differs based on contexts, considers the social marketing process and how effective it has been to date. It focuses also on how the context influences social marketing interventions and scrutinises its engagement with culture.

It examines how commercial marketing deals with the cultural concept and the relevance of culture to health and behavioural change initiatives. Lastly, it suggests the use by social marketers of a composite cultural context model developed in chapter 3; in order to understand the cultural and contextual realities of their markets.

### **4.1 The Genesis and meaning of social marketing**

Social marketing roots can be traced to Wiebe (1952), when he raised a fundamental question of why sellers of social issues like brotherhood were not as effective as commercial marketers that sold products like soap. He examined social campaigns to understand what accounted for their success or failure. He suggested that the more the conditions of the social campaigns resembled those of a commercial product campaign, the more successful they were likely to be. This idea was expounded when Kotler and Levy (1969) suggested that marketing is a persuasive societal activity that goes beyond selling of toothpaste soap and steel.

During this era of the 1960s, Marketing as a discipline was mainly seen from a commercial point of view and Kotler and Levys' argument was that the same persuasive logic that could be applied to social issues to achieve social change. Ultimately, Kotler and Zaltman (1971, p.5) defined social marketing as a social change management technology involving the design, implementation and control of programmes aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters.

The key concepts of marketing it uses, are segmentation, consumer research, product development and testing, communication, facilitation, incentive and exchange theory all geared towards maximising the response of the target audiences (Kotler and Roberto, 1989, p. 24).

The idea of Kotler and Levy (1969) of expanding marketing to social issues was not without criticism. The apologists, taking a traditional view, argue that marketing is good because it helps the economy and its domain should be limited to the firm. Laczniaak and Michie (1979) suggest that social marketing is not real marketing because marketing is valid only where there are markets, transactions and prices and therefore argue that as a discipline, marketing has little or no application to social causes. They, further, claim that social marketing is potentially unethical in giving power to groups of individuals to influence public opinion on contested issues such as pornography and abortion, as it influences individuals to accept new behaviours that may not be in their best interest.

Fox and Kotler (1980), however, contend that marketers have a right and an obligation to venture and look freshly at social phenomena from their discipline's perspectives. They underscore that social marketing should be perceived as adding lustre rather than disrepute to marketing's image, as at least the public can see some positive use of marketing in enhancing the quality of their lives, rather than only encouraging purchases and consumption of products driven by a profit motive, popularly considered as commercial marketing.

Marketing has been traditionally perceived as manipulative just as other disciplines and social groups that deal with convincing individuals such as religious leaders, lawyers, politician among others. However, if social marketers simply make the strongest possible case in favour of a cause without distorting the facts, then the approach may not be considered as manipulative. Fox and Kotler (1989) oppose the manipulative perception of social marketing by arguing that it is, indeed, a useful discipline in countering commercial marketing messages.

The support for social marketing, in spite of the many criticisms, continues. Many contributors agree on its core principles of using marketing concepts and tools to bring about social change (Bloom and Novelli, 1981; French and Blair-Stevens, 2005; Kotler and Lee, 2008; Dann, 2010). However, differences exist as to what constitutes

the focus and scope of social marketing. For instance, Andreasen (1994, p.110) defines social marketing as the adaptation of commercial marketing technologies to programmes designed to influence the voluntary behaviour of target audiences to improve their personal welfare and that of the society, of which, they are a part. The focus on voluntary individual behaviour change has, however, led to the adoption of downstream social marketing that focuses on changing the behaviour of individuals.

Downstream social marketing has been criticised as blaming victims without focusing on the other factors that may be contributing to their behaviour such as the social, structural and cultural determinants of behaviour (Donovan and Henley, 2003; Lefebvre, 2011). Voluntary behaviour has also been a focus of criticism as humans are flawed and have a self-destructive tendency as seen in gambling, alcohol and cigarette misuse; hence the need for regulation and coercion to protect individuals from their destructive tendencies and to protect other societal members (Rothschild, 1999; Donovan and Henley, 2003; Smith, 2011).

The traditional narrow focus by Social marketing on individuals' behaviours has been further challenged by Goldberg (1995). He uses a river with drowning individuals' metaphor, to illustrate that individuals may be drowning in troubled waters while bystanders watch condemning them for their lack of swimming skills. Other onlookers may be giving them coupons for swimming lessons, while others actively jump into the water to save them. He cites the need to explore reasons why the individuals fall into the water in the first place. There may be signs up the stream by attractive marketing models that may be encouraging them to jump into the waters because it is fun, or the reassurance from credible individuals that there is no need to worry as they dive into the water. Blame and counter blame games arise where marketers are criticised for their contribution into the drowning.

The marketers respond by arguing that it really is up to the individuals to know their swimming abilities before swimming regardless of the encouraging messages given. Other individuals argue that there is a need to improve the swimming curriculum to improve swimming skills, blaming the inadequacy of the curriculum.

Other community members feel that the signs need to come down as the marketing and advertising environment is the real problem. Others look up further and realise that many of the individuals that fall and slide back into the troubled waters are from specific demographic segments characterised by high unemployment, lack of education, limited access to health care among other social deprivation aspects.

The moral of the story/analogy is that the upstream factors are the ultimate source of public health problems. Some of the upstream approaches may include public policy action, changes in the social environment and changes in laws and regulations (Goldberg and Gorn, 1982; Winnet, 1995). There is a critical need by social marketers to link them to downstream conditions that focuses on individuals' behaviour, instead of blaming the victims and helping them after they have already drowned into the river.

Wallack, et al. (1993) also criticises social marketing for narrowly focussing on individuals' behaviour as the problem source in relation to health and diseases. He suggests the need to focus more on controversial sources of the problem, such as environments through which harmful products are made available to individuals. They further argue that it is not enough to give individuals skills to beat structural odds, but to change the odds so that more individuals have access to healthier choices. Some upstream issues, indeed, relate to marketing variables such as products, place, promotion and products that social marketers should address. Upstream and downstream strategies should be viewed as complimentary and not competitive, and the choice of whether to choose between upstream or downstream approaches should be based on cost benefit analysis of behaviours based on the target audience's point of view (Hornik, 1995; Winett, 1995). The usage of upstream, downstream and in-stream social marketing approaches in Kenya, is an area that has not been investigated compelling the need for this study.

A distinction between various approaches in social marketing is suggested by French, et al. (2011). They suggest that firstly; upstream social marketing focuses on policy and actions that address determinants of health. It should aid in understanding and evaluating how and why environmental and societal factors affect an issue of concern, and help address these anomalies by developing strategies to positively influence those factors. Secondly, in-stream social marketing approaches that concentrate on



actions and policies that may help individuals to cope with poor health and adverse conditions, they may find themselves in. Thirdly, downstream marketing centres on helping individuals change behaviour to improve health by evaluating and understanding how and why individuals make specific choices related to the issue on focus and the underlying aspects that affect their choices and certainly developing strategies to address these factors.

Downstream social marketing considers health related problems as caused by individuals' loose threads rather than the fabric of the society (Goldberg and Gorn, 1983; Wallack, et al., 1993). In contrast, upstream social marketing seeks to alter the fabric of the society by critically understanding and gaining insights into the contexts, causes, consequences related to the loose threads. It seeks to comprehend how the social institutions may be contributing into the loosening and fraying of the social threads. It should, ideally and positively look for ways of tightening and aligning the societal loose threads to the society fabric via any ethically feasible means.

Kotler (1980) explains the use upstream approach of lobbying in the legislative environment by commercial marketers, in order to have legislation and policies that favour their marketing objectives. Commercial marketers use many creative strategies to lobby such as entertaining legislators, opinion leaders and policy makers and also use of public relations to ensure that the regulatory environment is in their favour. In social marketing, this may sometimes mean taking the commercial marketing sector head on to deal with competition through warfare tactics and advocacy tools, especially in areas such as fast food and soft drink industries (Molnar, 2005), in order to tackle social and health issues such as obesity, alcohol misuse, smoking and their related industries (Slack, 2005).

French, et al. (2011) brings the various social marketing perspectives together by highlighting the need for a shift towards a more coordinated, sustained, evidence and intelligence-based approach built on a deep understanding of the issues that impact the target audiences' lives. They suggest the need to focus simultaneously on upstream, in stream and downstream approaches in order to effectively tackle social and health issues.

Donovan and Henley (2003) further advocate the need to seriously focus on social determinants as they argue that the primary future goal of social marketing is to achieve changes in these social determinants. Lefebvre (2011) accentuates the need to accelerate the focus by social marketers on social determinants of health, in order to bring about large-scale social change for population impact.

Social marketing concept and initiatives are perceived and understood differently by individuals. It is mainly confused with related concepts such as societal marketing, social responsible marketing and non-profit marketing (MacFadyen, et al., 2003). It is also confused with cause-related marketing, social advertising and social communication.

In distinguishing, commonly muddled up concepts, societal marketing entail incorporating social and ethical considerations into marketing practices that preserve or enhance the consumers' and society's well-being both in the short-term and long-term (Kotler, 1972). Social responsible marketing is an extension of corporate Social Responsibility (CRS) that helps business organisations self-regulate and recognise their activities and how they impact the stakeholders, taking into account economic, legal, ethical and philanthropic considerations (Ferrell and Hartline, 2011).

Non-profit marketing relates to the use of marketing tactics to further goals and objectives of non-profit organisations such as the use of advertising, public relations, fundraising, gathering information for decision making, relations with stakeholders among other activities, mainly meant to expand the organisation's horizon beyond internal operations to the external world (Wymer, et al., 2006). It is meant to benefit the organisation from a management orientation view because related marketing involves an alliance between a profit and a non-profit organisation (Varadaraan and Menon, 1988). It involves an offer from an organisation to contribute a specified amount to a designated cause when customers engage in revenue providing exchanges (Carringer, 1994, p.16).

Social advertising assigns advertising the primary, if not, the exclusive role in accomplishing social objectives ignoring other marketing Ps; while social marketing coordinates all the 4 or 7ps to achieve its social objectives. Social advertising may influence attitudes and behaviours. However, it is limited to that; it uses inadequately researched messages that may suffer from selective perception making it ineffective.

A further limitation is that many individuals may not know what to do after exposure to the message as the response mechanism may be ignored (Fox and Kotler, 1980). Due to these limitations, social advertising evolved to social communication that makes greater use of personal selling, editorial support and mass advertising. Social marketing is, however, distinct from social communication. It adds four elements to social communication such as marketing research to learn about the market, product development based on a marketing approach not sales approach, use of incentives to increase motivations and uses facilitation, by considering ways of reducing costs and increasing benefits using attractive and convenient response channels to facilitate behaviour change and maintenance. It further coordinates all the 4-7 marketing Ps to maximally motivate and facilitate desired forms of behaviour. This makes it appealing and appropriate to a wide variety of social problems. It is especially useful in areas where new information and practices need to be disseminated, when counter commercial marketing is needed like in discouraging cigarettes, alcoholic beverages, highly refined foods and when individuals need to be motivated to act by pushing them from intentions to action.

Andreasen (2002) suggests that it is the emphasis on voluntary behaviour change that makes social marketing unique compared to other behaviour change disciplines. This argument is, however, refuted by Donovan (2011) that suggests that commercial marketers do not really restrict themselves to always providing free and open choices. This is well seen in exclusivity deals in sponsorships that are considered legal, yet they usually restrict consumers' choices. He encourages social marketers to learn not to restrict themselves to voluntary behaviour choices. The concept of voluntary behaviour further invalidates the use of law in achieving social marketing objectives. Extreme cases require the need to force individuals to conform to healthy behaviours for their own good and the good of other society members by use of reinforcements and punishments. These may be well-supported by laws and policies, for instance, in drink and driving laws that serve to protect drivers and other road users as well as smoking free areas to protect other societal members.

An interesting debate surrounds the differences and similarities between social marketing and commercial marketing. Commercial marketing aims at establishing a market exchange for money, whereas social marketing is a welfare exchange that involves social behavioural change for tangible and intangible benefits such as

personal and societal well being (Brenkert, 2002). Anker and Kappel (2011) suggest that a new hybrid has arrived specifically commercial social marketing. They argue that it is the application of marketing techniques to encourage behavioural or attitudinal change in a target group in order to achieve a social goal that is conducive to a more fundamental corporate goal. They cite the case of Pampers back to sleep campaign that aims at encouraging parents to place babies on their backs to sleep instead of their tummies to prevent sudden infant death syndrome and Dove's campaign for real beauty that aims at dismantling stereotype ideals of beauty to improve women's self-esteem (Kotler and Lee, 2008). They contend that as much as the campaigns were driven by the need to support brand positioning, brand image and profits, the social goals were evident and insinuate that corporate social marketing or commercial social marketing is real. Donovan and Henley (2010), however, maintain that in truly differentiating social marketing from other confusing terms and disciplines, the underlying benchmark should be the understanding of the primary motivation and goal of the intervention. They claim that where the primary motivation is not to enhance the public good, based on United Nations Declaration of Human Rights as a guide to what public good means, then the intervention cannot be classed as a social marketing initiative.

Commercial social marketing raises ethical issues in cases as tobacco industry funding anti-smoking campaigns, where they have been found to subtly promote smoking to young people (Landman, Ling and Glantz, 2002). Anker and Kappel (2011, p.288) assert that if a business has a vested interest in promoting the behaviour or attitude which their corporate social marketing activities aim at preventing, then the underlying rationale for promoting the social cause is not to be trusted and they should shy away from Commercial Social Marketing (CSM) in that domain. This is indeed controversial in the sense that corporations are mainly brand, image and profit motive driven, thus what they, perhaps, call corporate social marketing may arguably lean more towards social responsibility than social marketing or pro-social marketing (Donovan and Henley, 2010). This is indeed an interesting area of controversy for further research.

#### **4.2. Why is the social marketing approach superior to other social change management approaches?**

Public health specialists and behavioural scientists have been in the field of social change especially in relation to health for long. However, while they are experts in assessing what people should do, they have not necessarily been experts in their assessments of the issues of concern, in communicating health or social change messages or in motivating or facilitating behavioural change as suggested by Egger, et al. (1993). They have, however, observed the success of commercial marketing and appreciated the systematic research based approach in the planning and implementation aimed at bringing about mass changes for profits. Some social change scientists have learned from this and consequently some have embraced the marketing tools in behaviour change (Egger et al., 1983; Kotler and Roberto, 1989; Fine, 1990).

In understanding who social marketers are and what they do, Smith (2011) brings in an interesting argument by using the metaphor of building a house. He argues that an effective social marketer is a general contractor who understands the professionals needed, their timings and costs, in order to improve efficiency and effectiveness in constructing the house. In the metaphor, the architect is the funding agency, homeowner is the population benefiting from the construction and specialists may be the communicators and other professionals, while the housing project is the social change.

It is the role of the general contractor to coordinate with and manage the relevant stakeholder to achieve the housing objective. Smith (2011) calls for the need to broaden the perspective to not only the consumers but to the donors, and bring in social entrepreneurs to add on the ability to understand and manage social change. He suggests the need for more grounding in change management systems and marketing knowledge, and stresses the need also to reflect on the interdisciplinary nature of social marketing, to borrow efficient tools from different disciplines to maximise social change. In critiquing the metaphor, social marketers could be seen as both the general contractors and architects, as they are the ones who plan and make intervention objectives, seek to thoroughly understand the target audiences in order to shape programmes to the realities of their markets and check on the project to its completion and evaluation.

Social marketing has been criticised as not being better than other health behaviour change approaches and not being ethical (Buchanan, et al., 1994). This critique may stem from a lack of understanding of what social marketing really entails. Hill (2002) underscores that health educators traditionally perceived social marketing as a collection of promotional activities or limited to a set of communication. Promotion is only a part of the marketing mix used by social marketer and essentially, is not equal to social marketing. Health educators struggle with the idea of creating programmes that fail to target all the persons, who could potentially benefit from an intervention driven by the belief that they must serve all the citizens (Quinn, et al., 2010). The aspect of segmentation is however crucial as different segments of the population may be affected by health or social issues differently. Health educators have also, mainly, focussed on health end points without giving attention to competition (Mcdermott, et al., 2011). However, failure to actively engage with competition may render the health and social change messages ineffective.

There are many strategies that can be used to achieve social change. Rothschild (1999) describes the use of education, regulation and marketing to affect behaviour change. He argues that education provides information and proposes unforced free choices. It, however, places the burden of costs and risks to individuals, offers a promise of future potential payback but is unable to reinforce directly. Regulation offers exchange but no free choices, as it uses sanctions for non-compliance and just as education, it places the burden of costs and risk on individuals. However, not all human behaviour can be regulated in democracies. Marketing, however, offers an explicit exchange, brings it to the target audiences and adds choices to the environment and best of all, considers costs and risks involved to achieve potential value. A marketing perspective appreciates self-interests of target individuals, benefits of exchange and the constraining nature of power and competition in the transfer of value. These aspects make it a superior approach in achieving social change.

Marketing the discipline from which social marketing draws from, is special in that it is assorted and uses knowledge from any discipline that meets the needs of consumers. It is experienced with lots of resources invested to understand its effectiveness and it is fluid enough and adapts itself to customer related issues. Smith (2011) argues that new theories, tools and technologies are emerging all the time and are not the answers to the complex social issues we face today. He suggests that what

is critical is a system that integrates them and further recommends that marketing is able to integrate disciplines with its multi-disciplinary approach to understand the consumers and persuading them. He compares marketing to democracy and contends that it may have its own flaws, but is better than all other forms that have been tried from time to time.

Social marketing perceives individuals as consumers with rights rather than citizens with obligations or students to be taught. It draws on robust research to understand target audiences, competition and the behaviour at hand before developing any interventions, rather than relying on experts or politicians' views (French, 2011). It focuses on making it easy for individuals to change by producing services and products that deal with barriers or help them get benefits that they care about. It is cost effective as it unearths the most cost effective target segments and sets realistic well-informed consumer focused smart objectives, likely to succeed. It draws on process research to improve implementation and summative evaluation for the purpose of learning to improve future interventions. These key highlights of social marketing make it a fluid and highly adaptable approach in enhancing and achieving social change in comparison to other social change approaches.

Kotler and Lee (2008) cite four main behavioural spheres where social marketing interventions are applied. Firstly, in health improvement as in encouraging healthy eating, physical activity, changing sexual behaviours, behaviours associated to conditions such as diabetes. Also, it is effective at encouraging the uptake of health behaviours such as breast-feeding, immunisation and oral health. Secondly, in the area of safety and injury prevention such as gun safety, domestic accidents, road safety, and prevention of domestic violence. Thirdly, in community involvement in areas such as blood or organ donation, education participation, volunteering, charity work. Fourthly, in environmental protection like encouraging recycling, conservation of water and energy, protection of wildlife, wild fire prevention, safe pesticide and anti-littering.

In reference to developing countries, Smith (2011) suggests that social marketing has been effective in reducing fertility rates, promoting condom use among gay men, immunisation uptake, promoting education for girls, energy conservation, saving children from dehydration and protection of bio diversity. These diverse attitudinal

and behavioural spheres, indeed, show case the robustness of social marketing and its versatility in bringing about social change. In their systematic review of social marketing effectiveness in areas of alcohol, tobacco and drug use and physical activities in over fifty-four (54) interventions, Stead, Hastings and McDermott, (2007) recommend that social marketing is a promising intervention approach that can be effective across a range of behaviours, with a range of target groups and in different settings that it can work upstream to influence policy as well as with individuals in downstream approaches.

### **4.3. The social marketing framework and process**

In order to identify social marketing initiatives, Andreasen (2005) suggests scrutinising criteria, which was adopted by the national social Marketing United Kingdom (French and Blair-Stevens, 2006). Firstly, the requirement for a programme to have behavioural change prerequisites and objectives in order to achieve a social goal. Secondly, the need for consumer research to understand experiences, values and needs of target audiences. Thirdly, segmentation and targeting use when selecting intervention target groups. Fourthly, the use of marketing mix, which involves the use the 4Ps of marketing- product, price, place and promotion. Fifthly, the need for exchange to motivate desired behaviour change and sixthly, competition that ought to be identified and dealt with in a program. Stead, Hastings and McDermott, (2007), however, recommend that the criteria are not rigid determinants but flexible indicators of a social marketing campaign. McDermott, Stead, and Hastings (2005) however claims that the criteria are more reliable than judging initiatives solely on the basis of how developers and implementers label their initiatives and imply that it a useful framework in differentiating social marketing initiatives from other forms of interventions.

In relation to what constitutes the social marketing process, both Andreasen (1995) and Weinreich (1995) suggest key stages involved consisting of: a) listening to target audience by background analysis, b) planning to set mission, objectives and goals, c) structuring to establish procedures and benchmarks, d) pretesting to try out key programme elements, e) implementing to put strategy into effect and monitoring to track progress and adjust strategy and tactics. The process was particularly set out for downstream social marketing, although, he later the same may be applied in upstream



marketing (Andreasen, 1997). Egger, Spark and Donovan, (2005) proposed the SOPIE model for health promotion intervention. S represents situational analysis where issues are identified, problems specified, resources and target audiences analysed via formative research. O signifies objective setting follows where overall goals and campaign goals, behavioural and communication objectives are set for the target audiences. P stands for planning stage involves message strategies, developing and pretesting materials, selecting media, identifying supporting components, I is for implementation by developing detailed programme procedures and involving other stakeholders and lastly, E is for Evaluation of the campaigns to monitor process and outcome evaluation.

Kotler and Lee (2008) describe ten steps to developing a social marketing intervention. Firstly, there is need to describe the plan, background, purpose and focus. Secondly conduct a situation analysis like the SWOT and PESTEL analysis of the problem to guide plan development. Thirdly, select target markets, fourthly, set marketing objectives and goals. Fifthly, identify target market barriers, benefits and competition, sixthly, craft positioning statements, seventhly, develop a strategic marketing mix based on the 4Ps.

Eighthly, outline a plan for monitoring and evaluation, ninthly, establish budgets and find funding sources and lastly, implement the plan and evaluate it. They, however, caution that a planner needs to be flexible and recognise the need to go back and forth in the steps while being inspired by research. Their approach mirrors more learning from commercial marketing in that vital aspects such as segmentation, strategic use of the 4ps of marketing have been included, although it is quite similar to Sopie (Egger, et al., 2005) and the process proposed by Andreasen (1995) and Weinreich (1995).

The total process planning model by French, et al. (2011) consists of five key stages: firstly, scoping that involves consulting with stakeholders, review of relevant information and understanding of audiences via research, segmenting the audiences and setting some evaluation criteria early enough that will measure the success of the intervention. Secondly, developing based on current services available and service provision, involving stakeholders to endorse and implement, use of behaviour change theories, developing barrier and exchange basis, and evaluation of testing of outputs and outcomes. Thirdly, implementing by use of a mix of methods to prompt and

facilitate behaviour change, use of national resources and by working with stakeholders. Fourthly, evaluating of the implementation stage based on what worked and what did not work and why it did not work based on the set outcomes and outputs envisioned in the developing stage, and fifthly, follow up based on sharing, learning with stakeholders and knowledge bases like journals.

The Social marketing process arguably reflects Kotler and Zaltman (1971, p.5) definition of social marketing, as a social change management technology involving the design, implementation and control of programmes aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters. Paramount in the social marketing process is what the theorists refer to as listening to audiences in background analysis (Andreasean, 1995 and Weinreich, 1995), situation analysis (Eager, et al., 2005; Kotler and Lee, 2008) and scoping (French, et al., 2011). Indeed, this first step forms the basis for other steps of planning, implementation and evaluating. It involves through formative research needed to understand the target audiences, their issues and realities in order to select target markets, set right objectives and goals and develop marketing strategies and mix. This is, arguably, the stage at which cultural and contextual realities are extremely necessary to inform the other steps of the process. It is perhaps also where most social marketing problems and ineffectiveness originate. Wymer (2010) argues that the effectiveness of social marketing is negated if the context within which individual behaviour is influenced is ignored. The extent to which social marketers in Kenya engage with their context has not been investigated and is certainly an area worth studying and investigating.

Quigley and Watts (2005) argue that the medical community is recognising that the society needs to focus more on the marketing that creates an unhealthy context and less on the individual. Considering, for instance, the case of obesity, Eggers and Swinburn (1997) suggest that strategies need to shift from viewing obesity as an individual disorder to considering it as a normal response to an abnormal environment. This is because individuals' ability to make healthy choices decline when their environment actively promotes less healthy options. Hoek and Gendal (2006) advocate for a typical approach that begins with regulatory change and concludes with educational campaigns targeting individuals. They submit that for social marketers to be effective, there is the need to first create a healthy context for the individual and then target them with educational messages.

Social marketers must, therefore, acknowledge and meliorate influences that deteriorate public health and wellness as they cannot counter the effect of industry marketing with public service messages (Gorn and Goldberg, 1992; Royne and Levy, 2008). For social marketers to make substantial improvements in public health and welfare, Quigley and Watts (2005) contend that there is a need to refocus on the commercial marketing theory and practice as a whole, and to consider how they can intervene in areas such as limiting promotion, product development, sponsorship, placements, pricing and distribution of unhealthy products. They also need to enlarge boundaries beyond targeting individuals with messages, to targeting negative influences reinforcing the undesirable behaviours by playing more of an activist role; an argument supported by the likes of Gorn and Goldberg (1992) and Wymer (2010), as they advocate for the need for upstream and in-stream social marketing approaches. The reality of healthy contexts, targeting of unhealthy influences in a multi-cultural society as Kenya, in relation to SM initiatives targeting HIV/AIDs, has not been studied before and is an interesting area worth investigating in this study.

Most social marketing problems and challenges that contribute to its ineffectiveness are more formidable than typical commercial marketing problems. They range from inadequate research, inadequate funding, the choice of wrong target markets and products formulation constraints while considering fewer pricing opportunities to decrease costs to consumers. They also include channels of distribution that may be harder to utilise and control, communication strategies that may be difficult to implement due to budget constraints, lack of marketing knowledge and skills by implementers and difficulties in evaluating social marketing efforts as most social problems may take a long time for any impact to be realised (Fox, 1980; Bloom and Novelli, 1981).

Social marketing's effectiveness has also been greatly hampered by a lack of understanding of what the discipline entails. Fox and Kotler (1980) argue that there will be a need for better trained social marketers rather than social advertisers, that are well grounded on knowledge and skills on market analysis, economic analysis, management theory and a good understanding of social disciplines that deal with attitudes and behaviour such as sociology, psychology, anthropology, communication theory and skills in social problem solving. They will need to work in challenging multicultural environments that necessitate sensitivity to cultural differences,

knowledge of relevant aspects of the cultures in which they work and have language competence necessary in dealing with specific social challenges. This, perhaps, suggests that cultural incompetence and insensitivity have been a contributor to ineffective social marketing interventions.

Common themes that emerge from the factors affecting the effectiveness of social marketing from the discussion so far (Bloom and Novelli, 1979; Novelli, 1980; Fox, 1980; Fox and Kotler, 1980), point to issues related to firstly, a lack of target audiences' contextual engagement. Secondly, cultural incompetency and insensitivity by programmers in planning, designing, implementing and evaluating of social marketing interventions. Thirdly, a lack of an in-depth understanding of social marketing by practitioners and social change advocates. These issues point to gaps in the use of social marketing in tackling social issues worth investigating within a multi-cultural set up as Kenya.

Perhaps, an understanding of the different contexts within which social marketing has evolved from, may probably help explicate the dilemmas gaps and challenges currently facing social marketing theory and practice.

#### **4.4. Social marketing in the developing and developed countries contexts**

Developed world is differentiated from developing world by the levels of poverty and development in social amenities. The United Nations composite indicator of poverty is based on access to necessities such as education, healthcare, living standards and ability to participate in community and decision making processes that affect the well-being of individuals concerned (United Nations Development Programme – (UNDP), 2010). Many developing countries certainly fall short in these key indicators of poverty especially in the continents of Africa, Asia and Latin America. International development involves the offering of foreign assistance by developed nations to developing nations to help lighten the poverty burden. A huge part of the poverty burden is, however, blamed on population growth.

Endeavours to reduce birth rates in developing countries' led to the notion of social marketing as an approach to family planning, social change that started with the Nirodh condom initiative in India in 1967. The initiative used elements of segmentation, mass media communication and strategic distribution to promote the

acceptance of family planning in India (Walsh, et al., 1993). Four years later in America (developing world context), Kotler and Zaltman (1971) coined the term social marketing as the use of commercial marketing methods for social change. Many donor agencies like United Kingdom's Department for International Development (DFID), German (KFW), United States Agency for International Development (USAID), United Nations agencies like UNFPA and UNAIDS as well as NGOs like Population Service International (PSI), DKT International, Academy for Education Development (AED) all use social marketing approach in the several initiatives they fund in the developing countries.

Social marketing in developing countries mainly involves the promotion and access to products like condoms and mosquito nets and services like family planning, screening of malaria, HIV/AIDs and other public health concerns. This differs from social marketing in developed counties that mainly involve marketing of ideas and lifestyle changes (Cairns, et al., 2011). Social marketing, in both contexts, is similar in that interventionist all use social marketing principles such as consumer centric approach to programme planning, implementation and evaluation, use of exchange theory and marketing tools such as research, segmentation and competition analysis, although in developing countries many initiatives may not actually be labelled as social marketing programmes.

Cairns, et al. (2011) suggests 5Bs to bring about the differences in how social marketing has evolved in the developed and developing context. The first B is the benefactors referring to donors, mainly from developed countries commonly referred to as bilateral and multilateral donor agencies as well as international NGOs. They, mainly, fund social marketing initiatives in the developing countries. The donors determine the availability of resources, methods to be employed in the programmes, priorities, timelines and evaluation based on their strategies and rationale for international development programmes. Their support is mainly short-term and this brings in the challenge of sustainability of programmes post donor support, to both the governments and people in the developing countries.

Donors are key stakeholders in social marketing initiatives; however, the bone of contention lies in their reasoning and strategies for international development that guide their decisions making process. Their thinking is arguably informed by their

western contexts, experiences and cultures and perhaps, subject to self-referencing criteria. This, arguably, may skew their decisions and strategies for developing countries, rendering them culturally incompatible, as they may not be based on an understanding of the cultural and contextual realities of the developing countries. This is in sharp contrast to funding for social marketing initiatives undertaken in developed countries, which are mainly funded by their governments or development partners, with decisions and strategies mainly guided by an understanding of their cultural and contextual realities.

Airhihenbuwa, et al. (1992) suggests that it is counterproductive to target individuals for most health risk reduction efforts without considering the effects of those individuals' cultures, languages and environments. They further assert that it is vital to manipulate the social, political and environmental forces that influence health behaviour within the context of particular cultures. The level of cultural competence most benefactors and international agencies decision makers and employees hold, while policing aid and programme decisions for developing countries may, perhaps, be questionable. It may range from cultural incompetence and insensitivity to probably, cultural apathy.

Key to understanding the culture of a market is the need for cultural competence by the interventionist and funders. A distinction has been made for the various levels of cultural capacities by Winkelman (2009). He suggests that cultural awareness involves an understanding of the importance of cultural differences, while cultural sensitivity relates to being able to provide an appropriate response based on the knowledge of cultural differences. Cultural competence refers to having capabilities to deal with cultural differences effectively in everyday life, whereas cultural responsiveness falls between sensitivity and competence, referring to the ability to respond to needs in a manner that is congruent with the cultural expectations. Cultural proficiency involves the ability to transfer cultural knowledge and skills to others by providing them with the skills to effectively manage cultural differences.

Desired from interventionist and donors is perhaps cultural competence if not cultural proficiency. Many donors and interventionist, perhaps, may be lacking in basic cultural awareness skills. This may incline them to push for culturally incompetent interventions that may be deemed as culturally insensitive and possibly doomed to

fail, as they may not resonate well with the target markets cultures. Audiences may, therefore, perceive a form of cultural imposition and alienation, mainly resulting in overt or covert cultural rebellion. This may be evidenced by programme resentment and a lack of cooperation with programmers, issues that possibly may lead to the failure of many interventions from a cultural context perspective. It is, however, worthwhile investigating this issue to understand it more clearly.

The second B refers to the benefits. In richer countries social marketing interventions tackle quality of life and well-being problems linked to affluence such as obesity, mental ill health, and stress linked up to materialistic lifestyle, referred to by James (2008) as 'affluenza'. In developing poorer countries, social marketing initiatives reflect poverty and struggle to survive and meet the basic day to day needs such as food, clean water, basic health care, education, information, girl child education, among other realities mainly taken for granted in consumer economies (Peattie and Peattie, 2011). This is not to say that with the developing middle class and upper class in developing countries; 'affluenza' issues are not a reality, as the top and middle class struggle with similar issues too. The scale or percentage is arguably smaller, as the majority of individuals in many developing countries such as Kenya live below the poverty line, without any benefit or social support from the local or central governments.

Due to the realities and challenges that characterise developing countries such as huge poverty burden, struggle for survival, inequalities, lack of firm regulations and controls due to corruption related problems; social marketing in developing countries is able to deliver key benefits such as quality assurances, low product prices, accessibility and sustainability of essential products such as condoms, mosquito nets, family planning services among other crucial services. This is made possible by interventionists partnering with commercial marketers such as local small-scale entrepreneurs for accessibility and continued supply to the urban and rural folk of these essential social marketing related products.

Developing countries find many of their citizens in extreme poverty without much help from their governments. This is compounded by underdeveloped infrastructure and social amenities such as hospitals, clinics, roads, libraries, and community centres among other essentials. This is, unlike, in the developed world, where such facilities

are abundant and well developed, making it easy to access information and benefits related to social marketing initiatives. For instance, in England, health centres with general practitioners (GP) are free for citizens and locally available, whereas in a developing country like Kenya especially in the rural set up, individuals have to travel for many kilometres on all-weather roads, in search of doctors or nurses to provide any professional health services. In contrast, small-scale entrepreneurs such as local shopkeepers and kiosks' owners are found in both urban and rural areas. Social marketers may find it easy to link up with these small-scale traders, to stock up social marketing products such as condoms, mosquito nets treatments or others at low prices for use by local people. These traders may also be trained to offer basic education to the rural population on social marketing products, their benefits and uses, making information and products easier to access.

The third B is barriers. Social marketers in developing countries like Kenya face a myriad of challenges related to poverty and underdevelopment compared to those in a developed context as England. All weather roads, lack of telecommunications infrastructure, high illiteracy levels, lack of trained personnel, substandard products dumped from other countries, socio-cultural factors such as beliefs, myths, superstitions, cultural discrimination of the girl child and women, language challenges among others, may represent few of the many challenges faced by social marketers in Kenya. In England, social marketing initiatives may fail due to the untrained personnel, logistics and other factors but certainly, Kenya's situation representing the developing context will be worse. Indeed, navigating cultural based challenges may be more problematic as compared to the infrastructural issues, bringing the need to engage with cultural and context environment to the critical list of barriers and competition for social marketers to deal with in developing countries contexts.

Branding is the fourth B. Developing countries lack universal basic medical and education access. Drugs, advice and health services are mainly paid for, with little or no consumer rights protective measures (Travis and Casells, 2006). Branding, therefore, helps reduce uncertainty and risk of products associated with social marketing initiatives in these contexts. Social marketers usually choose between manufacturers model and own brand models. Manufacturers' models use commercial manufacturers and distributors working with development organisations to avail



products to consumers. Own brand models involve social marketing organisations buying directly from manufacturers, branding and setting prices for services or products and sometimes, may also involve the use of commercial distributors. Branding strategies help with information gaps, as distributors educate the consumers on the benefits and usage of products. However, branding strategies may perhaps need to be blended to the cultural and contextual realities of the target groups in order to be successful.

The last B is the behaviour change communication, which aims to promote beneficial behaviours together with their determinants as the norm and ensure consumers are aware of how to access and appropriately use social marketing benefits. Freire (1970) suggests that externally influenced language and imagery can act as Trojan horses for alien cultures and values, and may be a risk to the social capital of those it aims to benefit. Chambers (1983) suggests the need for participatory research and communication methods to make communication fit for purpose. Hofstede (1994) suggests that individualism as a cultural concept refers to the extent to which individuals view themselves as independent and autonomous, while collectivists see themselves as integrated into groups as found in Asia, Africa and Latin American countries. He further accentuates that communication modes, methods and acceptance by individualists and collectivists groups may differ.

Aaker and Williams (1998) also support the need to consider cultural divides in communication. They claim that advertisements emphasising individualistic themes are more favourably received in the United States than in China, due to the individualistic and collectivist divide. Collectivist cultures promote harmony within small supportive groups and have lower disease levels than individualistic cultures (Triandis, et al., 1988; Bond, 1991). This may be explained by the fact that collectivists offer more social support, essential for self-esteem and stress management and vital for promoting health and preventing health related disorders, perhaps lacking in individualistic societies (MacLachlan, 2006). Communication is, therefore, cultural-specific and perhaps, may need to reflect the cultural contextual realities of any programme's target audiences. The extent, to which programmers in Kenya reflect this aspect, may need further investigation.

Cairns, et al. (2011) discussion of 5Bs in social marketing (benefactors, benefits, barriers, branding and behaviour communication) suggests crucial contextual differences in social marketing practices and understanding in developing and developed countries. It further reinforces the need for cultural contextual engagement with target audiences. Cultural factors exert a major influence on consumer behaviour, as culture is the most fundamental determinant of a person's wants and behaviours (Albaum, Duerr and Strandkov, 2005). The cultural theme resonates well with Lefebvre (2011) argument that the social marketing approach should embrace an understanding of the determinants, context and consequences of current behaviours and desired ones, from the point of view of the audiences not from any one or set of theories and models. Social marketers, in the developing countries, face many social cultural challenges as compared to those in developed economies. Consumption and behaviour choices cannot, therefore, be understood, without considering the cultural and contextual realities in which these choices are made, as culture is the lens through which people view their world. Sexual behaviour choices are key issues in the spread of HIV/AIDs in Kenya that social marketers fighting the pandemic deal with; however, no studies have delved into the cultural and contextual realities that impact their programme work, necessitating this kind of study.

#### **4.5. Social marketing and culture**

Culture is a broad and extremely complex concept because it involves virtually every part of an individual's life and touches all human needs both psychological and physical (Jain, 2001). Taylor (1871) cited by Jain (2001) views culture as that complex whole that includes knowledge, beliefs, arts, moral, laws, custom and any other capabilities and habits, individuals acquire as members of a society. Triandis (1972) suggests, from a psychological point of view, that it is the shared perception of the social environment. Hofstede (1991, p.5), from an engineering point of view suggests that it is the collective programming of the mind, which distinguishes the members of one group or category from those of another. It is a learned, shared, compelling and interrelated set of symbols whose meanings provide a set of orientations for members of society that provide solutions to problems that all societies must solve if they are to remain viable (Terpstra and David, 1991, p. 6).

Commercial marketers do acknowledge that consumer needs, motivations and behaviours are largely driven by cultural nuances of the target audiences. This is because culture influences how information is sought, received, processed and interpreted greatly, influencing buying motivations and behaviours (Briley and Aaker, 2006). They take cultural forces seriously and consider them critical to their success or failure in a market. They ensure that cultural forces inform their marketing strategies, decisions, tools and mix choices. They are aware that ignoring these forces may lead to costly cultural blunders that can result in embarrassment, loss of customers, missed opportunities, legal consequences, tarnished brands, cooperate reputations and huge costs for damage control (Dalgic and Heijblom, 1996).

Commercial marketers are aware that they cannot afford to assume homogeneity of cultures across the globe or even within countries (VanHeerden and Barter, 2008). They therefore research, study target markets and analyse their cultures to inform their decisions. They are aware that all stages of consumption process from seeking of products, accessing, buying behaviour, consumption characteristics and disposing are all heavily influenced by the culture in which the consumer thrives (Raju, 1995). Jain (2001) stresses that marketing oriented firms make decisions and consider strategies based on their customer points of views. These are mainly shaped by their lifestyles and behaviour patterns, mainly heavily informed by their cultures.

Social marketing on the other hand may have much to learn from its parent root discipline commercial marketing, in as far as engaging culture is concerned. The extent, to which social marketing programmers in Kenya engage the cultural realities of their audiences, is a gap worth investigating in this study. Considering developing countries context, culture may be seen in the triad of competition, costs and barriers. Noble and Basil (2011) suggests that many social marketers do not address competition in their initiatives at all, while others cursorily address it.

Andreasen (2005) suggests four levels of competition in social marketing. Generic level competition refers to forces that prevent attention from a social marketer's broad topic area. Enterprise level competition refers to forces within industries, product level competition suggests forces related to products while brand level competition relate to specific brands that deter attention from a social marketers focus area. These four levels can be categorised along competing versus complementary and entity

versus non-entity based-competition. Conceptualising competition at these levels of abstraction may reveal some insights, but not those necessarily relating to cultural challenges found in developing countries. The notion that may perhaps sound plausible in developing countries context may be that of cultural complementary and competing forces. However, they still do not explicate how social marketers would unearth or navigate cultural realities in the scoping, designing, implementation and evaluation stages of their social marketing initiatives.

Kenny and Hastings (2011) propose that norms powerfully influence behaviour to a greater extent than other demographic factors, however they are regularly misperceived. Correcting these misperceptions has the potential to bring about positive behaviour change, especially when applied to both downstream and upstream social marketing. They, however suggest that unfortunately, norms based campaigns have been ignored by social marketers and research is necessary to examine social norms perceptions, their origin and formation in order to understand how to target them with social marketing initiatives. Much as norms based campaigns could perhaps be effective within a culturally rich multi-cultural context as Kenya, there is no evidence that social marketers have taken advantage of these campaigns, pointing to a need to investigate why they have not been undertaken and what can be done about them, necessitating this kind of study.

Lee, et al. (2007) suggests that in order to use normative influence effectively, social marketers must be able to distinguish between the different types of norms, their formation and their impact upon behaviour. Social norms studies have however been challenged by the inconsistent use of the terminology, signifying conceptual confusion (Rimal and Real, 2003). Social norms are understood differently: as social influences (Dusenbury, et al., 1994), as peer influence that may either be direct or indirect (Borsari and Carey, 2001) and as normative beliefs (Maddock and Glanz, 2005).

Norms may be broadly described as descriptive and prescriptive. Descriptive norms refer to perceptions of what others do in given situations. They influence behaviour by way of example especially in ambiguous situations since they require little cognitive power (Lapinski and Rimal, 2005; Cialdini, et al., 2006).

Prescriptive norms are guided by opinions and values defining how people ought to behave. They may be seen as subjective norms, which refer to perceptions of significant people towards how an individual should behave in a given situation. Injunctive norms relate to what is approved by most people (Cialdini, et al., 1991). Personal norms are usually based on moral or personal values that form standards of an individual's behaviour (Schwartz and Howard, 1982). Failure to comply with social norms may result in informal social sanctions (Rimal and Real, 2005). The need for compliance is driven by motivations heavily valued by collectivists compared to individualist cultures such as positive social identity, need for acceptance and avoidance of being ostracised.

Normative influence research has led to many theories being postulated that seek to understand their relationship with behaviour such as the theory of reasoned action (Ajzen and Fishbein, 1980), social identity theory by Turner (1982), social learning theory (Bandura, 1986), the focus theory of normative conduct by Cialdini, et al. (1990), theory of normative social behaviour (Rimal and Real, 2003; Rimal, et al., 2005) among others. Significantly, the theory of normative social behaviour suggests a complex relationship between descriptive norms and behaviour, mainly moderated by injunctive norms, outcome expectancies, group identity, behavioural identity and peer communication.

Norms may, however, be misperceived. Normative norms misperceptions include, pluralistic ignorance that occurs when individuals incorrectly perceive that others behave or believe differently, making individuals engage frequently in the misperceived behaviour (Prentice and Miller, 1993). False uniqueness is another misperception that occurs, when people that abstain from a particular behaviour, incorrectly view themselves as more unique than they really are. This makes them withdraw from interaction with others. Thirdly, false consensus that occurs when individuals believe that others are like them, when in reality they are not, in an effort to justify their behaviour (Sanders and Mullen, 1983). Correcting these misperceptions may affect behaviour change by harnessing the power of both descriptive and prescriptive norms (Kenny and Hastings, 2011).

Social norms considered in developing countries contexts as Kenya, ideally point to the influence of culture on behaviour. Descriptive, prescriptive, both subjective and injunctive norms are arguably based on the cultural beliefs, attitudes, values, practices, social symbols and taboos. Personal norms may also be founded on cultural heuristics. This, perhaps, points to the need to effectively engage culture in social marketing initiatives especially in developing countries, as culture drives behaviour consciously and unconsciously, in order to understand social norms and their effect on behaviour change. Could a lack of critical engagement with culture explain the little impact health related messages have had on behaviour change, especially in relation to HIV/AIDs especially in Kenya, this is a gap worth investigating.

Segmentation and targeting are critical components of commercial marketing and social marketing. Wind and Bell (2002) suggest that no service or product appeals to all consumers; even those that purchase similar products may have diverse reasons for buying them. A popular segmentation variable in social marketing is behavioural basis, where individuals are divided based on their engagement in or response to certain behaviour (Kotler and Armstrong, 2004). Psychographic segmentation relates to dividing individuals on the basis of social status, lifestyle, attitudes, aspirations and self-image among other attributes. Psychographic segmentation may help in the development of communication campaigns, branding and positioning, although it may not be a predictor of health behaviour (Donovan and Henley, 2003).

Geographic segmentation considers locations in order to customise offerings to local needs and preferences. Benefits sought may also be a basis of dividing individuals into groups in order to effectively deliver the desirable benefits effectively. Models and theories have also been used to subdivide individuals, for instance Prochaska, et al. (2002) trans-theoretical model that subdivides individuals into different stages: pre-contemplation, contemplation, preparation, action and confirmation/maintenance and helps identify strategies of interventions at various stages. Hastings (2008), however, cautions that it is worth noting that individuals do not necessarily move in a linear fashion through each stage, making this basis of segmentation complicated.

Donovan and Henley (2003) suggest the use of TARPARE model to understand segments and their viability, based on resources available to interventionists. T- total number of people in a segment, AR- At risk proportion in the segment, P- persuasibility of the audiences, based on their feasibility to change attitudes or behaviour, A- accessibility of the target audiences based on cost efficiency, R- resources required to meet audience needs and E-equity-social justice issues. Good segmentation helps identify the groups worthiest pursuing (Yankelovich and Meer, 2006).

Lotenberg, et al. (2011) suggests that in spite of market segmentation and targeting being critical to social marketing, the concepts are often under-used, and in few instances, they are used narrowly to guide development and delivery of communication. There is, perhaps, the need for social marketers to use them in identifying new target markets, marketing mix decisions as in developing products, informing pricing and distribution in order to increase customer satisfaction and also in resource allocation. Much as geographical, behavioural, benefits sought, psychographics, demographic segmentation may be useful, in the developing countries contexts, perhaps cultural theme may be the critical motivation behind much of health-related behaviour and social change related issues and may need greater engagement with in programme work. The use of cultural segmentation and the benefits or harms that may be associated with it in social marketing campaigns in Kenya, an area worth investigating.

Pasick, et al. (1996) suggests the need for cultural tailoring which they refer to as interventions, strategies, messages or material, which conforms to cultural characteristics that influence behaviour and health. They argue that too much focus has been broadly defined by the racial or ethnic groups, and interventions have been characterised by insufficient awareness of cultural dimensions relevant to health and behaviour. They indicate the need for cultural tailoring to guide problem identification, objective setting, theory selection, evaluation design and implementation in social marketing interventions targeting ethnic groups. They, however, do not explicate in depth, how programmers can engage with cultural tailoring.

Zainuddin, Previte and Russell-Bennett (2011) highlight the importance of understanding customers' perception of value in relation to the consumption of social marketing products. They submit that this is a necessary first step in designing social marketing interventions that can effectively change social behaviours to benefit the society. The concept of value in social marketing interventions is deeply embedded in the understanding of market contexts and cultures. This understanding is critical in order to unearth the intrinsic and extrinsic aspects that impinge on value, as they are mainly contextually bounded and subjectively experienced (Vargo and Lusch, 2008). Cultural context analysis may help unearth various dimensions of value such as the functional, emotional, social and altruistic aspects, from an experiential rather than economic perspective (Holbrook, 2006). This understanding, may, perhaps be critical in guiding the selection of appropriate strategies, decisions and actions for effective value adding social marketing interventions. Value perceptions in relation to social marketing products related to HIV/AIDS campaigns in Kenya, would benefit greatly from a cultural and contextual understanding of what is valued or not in relation to sexual consumption. This area has not been investigated compelling the need for this study to understand value and exchange in relation to HIV/AIDS campaigns.

Culture is, therefore, a force that social marketers cannot afford to ignore, as it can be either a barrier to health and desired behaviour or a protective factor. It can thwart health interventions, reinforce and perpetuate behaviours that impinge on well-being and may be the key factor that explains differences in health amongst people within and between different countries (Health Canada, 1998; Young, 1998; Kindig and Stoddart, 2003; Eckersley, 2006). The need to centralise culture in interventions is emphasised by Winkelman (2009). He suggests that culture affects health by influencing our perception of various aspects that impinge our well-being. This includes our understanding of health conditions, behaviours that expose us to diseases, reasons that prompt us to seek care, how we describe our symptoms, appropriate treatments appreciated and our compliance with treatments.

Airhihenbuwa, et al. (1992) suggests that it is counterproductive to target individuals for most health risk reduction efforts without considering the effects of their cultures, languages and environments. MacLachlan (2006) proposes the need for three vital elements in appropriate health interventions; the need to understand socio-cultural symbolism, a commitment to multi-culturalism and cultural tolerance in order to



understand how different people understand their health and suffering. La Roche and Maxi (2003) recommend that cultural differences should be addressed as assets that can help in therapy rather than constructed as deficits.

In relation to HIV/AIDS, Wilson and Miller (2003) suggest that interventions that integrate cultural factors into HIV prevention themes and content have confirmed the pervasive influence of culture in risk perception, risk taking behaviours and adoption of protective behaviours. UNESCO (2001) attributes ineffective HIV/AIDS programmes to a lack of openness in many societies regarding sexuality, male-female relationships, illness and death, taboos rooted in cultures and stress on the need to understanding what culturally motivates behaviours. They further underscore the need for considering culture in the development of programmes addressing HIV/AIDS attitude and behaviour change.

They contend that culture ought to be engaged with in three main respects: context, referring to the environment for HIV/AIDS communication, the content, based on values and resources that can influence prevention education for culturally appropriate content and lastly the method by embedding prevention and care in local cultural contexts in a stimulating and accessible way. They suggest a five point criteria that may help in formulating and achieving effective HIV/AIDS projects: firstly, cultural appropriateness, secondly, fully respectful of human rights, thirdly, gender responsiveness, fourthly, age responsiveness and lastly, involvement of people living with HIV/AIDS at every stage of the projects.

Airhihenbuwa (1995) suggests that public health, social and behavioural sciences mainly pay lip service to the importance of culture in studying and understanding target audiences' behaviour, without actively inscribing the cultural understanding at the root of health promotion and disease prevention programmes. He further claims that this lack of engagement with target audiences' culture, has led to the imposing of westernised models of prevention and interventions being used to drive health promotion and disease prevention practices in other parts of the world. These are based on individualistic cultures that differ from collectivist cultures, rendering many of these interventions futile due to cultural incompatibility. These criticisms levelled towards health and behaviour change social marketing initiatives, clearly point to the need for social marketers to engage meaningfully with cultural and contextual

realities of the target audiences. The extent to which programmers in Kenya engage their cultural environment is indeed a gap that needs to be explored and investigated within the Kenyan context.

Much as culture is central and critical to social marketing initiatives, the lack of meaningfully engaging with it, perhaps, stems from the fact that the cultural concept is challenging because it is broad and extremely complex. This is because it virtually involves every part of an individual's life and touches all human needs both psychological and physical (Jain, 2001). There is a need to simplify the concept in order to understand, analyse and engage with it, meaningfully. Perhaps, an understanding of how the commercial marketers deal with culture may give social marketers insights as to how to navigate the complex cultural terrain and apply it to social change.

Different international and cross-cultural marketing authors and researchers have suggested key cultural variables that marketers operating across different cultures need to engage with, to avoid cultural blunders and costs. A discussion of various cultural elements in chapter three locates various elements relevant to commercial marketers. Terpstra and David (1978) and Albaum, et al. (2002) suggest eight relevant elements of the social cultural environment as being language, religion, values and attitudes, the law, education, politics, technology and material culture and social organisation.

Some of the factors they considered are part of the macro environment that a marketer would certainly need to deal with in the PESTEL analysis (political, environmental, social, technological, economic and legal), leaving key cultural variables possibly as language, religion, values and attitudes, and social organisation. Ganon (1994) suggests that elements of culture relevant to marketers are: material life, social interactions, language, aesthetics, religion and faith, pride and prejudice, ethics and mores. Katobe and Helsen (2011) further suggest seven elements of culture relevant to marketers as being: material life, language, social interactions, aesthetics, religion, education and values. These lists reflect the vital elements considered by other authors such as: Terpstra and David (1978), Ganon (1994) and Albaum, et al. (2002). Hall (1959) suggests a cultural map that may help in understanding a society's culture. It consists of variables such as: interactions with the environment, association based on

structure and organisation of a society, subsistence relating to livelihood and living and bisexuality based on differentiation of roles and functions along sex lines. It also includes other variables such as: territoriality that explains the possession, use and defence of land and territory, temporality that explains the use of time for various activities, learning based on patterns of transmitting knowledge, play that explains how individuals' in a society relax, recreate and enjoy themselves and lastly, exploitation that relates to how individuals use skills and technology to turn natural resources to satisfy their needs and wants.

A blend of the cultural elements suggested by Hall (1959) and Katobe and Helsen (2011) may arguably provide a richer perspective to explain the key elements of culture that may be relevant to both commercial and social marketers to inform their decisions, strategies and actions. However, the gleaning of cultural variables only does not quite give a contextual understanding without a consideration of the macro and micro environment that affect marketing strategies, choices and marketing tools and concepts keenly considered by commercial marketers.

Macro environmental factors include political-legal, demographic-economic, social-cultural and technological-physical environment (Humphrey, 1960). Political legal environment involves changes in legislation, government priorities and the influence of pressure groups that lobby government actions. Upstream approaches by social marketers may be used to increase the level of political will to make legislation and policy changes that may facilitate the changing of social norms and increasing salience and concern over social issues in the general population as suggested by Henry (2001).

Social marketing may be used to complement changes in legislation and also reinforce existing legislations that affect the issue in focus. Lefebvre (2007) highlights the need for agenda setting theory, which may be used for public policy in upstream social marketing to deal with the context of the behaviour in focus.

In the demographic-economic environment, commercial marketers analyse demographic trends including population growth and distribution, age, education, ethnicity, household (Kotler, 2001) among other variables, to inform key marketing tools such as segmentation, strategy and the marketing mix. This information may also be relevant to social marketers as well in making vital decisions on marketing

tools such as segmentation, strategy, the marketing mix and also to understand barriers, costs, benefits and competition perceived or encountered by various demographic segments of interest to the issue on focus.

The technological-physical environment trends are important to marketers such as: the rate of technological change, budgets for technological innovations and commercial opportunities (Kotler, 2001). Social marketers also need to analyse these technological trends and consider how technology may be used to enhance their health and social change agenda. Lefebvre (2007) challenges programmers to embrace modern technology and social network dynamics to innovatively expose audiences to products, opportunities and messages that lead to behavioural change.

Social-cultural environment relates to the beliefs, values and social norms that individuals hold. Persistence of core values over time, shift of norms over time and sub-cultures, role of social institutions is vital to marketers (Kotler, 2001).

Other contextual factors that may explain differences between the rich and poor health outcomes may be attributed to ten health determinants as suggested by Wilkinson and Marmot (1998) that include: social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. They suggest that individuals in lower rungs of the social ladder have generally twice the risk of serious illnesses and premature deaths than those near the top. This may be explained by poverty and stress that increases their vulnerability to lifestyle risk factors and hormonal and immune systems that contribute to morbidity and mortality.

Other contextual factors may relate to land use as relates to the built and physical environment that characterise where individuals live. Poverty again accounts for poor living conditions such as overcrowded housing, inadequate sanitation, inefficient rubbish disposal, lack of clean water supplies and insufficient protection against pollution and temperature extremes (Marmot, 2000).

Poverty again may also account for low social efficacy as individuals feel that they cannot control their environments, resulting in fatalistic and pessimistic view of the future. This leads to limited planning for the long term and less persistence in long-term healthy behavioural patterns (Henry, 2001). It may also account for disadvantaged early childhood experiences where children are not protected from risk

factors founded on weak families, school and friends' bonds, unhealthy beliefs, expectations of failure, lack of standards against criminal behaviour and early sexual activity (Lehman, et al., 1994) that may all perpetuate a vicious cycle of poverty.

Another important contextual variable is the social capital highlighted by Putnam (1995) as a feature of social organisation. It includes networks, norms and trust that facilitate coordination and cooperation for mutual benefit and is also believed to be an important determinant of health (Lomas, 1998). It may explain degree of interaction in formal, informal and of civic engagement, trust, mutual obligation and care in the community. Arguably, improvements in health may be achieved with increase in community involvement, supportive networks that may perhaps reduce isolation and foster social cohesion. A good example is the use of HIV support groups that provide forums to share ideas, experiences, boost morale and self-worth and promote a sense of well-being among its participants.

Donovan and Henley (2010) suggest that the success of social marketing interventions depend partly on the marketer's accurate analysis of the complex environment of the target audiences. Environmental analysis may reveal competitive forces, opportunities and threats that social marketers may act on to affect changes either upstream, in-stream or downstream. No study has explored and investigated the complex multi-cultural environment of Kenya and its impact on social marketing programme work, necessitating this study to fill this gap.

Operating environments of commercial marketers consisting of variable such as: suppliers, customers, competition, stakeholders and intermediaries. The micro/internal environment made up of programmers' key functional areas such as marketing, production, finance, research and Human Resources and how these three environments relate to each other to influence strategic choices, marketing tools and the marketing mix (Palmer and Hartley, 2002). The operating environment that reflects the realities in which social marketers operate in, focuses on aspects such as the physical environment, national and international trends, stakeholders, suppliers of similar and related products, competition, employees' skills and cultural competency and health care systems such as folk, popular and professional (Kleinman, 1980).

After considering all these suggested models of dealing with health, this study proposes the use of a composite model formulated in the literature review of culture in chapter three, based on a blending of cultural elements borrowed and adapted from Hall (1959); Humprey (1960); Kleinman (1980); Blum (1983); Evans and Stoddart (1994); Ganon (1994); Airhenbuwa (1995); Jain (2001); Katobe and Helsen (2011) in understanding cultural and contextual variables. This study suggests that the use of this composite model may perhaps give programmers an in-depth insight into the cultural and contextual realities of markets targeted for social marketing interventions, in order to inform and guide their decisions, strategies and actions. All the elements of the model are extensively discussed in chapter three, and the model is shown in figure 10. The next step is to use the variables in the model, in a culturally rich context as Kenya to check its robustness in scoping the cultural contextual realities of a market and its ability to inform the designing, implementing and controlling stages of social marketing interventions.

#### **4.6. Chapter Summary**

Wiebe (1952) challenged marketers to sell brotherhood in the same manner as they sell soap implying that commercial marketing was successful in influencing target audiences' attitudes and behaviours. The concept was later picked by Kotler and Zaltman (1971) who together coined the term social marketing. To date, many other contributors have embraced the concept, giving it their viewpoints resulting in misconceptions of what social marketing entails. Concepts such as social advertising, social communication, societal marketing, corporate social responsibility, non-profit marketing, as well as corporate social marketing have all been confused for social marketing.

Donovan (2010) argues that the litmus test for true social marketing interventions is the motive of the intervention. He argues that if an intervention is not motivated by the need to achieve social good, it is not social marketing. However, for a long time, programmers have focussed on targeting individuals without much regard to the context of behaviours and related cultural realities such as beliefs, attitudes, values, practices, taboos, and symbols among other cultural variables that impact on individuals' behaviour.

Social marketing practice differ between developed and under developing countries due to differences in contextual and cultural realities. Lefebvre (2011) argues that the social marketing approach should embrace an understanding of the determinants, context and consequences of current behaviours and desired ones from the point of view of the audiences, not from any one or set of theories and models. This points to the need to thoroughly understand contextual and cultural drivers of behaviour as culture involves virtually every part of an individual's life and touches all human needs both psychological and physical (Jain, 2001).

Airhihenbuwa (1995) however argues that public health, social and behavioural sciences mainly pay lip service to the importance of culture in studying and understanding target audiences' behaviour. They do not inscribe cultural understanding at the root of health promotion and disease prevention programmes, making many interventions futile. The cultural concept is, however, quite broad and little has been done in social marketing as a guide on how to engage with this broad concept. This study proposes a composite model formulated in chapter three after good literature review on culture that may guide social marketers in understanding and targeting cultural and contextual realities, for effective and value-added social marketing interventions. The composite model captures cultural variables as well as the operating and macro environment variables to understand target markets realities for effective social marketing interventions.

The next logical step is a discussion of the research design, methods and methodology that aid in a deep understanding of how social marketing programmers engage the cultural and contextual realities of their market in their programme work.

## **5. Chapter Five Research Methodology**

### **5.0. Chapter introduction**

This chapter discusses the basis for choosing qualitative research design for this study. It focuses on the chosen research methods as a qualitative questionnaire and qualitative interviews. It discusses the sampling basis as geographical, centred on purposive and judgmental methods and steered by theoretical concerns in order to understand cultural and contextual realities of ethnic groups of Kenya. Data analysis is discussed under thematic content analysis, which offers the flexibility needed by the researcher to understand cultural nuances from the point of view of programme managers. Lastly, it discusses report writing, which is guided by case and thematic analytical methods.

### **5.1 Research paradigms**

Researchers are always faced with the question of whether to go for qualitative or quantitative in their research endeavours. Ontological and epistemological issues underpin choices on the nature of research, strategy chosen, questions formulation, research design and methods, all necessary for epistemological integrity (Marshall and Rossman, 2006). Ontological issues, in research, relate to the nature and forms of social reality. Crotty (2003) suggests that ontology relates to the study of being, with emphasis on the theory of existence. Blaikie (1993, p.6) further implies that it is the claims or assumptions that a particular approach to social enquiry makes about the nature of social reality or how people exist in the world. It helps in understanding claims of knowledge that determine ontological positions taken by realists or relativists. Realists hold to the view that the real world is out there and exists, independent of the actors. It is made up of objects and structures with causes and effects that may be studied using appropriate methods of data collection and analysis.

Relativists, on the other hand, hold on to the view that the world is unstructured, diverse and claim that cultural and social frames determine our understandings and experiences, making interpretations of our social reality, critical and valid. Variations to the realist and relativist position exist. Willig (1999) advocates the need for relativism without considering the impact of social structures while naive realism offers a narrow understanding of existence as it may, for instance, consider behaviour



from only a biological or social point of view. Critical realism, on the other hand, is more accommodative and seeks to question broader issues in order to understand social reality. For instance, it may consider the need to understand behaviour from biological and structural perspectives.

Epistemology refers to the philosophical theory of knowledge that questions how we know what we know, as a means of understanding what may constitute true or false claims of knowledge. King and Horrock (2010) discuss three forms of epistemological positions researchers may assume: realist position that assumes a realist ontological stand seeking to produce objective reliable and representative data, with the researcher pursuing objectivity and detachment from the objects of study.

They also discuss the contextual epistemology, where context is integral to understanding individuals' experiences. Data is inclusive of context in visualising the cultural and historical meanings of systems and subjectivity of the researcher becomes a part of the research. Geertz (1973) cites the need for thick descriptions of social settings events and individuals in qualitative research for contextual understanding of social behaviour under contextual epistemology. Thirdly, they suggest constructionist perspective that uses language to construct social reality based on verbal exchange. The researcher becomes a co-producer of knowledge and is reflexive and aware of language use. Indeed, the four critical questions in research that touch ontological, epistemological, methodological and method issues go hand in hand and cannot be viewed in isolation (King and Horrocks, 2010). They operate as a foursome from which two distinct paradigms emerge, the qualitative and quantitative research approaches (Holliday, 2002).

Bryman (2008) suggests five paradigms: positivist, post positivists, interpretive, critical and postmodern approaches to research; although they can be understood from the two parent paradigms of quantitative and qualitative approaches. Seale (1999) indicates that in post positivism the researcher maintains some positivist elements like quantification and causal factors while also using interpretivist issues like subjectivity and meaning. It reflects the criticism directed at positivism, shares its similar beliefs, but it goes further to claim that we can only know social reality imperfectly and probabilistically. While objectivity remains an ideal in post positivism, qualitative technique is mainly employed to check the validity of findings.

Post positivism holds that only partially objective accounts of the world can be produced because all methods are flawed (Denzin and Lincoln, 1994). On the other hand, post-modernism contends that the era of big narratives and theories is over, therefore, local temporally and situational limited narratives are now required in reappraisal to modern cultural and identity issues (Flick, 1998, p.2).

Quantitative approach leans more towards the realist ontology of positivism and epistemologically on objectivism. Positivism entails five features as suggested by Bryman (2008). Firstly, phenomenalism where true knowledge is only confirmed by senses. Secondly, deductivism where the purposes of theory is primarily to generate hypotheses, that should be tested to explain relationships or laws. Thirdly, inductivism where gathering of facts related to laws is necessary to arrive at knowledge. Fourthly, objectivism where research should be conducted in a value free way and fifthly, only scientific statements confirmed by senses are true domains of science as opposed to normative statements that cannot be confirmed by senses.

Quantitative research requires the researcher to be objective and detached from objects of research and may use experiments, quantitative questionnaires among others, as instruments to study reality. It generally aims to offer explanations leading to control and predictability. According to Denzin and Lincoln, (1994) quantitative methods ontologically stem from naive realism that holds social reality as real and knowable, and epistemologically based on objectivity assumed to lead to true results. It mainly uses quantitative techniques in experimental science to explain phenomena and mainly favours making generalisations.

In quantitative research, measurement is extremely important as it helps in defining differences between or in the phenomena being studied, by providing devices for understanding variations and also helps in identifying the degree of relationships between concepts being studied. Measurement entails two main themes in research, the need for validity (do indicators of concepts really measure that concept it claims to measure) and reliability (consistency of a measure of a concept) for any research to be credible. Causality, in quantitative research, is mainly concerned with explaining causes of variations in variables mainly between independent and dependent variables. Generalisation is mainly concerned with applying findings of a research beyond the context of the research. This entails getting a representative sample from a

population based on probability sampling where random selection of study subjects may help to reduce biases. Replication entails explaining explicitly procedures of carrying out research for other researchers to be able to reproduce similar researches.

Quantitative research offers advantages such as, the results may be statistically reliable and may be generalised to a population, depending on how well the research is designed and executed. On the other hand, quantitative research has been criticised for its failure to differentiate between people and other realities of the natural world. This is mainly because human beings are the masters of the planet, due to their reasoning capabilities and they should not be regarded and studied in the same way as objects of natural sciences like molecules. Again the design relies heavily on the research instruments because of the need to be objective and reduce reactance, a point that is not practical when dealing with human beings due to their subjective nature, hence the need for flexibility to understand how they construct their world.

Ontologically qualitative approach leans more on critical realism and relativism. Epistemologically, it rests more on interpretivism that broadly deals with describing aspects of the social world by offering a detailed account of the social settings, processes or relationships. It is about understanding the different interpretations and meanings of human experiences in what Max Weber 1864-1920, in Bryman (2008) referred to as (*verstehen*), founded on the claims that human beings and objects are different as their behaviour is influenced by values, plans and purposes held rather than the need to explain (*erklaren*) taken by naturalist.

Oakley (1999, p.156) describes the qualitative paradigm as being concerned with understanding behaviour from actors' frame of reference. It is subjective, the researcher is close to the data and uses grounded, discovery oriented, exploratory, expansionist, descriptive and inductive techniques. It is process oriented, produces real and rich deep data, though ungeneralisable but holistic and assumes a dynamic reality.

Denzin and Lincoln (1994) argue that qualitative research, ontologically, is grounded on constructivism, as the knowable world is that of meaning attributed by individuals and relativism as multiple realities exist that vary among individual groups and cultures. Epistemologically, it is based on non-objectivity or subjectivity in search of meaning with the end goal being, to comprehend the knowledge that emerges from the reality being studied via interactions between the observer and the observed.

Approaches within qualitative research are categorised by Gubrium and Holstein (1997) under four idioms. Firstly, naturalist that gives priority to understanding sub-cultures preferring to deal with actors, meanings and usually collect data via observations and interviews. Secondly, emotionalists that favour understanding experience because of the subjectivity and emotions that can be best tapped using open-ended interviews as data collection instruments. Thirdly, Ethnomethodologist that prefer understanding interactions, how members assemble phenomena and mainly use audio/video recording for data collection. Lastly, postmodern theorists that prioritise sign systems and prefer to deal with concepts of representation and reflexivity and collects data using any viable instruments. The approach chosen, really depends on the social reality being studied.

The various traditions of qualitative research include: cultural ethnography (Agar, 1985; Quinn, 2005), institutional ethnography (Campbell and Gregor, 2004), comparative historical analyses (Skocpol, 2003), case studies (Yin, 1994), focus groups (Krueger and Casey, 2000), in-depth interviews (Glaser and Strauss, 1967; McCracken, 1988; Patton, 2002; Quinn, 2005), participant and nonparticipant observations (Spradley, 1980) and hybrid approaches that blend these approaches.

Qualitative research offers key advantages to researcher in that the researcher can interact with the sample being studied to gain a deeper understanding of the issues being studied; unlike in quantitative design where objectivity is paramount. It offers flexible designs that can help the researcher adapt to questions in response to short term developments in the research process to probe areas of interest arising, unlike quantitative design that is highly structured. Critics argue that qualitative research is too subjective and mainly based on the subjective views of the researcher as to what may be considered interesting or important, unlike the quantitative research that is designed in a more objective way. They also argue that qualitative designs are

difficult to replicate, unlike, the quantitative design and claim that qualitative studies are difficult to generalise to other settings. It is, indeed, difficult to replicate real life scenarios because individuals construct the meaning of their world depending on their contexts, however moderatum generalisations in qualitative research are indeed possible (Williams, 2000), by drawing comparisons and linkages with findings from other researchers relating to comparable groups.

Research methods and methodology terms are used interchangeably but refer to different scholarly concepts. Mason (1996) argues that methodology is a general approach to study research topics, an overall research strategy that shapes the methods that are used and how each method is expended. Gray (2003) posits that methods refer to tools of data collection used by researchers to interrogate sources and construct data such as interviews and questionnaires, while methodology describes the philosophical meaning, the approach or paradigm that underpins research. Methods used may be similar like questionnaire, however the methodology used, differentiate their purposes and uses, eventually producing different data.

Methods also differ based on the ontological and epistemological perspectives adopted by the researcher and are guided by the research needs and questions. Knowing what you want to find out, leads inevitably to the question of how you will get that information (Miles and Huberman, 1984, p. 42). Silverman (2005) in the table 4.1 below compares the use of various research methods based on the two distinctive research methodologies; emphasising that the methods chosen under each research design approach may be similar but the underlying philosophies differ.

<b>Method</b>	<b>Methodology</b>	
	Quantitative research	Qualitative research
Observation	Preliminary work e.g. prior to framing questionnaires	Fundamental to understanding another culture
Textual analysis	Content analysis - counting in terms of researcher's category	Understanding participants categories

Interviews	Survey research - mainly fixed choice questions, administered to random samples	Open ended questions, administered to small samples
Transcripts	Used infrequently to check the accuracy of interview records	Used to understand how participants organise their talk and body movements.

**Table 13- relationship between methods and methodologies adapted from Silverman (2005).**

Interestingly, all researches will have both quantitative and qualitative elements with the differences only being in the balance between the methods chosen (Bryman, 2008). Indeed, the two research methodologies complement and depend on each other, in that quantitative analysis is often depended on qualitative analysis. Qualitative analysis provides the basic reasoning upon which successive stages of quantitative analysis are based. Some researchers use mixed research design where they borrow elements of both the qualitative and quantitative designs to enhance their studies and offset the weaknesses inherent in each of the designs.

The debated distinctions in research paradigms are somewhat diminishing as researcher focus more on the supreme purpose of research to enhance knowledge through logical means. Many of them are increasingly using both qualitative and quantitative approaches in a triangulated manner to know more about the world.

## **5.2 Why qualitative research approach for this study?**

Qualitative research is the chosen approach for this study. This is because qualitative research is well suited for understanding phenomena within their context, helps uncover links among concepts and behaviours, and aids in generating and refining theory (Glaser and Strauss, 1967; Miles and Huberman, 1994; Crabtree and Miller, 1999; Patton, 2002; Campbell and Gregor, 2004; Quinn, 2005). This study focuses on exploring and understanding the cultural and contextual realities of programmers using social marketing approaches in their HIV/AIDS related interventions in Kenya. It naturally renders itself to the qualitative approach because it aims at understand deeply the subjective themes of culture, context and sensitive issue of HIV/AIDS and how these issues are engaged with, to inform and manage social marketing initiatives.

The study, thus, takes a contextual epistemological position founded on the belief that all knowledge is local, provisional and situation dependent (Madill, et al., 2000). It also takes cognisance of the fact that everyday life is influenced by a myriad of factors, relations and activities where facts or views cannot be proportionate with, or reducible to a de-contextualised view of human nature (Jaeger and Roosnow, 1988).

A contextual consideration suggests a critical realist position that seeks to explore and understand cultural mapping and how culture is engaged by the programmers using social marketing approach in their related HIV/AIDS programmes. The interpretivist philosophy is useful in understanding different cultural meanings and how the meanings differ among different groups (Schutz and Natanson, 1982).

Kenya has many tribal groups each taking pride in their own language and cultural heritage. These different and distinct tribal groups evoke ethnocentrism, stereotyping and biases. This means that cultural meaning has to be understood from the players or group's point of view and how they construct it subjectively. This is in line with what Guba and Lincoln (1994) submit of qualitative research, being ontologically grounded on constructivism, as the knowable world's meaning, is based on the meaning attributed by individuals. However, meanings are relative as multiple realities exist that vary among individual groups and cultures.

Qualitative approach rather than quantitative is better suited to explore and understand meanings and motivations of beliefs, attitudes, values and behaviours, fuelled by cultural nuances and linked to the sensitive topic of HIV/AIDS from the point of view of the people studied (Hammersley, 1992). Interpretivist epistemology and constructionist ontology are key philosophies of qualitative rather than quantitative research (Byrman, 2004). It further offers key advantages to the study in that the researcher can interact with the sample being studied to gain a deeper understanding of the issues under investigations (culture and HIV/AIDs), unlike in quantitative design where objectivity is paramount. Its flexible designs can help the researcher adapt questions in response to short-term developments in the research process to probe areas of interest arising, unlike quantitative design that is highly structured.

Qualitative paradigm is well suited for locating meanings people place on events, objects, processes, situations and structures of their lives, their perceptions, assumptions, prejudgements and presuppositions (Van Manen, 1990; Berg, 2001) in order to understand the context and cultural nuances and how they influence interventions using social marketing logic in the area of HIV/AIDS within the Kenyan context, in the best way.

Qualitative research has been criticised on reliability and validity issues. The researcher needs to document the research procedure to enhance reliability (Kirk and Miller, 1986). On validity there is need to offer sound explanations and consider contradicting data rather than only using anecdotalism (Silverman, 2005). Another issue is that qualitative studies are difficult to generalise to other settings, as it is difficult to replicate real life issues. Williams (2000) contends that *moderatum* generalisations are indeed possible by drawing comparisons and linkages with findings from other researchers relating to comparable groups.

Interesting, although qualitative and quantitative approaches have been viewed historically as mutually exclusive, firm distinctions are increasingly recognised as inappropriate and counterproductive (Ragin, 1999; Sofaer, 1999; Creswell, 2003; Skocpol, 2003). Mixed approaches are being used simultaneously or sequentially as deemed appropriate by the researcher (Creswell, 2003). The use of qualitative research does not imply a commitment to innumeracy (Kirk and Miller, 1986, p.10).

In support of mixed approaches, Kaplan (1998) argues that numbers and words are both needed to understand the world and, Gherardi and Turner (1987) suggest that the issue, is one of knowing when it is useful to count and when it is difficult to count at all. Rossman and Wilson, (1994) indicate the need to use both research families to enable confirmation or corroboration in research via triangulation. This can help in the better analysis of data, providing richer details and new lines of thinking through paradoxes that may help turn ideas around and provide fresh insights to a researcher. This study endeavours to use triangulating by using different data collecting instruments such as qualitative questionnaires and interviews. It also triangulates in the sampling by combining stratified and purposeful sampling as well as in the analysis by combining across case and within case analysis.



### **5.3. Research methods**

Methods refer to those different techniques of research, which any researcher employs to construct data and interrogate its sources and researchers based on their choice and use of methods on the underpinning approach or paradigm (Gray, 2003; Mason, 1996). Contention arises in the existence and use of qualitative and quantitative surveys. Jensen (2010) asserts that the concept of qualitative surveys is real; although, mainly unreported and confused for grounded theory. He opposes the view that surveys only cover quantitative studies that aim at describing numerical distributions of variables in the population and submits that there is a qualitative way of defining and investigating variations in population that does not aim at establishing frequencies' means or other quantitative parameters. It aims at determining the diversity of some topic of interest within a given population. It focuses on meaningful variations based on relevant dimensions and values within a population.

Qualitative and quantitative surveys are similar and only differ firstly in the objectives of the sampling criteria, in that qualitative survey aims for diversity samples to achieve data saturation, while quantitative surveys focus on probability to ensure precision of estimation for the sake of generalisation. Secondly, they differ in the analysis in that qualitative surveys aim for diversity analysis while quantitative surveys aim for distribution analysis. This study uses qualitative survey as described by Jensen to achieve diversity samples and for diversity analysis.

This study uses qualitative paradigm due to the need to deeply understand the central themes of context and culture and the need to understand how programmers using social marketing in HIV/AIDS related programmes engage with these variables in a multicultural context as Kenya. Qualitative survey/inquiries via the use open-ended questions grounded on the variables in the cultural context assessment composite model are used in this study. The study probes subjective, sensitive and emotional aspects of culture and HIV/AIDS, and open-ended questions are well-suited to capture programmers' points of views to provide rich explanations of how they engage cultural and contextual realities of their target audiences, in line with the qualitative research need for thick descriptions (Geertz, 1973).

The qualitative open-ended question guides are administered via the use of well-briefed research assistants. Others are sent via emails after the consent of identified technologically savvy programmers that consent to participate in the research. Interviews are also used via the use of technology such as phone, Skype and other forms of online meetings and chatting as Facebook and Yahoo Messenger. The use of technology offers flexibility and saves on travel costs and time due to the wide geographical dispersion of the various tribal groups in Kenya and the poor road networks. Mathews and Cramer (2008) suggest that the use of technology has potential in research as both the software and hardware decrease in cost. However, (Hewson, 2007) argues that it may restrict the sample to participants who only have the technology. With emails, there is the disadvantage of low response rate; although, follow-ups and reminders via telephones or emails are used to help improve the response rates.

The study is cognisant of the criticism, levelled at qualitative approaches and methods as being a form of social control and bias. However, the same may be said of quantitative questionnaires as they also shape the responses given by respondents and arguably, have their degree of biasness (Silverman, 2005). Other issues that can distort interviewees' responses range from problems of self-presentation, misrepresentation of facts, context of interviews, status of the interviewee and interviewer and the difficulty of penetrating private world experiences of interviewees (Denzin, 2006).

This study seeks to understand the experiences of programme officers or managers who arguably have the experiences of dealing with cultural challenges in their work. Programmers are arguably best placed to offer valid explanations of their cultural experiences, thus, minimising misrepresentation of issues. Programme officers and managers are chosen as respondents in this study as they are expected to have some reasonable levels of programme experience and understanding, and are well placed to share their programme experiences. Any ambiguous issues raised in the qualitative open-ended guides are followed by qualitative interviews for clarity. There is also the risk of respondents not being able to understand the questions in any survey.

In this study, the questions are simple, straightforward and the open-ended questionnaires are pilot tested with research assistants to correct any ambiguities before being passed on to the participants. Further, the research assistants are trained via extensive discussions with the researcher on the questions in the qualitative guide before they administer them to programmers, especially those without access to technology.

Patton (2002) suggests the need for triangulation in research. In methods of triangulation, apart from the use of qualitative interviews and open ended questions, this study uses various forms of secondary sources and documents ranging from: library, policy, historical, statistical, media, international organisations' related documents (Corbetta, 2003), to enrich and inform all the chapters in order to understand the complex concepts of culture, Kenyan tribal groups, the sensitive theme of HIV, and interesting theory and practice of social marketing.

#### **5.4. The qualitative open ended guide and qualitative interviews**

The research instruments are grounded on the conceptual framework on cultural context assessment composite model formulated in chapter 3. The composite framework borrows and blends various theories of culture (Hall, 1959; Humprey, 1960; Kleinman, 1980; Blum, 1983; Evans and Stoddart, 1994; Airhihenbuwa, 1998; Katobe and Helsen, 2011).

The instruments seek to glean how programmers using social marketing approaches in their HIV/AIDS related programmes engage the various cultural variables and contextual realities in their programme work. Sampling is made via purposeful sampling to ensure diversity and variety in ethnic tribes' representation in the study, as they are located at different geographical locations within Kenya. The questions glean various cultural variables at the micro, operating and macro levels to understand the challenges faced by the programmers; how they deal with them and from their experiences, suggestions on the most appropriate ways for dealing with these cultural challenges using upward, in-stream or downstream social marketing approaches.

The open-ended questions are written in simple English language for programme officers to understand and are pilot tested and corrected before being administered to respondents. The questions are a blend of the six types of questions (Patton, 2002) suggests: background/demographics, experience/behaviour, opinion/values, feelings, knowledge and sensory questions. A copy of the questionnaire is attached as part of the appendix. The qualitative interviews are primarily based on the preliminary analysis of the duly completed and received qualitative inquiries from participating programmers, as it seeks clarifications on ambiguous responses. Qualitative interviews are preferred as they yield direct quotations from people about their experiences, opinions, feelings and knowledge (Paton, 2002)

Surveys generally attract low responses. To motivate response rates, the researcher first emails purposefully the selected participants to establish a rapport, explains research aims and objectives, and seeks the consent of respondents. Emails and calls are used to ascertain the preferred method of receiving the qualitative enquiries schedules. After about two months, follow up emails and calls are made to further remind respondents of the need to submit the completed qualitative surveys and find out if there are any challenges, clarifications or assistance needed by respondents in answering the questions. An interesting insight from Lunt and Livingstone (1992) that gave a twenty-page questionnaire to 241 respondents and gave a nominal amount of £2, consequently got a 91% response rate is considered. Consequently, the researcher offers a sum of £3 as a thank you token for each set of completed qualitative schedules to the respondents.

The rationale behind this small incentive is to thank programmers for their time and effort in responding to two detailed qualitative open-ended schedules. The researcher is cognisant of the ethical questions, this small token may raise, however it can be logically argued that it is contextually befitting within the Kenyan tradition of thanking individuals instrumentally, not just verbally for their kind gestures or acts. Indeed, most Kenyans do not appreciate an empty thank you but appreciate it more when accompanied by some functionally practical tokens or gifts that can be used to meet their day-to-day needs; however, small. Cash has and will always be a practical incentive, however little, unlike culturally irrelevant gifts such as flowers or a verbal thank you. Indeed, £3 is a nominal amount that can only buy a plate of chips/fries and a drink in Kenya, just to emphasise the insignificance of the amount offered.

### **5.5. Ethical issues**

Ethical issues arise from many area and stages of the research process. Marshall and Rossman (2006) referred to epistemological integrity as concerning the integrity in areas such as the nature of the research, overall strategy, design and methods and research questions. The basis and rationale for choosing the qualitative research approach, qualitative questionnaires and interviews, have all been well explained in this chapter. Some of the other ethical issues in this study include getting the informed consent of the participants, debriefing of respondents, right to withdraw from study by participants and maintaining confidentiality of respondents (Willig, 2001).

In this study, research procedures, aims and issues of confidentiality are all well explained to the participants by the researcher before data collection and a promise of debriefing is given that any publications arising from the study should be shared with them. The respondents are further expected to read the information from participation sheet and sign consent forms as evidence of their consented participation. Since the researcher is dealing with human subjects, the university gives ethical clearance before the data is collected as a part of University of East London's (UEL) ethical clearance procedure.

Another ethical issue is the payment of £3 thank you token to the respondents. Ethically, it may be deemed unethical, however put in context, most Kenyan expect a thank you gesture for their time and participation, especially, in responding to two long qualitative schedules.

### **5.6. Sampling and data collection process**

In quantitative studies, samples are chosen that are statistically representative of the population being studied due to the need for drawing generalised conclusions. This is not the case in qualitative studies, as the study approach does not claim to seek for generalisation. Qualitative sampling techniques do not aim at statistical representativeness. It seeks to relate samples to the social world and phenomena for diversity and variety of positions or dimensions in relation to the research topic (King and Horrocks, 2010).

Jensen (2010) suggests that in qualitative surveys, samples are selected based on diversity and research purposes, with the aim of data saturation to cover population diversity as opposed to quantitative surveys that focus on probability chancing sampling for the sake of precision of estimates.

There is, therefore, the need to choose sample that controls various dimensions of research deemed important to the theoretical aspects of this study. Sampling aims to include most tribal groups in Kenya to understand how similar cultural and context variables are experienced by different tribal groups under purposive targeted sampling method. Sampling is generally divided into probability and non-probability sampling. Probability sampling includes: simple random, systematic, stratified, cluster and stage sampling, while non-probability sampling includes: convenient, voluntary, quota, purposive, dimensional and snowball sampling and others like event and time sampling (Blaxter, Hughes and Tight, 2001). Qualitative inquiry typically focuses on relatively small samples, even a single case, selected purposefully to permit inquiry into and understanding of a phenomenon in an in-depth manner. This leads to selection of information rich cases that one can learn a great deal from, in relation to the issues of central importance to the purpose of the research (Patton, 2002).

The composite cultural contextual model is used to formulate the open-ended questions used to collect qualitative data. The focus, therefore, is on the eight former administrative provinces of Kenya that include The Eastern, North Eastern, Coastal, Central, Rift Valley (North Rift Valley and South Rift Valley), Nyanza, Western, and the Nairobi provinces. The new Kenyan constitution of 2010 created forty-seven (47) counties from the eight Kenyan former providences. However, in relation to the cultural and contextual reality, the eight provinces are arguably a better focus, as they represent a wider view of the geographical mapping rather than the counties that subdivide tribal groups.

A Combination of non-probability sampling techniques has been used to choose programmes to study in each province. Purposive sampling is used to seek out groups, settings and individuals where the process being studied is most likely to occur (Denzin and Lincoln, 2005) based on the different tribal/ethnic groups. Qualitative samples tend to be purposive rather than random (Morse, 1991; Kuzel, 1992) mainly because social processes have logic and coherence that random sampling can reduce

to uninterruptable sawdust. The programmes considered for this study are those that mainly focus on HIV/AIDs related issues targeting different demographic groups such as children of ages 0-12 years, the teenagers (from 13 to 19), young adult men and women of working age (20 to 60 year), grandparents - generally those with grandchildren, in line with demographic segmentation in marketing. Special and groups of interest such as the gay, lesbians, commercial sex workers, orphans, widows, people living with HIV/AIDS (PLWAS) are considered to enrich the study and provide the variations and diversity to the various context and cultural dimensions' realities. Programmes are chosen from each of the eight provinces of Kenya representing the criteria of: children, youth, men, women and the elderly or grandparents and other special groups.

Six programmes are chosen based on the various non-probability sampling styles including: convenient, voluntary, snow balling, typical cases that typify specific tribal cultures in different regions, confirming and disconfirming cases sampling used to ensure that various tribal cultures are well represented, as well as extreme or deviant case sampling strategies, to ensure that programmes that have highly unusual manifestations of tribal cultural influences (Kuzel, 1992) are also represented. Lincoln and Guba (1990) advocates for maximum variation sampling as a deliberate hunt for negative instances or variations as a way of increasing confidence in analytic findings on the grounds of representativeness. Peripheral sampling is also used to learn and obtain contrasting and comparative information that may help understand the different Kenyan tribal cultures. Lists of Non-Governmental organisations and community based organisations that deal with HIV/AIDs are scrutinised from National HIV/AIDS Coordinating Council (NACC) - the government national organ that coordinates all HIV/AIDS activities in Kenya and KANCO-Kenya Aids NGOs Consortium, and program/programmers contacts are noted and taken for the purpose of making an initial contact with the programmers to interest them in the study and seek their participation commitment and consent.

Qualitative survey questionnaires and interviews are used to collect data. The respondents that prefer to type the qualitative schedules are advised to email them back to the researcher as attachments. Those that cannot type are requested to hand fill them and contact the research assistants or the researcher to organise for collection. The research assistants print, photocopy the questionnaires and organise to

meet programme officers that need assistance in filling the qualitative schedules. The research assistants collect the hand filled questionnaires and hand them over to the lead research assistant for typing, before the typed copies are sent to the researcher as attachments via email and afterwards the hard copies are sent to the main researcher via mail.

After receiving the duly completed qualitative questionnaires, the researcher looks through each one of them for completeness and undertakes the initial analysis. This helps in compiling qualitative interview questions to clarify ambiguous issues. The researcher arranges a qualitative interview with respective programmer either via phone or online meeting to probe issues of interests, further. Qualitative conversations are mainly used for follow up interviews using online chat via Skype, Yahoo chat or telephone conversations while the researcher takes notes for further analysis.

### **5.7. Data analysis**

Qualitative data analysis aims to provide a rich and deep analysis. Analysis is however an on-going, iterative process that begins in the early stages of data collection and continues throughout the study (Corbetta, 2003). It begins with transcription where recorded material is converted into text as a first step in analysis as it helps the researcher in getting well-acquainted with their data (Langridge, 2004). Miles and Huberman (1994) suggest that a researcher steadily moves among four codes in data analyses: data collection, reduction, and display and conclusion drawing/verification in a continuous iterative cyclical way.

Firstly, data is collected using chosen instruments. Secondly data reduction/data condensation follows that entails selecting, focusing, simplifying, abstracting and transforming data existing into notes or transcriptions. It plays a critical role because it is the part of analysis that sharpens sorts, focuses, discards and organises data in such a way that conclusions can be drawn and verified. Thirdly, data display consists of organising, compressing and assembling of information to aid in conclusion drawing. It may use matrices, graphs, charts and networks to assemble organised information into immediately accessible compact form so that the analyst can see what's happening and either draw-justified conclusions or move to the next step of analysis. Fourthly, conclusions drawing/verification is the last part of analysis that



involves noting regularities in patterns, explanations, possible configurations, causal flows and propositions, and require an open and sceptical mind. Conclusions are verified as the analyst proceeds by use of thoughts, elaborate argumentation and reviews.

Qualitative data analysis may use various techniques and methods that may involve affixing codes, noting reflections on margins, sorting and sifting through material to identify similarities and differences in relationships between variables, patterns, themes, subgroups, processes, elaborating generalisations and confronting generalisations with formalised knowledge (Miles and Huberman, 2002). A popular qualitative analysis method is the thematic analysis/content analyses that involve identifying themes within the data. It is a flexible method that gives the researcher a chance to decide what to include, discard and how to interpret data. Content analysis is used to refer to any qualitative data reduction and sense making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings (Paton, 2002, p.453). The core meanings found through content analysis are the patterns or themes that refer to recurrent and distinctive features of participants' accounts, characterising their perceptions or experiences that the researcher sees as relevant to their research questions (King and Horrocks, 2010).

Thematic analysis is a flexible approach that can be used for quantitative or qualitative data and may be used in a deductive or inductive way, depending on the purpose of the study. Its flexibility is supported by the fact that it is applicable to many unstructured information such as transcripts of semi and unstructured interviews and other qualitative forms of studies (Bryman, et al., 1996). Cole (1988) asserts that it is a method of analysing written, verbal or visual communication messages. It finds its roots in quantitative studies reflected in Berelson (1952) reference to content analysis as the research technique for the objective, systematic and quantitative description of the manifest content of communication.

Thematic analysis was first used in the 19<sup>th</sup> century as a method for analysing hymns, newspapers, magazines, articles, advertisements and political speeches (Harwood and Gary, 2003). It was later used in mass communication and media studies and Hosti (1968) expanded its application beyond mass media to include qualitative studies.

Currently, it is used in various disciplines such as communication, journalism, sociology, psychology and business and its use has grown steadily (Neundorf, 2002). It is appealing as an analytical method because valid inferences from data can be made to provide knowledge, new insights and a representation of facts as well as providing a practical guide to action (Krippendorff, 1980). The key objective of content analysis is to attain a broad description of the phenomena and the outcomes of the analysis are concepts or categories that may be used to build a model, conceptual system, conceptual map or categories (Elos and Kyngas, 2008).

The main challenge in thematic analysis, however, lies in striking a balance between within case and cross case analysis. When within case themes are neglected, themes become abstract notions detached from particularities of personal experiences. In situations where cross case analysis themes are neglected, a disjointed collection of cases results that ineffectively answer the research questions. Themes therefore ought to be organised and may be presented as simple lists with a numbering system in a table or column form when dealing with many themes, or via tree diagrams with subthemes branching off each main theme (Braun and Clarke, 2006), plausible when dealing with few themes. Key to thematic analysis is the ability to demonstrate how themes are developed and how a researcher arrives at the final thematic structure. This relates to the concept of auditability of analysis, generally considered as important quality criteria in qualitative studies (Kings and Horrocks, 2010).

Qualitative content analysis is the chosen method for data analysis in this study. The chosen research instruments - qualitative open-ended question schedules and qualitative interviews provide written data for analysis. Qualitative content analysis suits this study because generally it refers to any technique for making inferences by objectively and systematically identifying specified characteristics of messages (Holsti, 1968). The qualitative questionnaires used in this study certainly yield huge qualitative data that needs to be inferred using themes. The cultural context assessment composite model formulated in chapter 3, provides the elements of context and cultural assessment that provide themes that may be gleaned for further meaning. Content analysis is chosen for this study because it further offers major benefits such as it is a content sensitive method (Krippendorff, 1980) and is

concerned with meanings, intentions, consequences and context (Downe-Wmboldt, 1992). These advantages make it well-suited to analyse sensitive information relating to HIV/AIDS, context and culture.

The challenge of using content analysis, however, is that there are no simple guidelines for data analysis as each inquiry is distinctive. The results of the analysis really depend on the skills, insights, analytic abilities and style of the investigator. Content analysis is indeed a challenging and labourious process that involves interpretations, attaching significance to findings, offering explanations, drawing conclusions, extrapolation, imposing order, dealing with rival interpretations and confirming cases and data irregularities (Hoskins and Mariano, 2004). It is, however, arguably flexible enough to suit the analytical abilities and needs of a qualitative researcher (Patton, 2002). Jensen (2010) suggests that the rationale for data analysis in qualitative surveys is diversity analysis, which involves at the first uni-dimensional level of analysis, coding data in objects, dimensions and categories as opposed to distribution analysis used in quantitative surveys. At the second or multidimensional level, qualitative surveys focuses at case level, combinatory analysis, synthesis of diversity while at concept level uses holistic synthesis by case or concepts as opposed to unit-oriented cluster analysis or variable-oriented factor analysis in quantitative surveys. The third level of analysis, qualitative surveys use deterministic explanation, pattern analysis, qualitative content analysis (QCA) and combinatory analysis while quantitative surveys use probabilistic explanations using discriminate analysis, regression among other tools of analysis. This qualitative survey uses coding, combinatory analysis, synthesis of diversity, holistic synthesis and pattern analysis.

## **5. 8. The analysis process**

Content analysis may be used inductively or deductively. Deductive approach may be used in areas where little is known about the phenomenon or where knowledge is fragmented (Elo and Kyngas, 2008). Inductive content analysis categories are derived from the data moving from the specific to the general, while deductive content analysis involves moving from general to specific and a structure of analysis is done based on previous knowledge. This method is mainly used in theory testing (Kyngas and Vanhannen, 1999).

Inductive analysis involves interacting with data to discover patterns, themes and categories, in contrast to deductive analyses where the data are analysed according to an existing framework (Paton, 2002).

Qualitative analysis is arguably a blend of both inductive and deductive approaches. Inductive in the early stages when developing a codebook for content analysis or when identifying themes, patterns and categories in open coding (Strass and Corbin, 1988, p.223), grounded in the data (Glaser and Straus, 1967), while at the confirmatory stage of analysis may be deductive, like when deriving hypothesis from data and interpreting it. Taylor and Bogdan (1984, p.127) suggest that analytical induction begins with an analyst's propositions or theory driven hypotheses. It is a procedure for verifying theories and propositions based on qualitative data and a good example of moving from deductive to inductive analysis, like when using a theoretical framework and later looking for patterns and insights.

Inductive and deductive content analyses involve three main phases: preparation, organising and reporting. The first step in the analysis is the immersion in the data to comprehend its meaning in its entirety (Crabtree and Miller, 1999; Pope, Ziebland and May, 2000). The researcher is supposed to make sense of the data by reading it several times for familiarity before insights or theories spring forth from the data (Polit and Beck, 2004). Reviewing data without coding helps identify emergent themes without losing the connections between the concepts and their context. After familiarity with the data, the researcher needs to choose the units to be analysed, which may be words or themes.

Decisions of what to analyse, in what detail and sampling issues, are vital before selecting units of analysis as asserted by Cavanagh (1997). Ideally, the unit of analysis may depend on the research question and take the form of a word, sentence, and portion of pages or words, number of participants in discussion or time used for discussion (Robson, 1993; Polit and Beck, 2004). Researcher should, however, ensure that suitable units of analysis chosen are large enough to be considered as a whole and small enough to be kept in mind as a context for meaning unit during the analysis process (Granehiem and Lundman, 2004).

The next logical step after familiarity with the data is coding. Codes are category labels, not a filing system and may be categorised as descriptive codes that entail little interpretation and interpretative codes that entail more inferential and explanatory analysis (Miles and Huberman, 1994). Indeed, coding is a critical aspect of content analysis and entails the use of a coding schedule and coding manuals. Coding schedules are based on the variables chosen by the researcher to investigate a phenomenon, while the coding manuals are the instructions that guide the coding process to ease replication of studies by explaining, explicitly, how the coding process is done as a part of disclosure (Gubrium and Holstein, 1997) and helps increase the reliability of the study.

Deductive content analysis is exemplified by the template analysis (Crabtree and Miller, 1992) that uses a template like coding structure applied to data and revised as necessary until it captures the analysts' understanding as much as possible. An initial template is constructed on the basis of a sub sample of data set and then applied to subsequent transcripts and revising of codes is done as deemed necessary by the researcher. It uses priori themes that may lead to a rigid approach to analysis; hence researchers are advised not to identify too many priori themes. It is advantageous in that it can be used with any size of study, works well where there are distinct groups within the data set that a researcher wishes to compare and allows the flexibility of identifying some themes in advance. It is also well suited for studies with theoretical or applied concerns that may need to be incorporated in the analysis.

The next logical step after saturating the descriptive codes is an interpretation of their meaning. After coding, grouping is done to reduce the number of categories by grouping similar categories and separating them from dissimilar ones. This is done by comparing, contrasting and interpreting codes to increase the understanding of the phenomena and generate knowledge (Burnard, 1991; Dey, 1993; Cavanagh, 1997). Grouping descriptive codes that share meaning and labelling them, creates interpretative codes. This, indeed, entails organising codes, creating categories, abstracting meaning from them and giving them appropriate labels. Abstraction is about forming general descriptions of the research topic through generating categories (Polik and Beck, 2004). Characteristic words are used to name categories, similar sub-categories are grouped together and the abstraction process goes on as far as it is

reasonable and possible. After the interpretive codes, the researcher identified overarching themes that characterise key concepts from descriptive and interpretive codes but abstracted at a higher level.

A matrix approach to data analysis uses visual displays of data, where units of analysis are tabulated against key concepts or issues relevant to the research question (Miles and Huberman, 1984). These visual displays help in the analysis of data via comparisons and make the process transparent. It uses different matrices such as within cases and across cases matrices for analysis purposes. Triangulation in analysis may involve a combination of both matrix and template approach, where matrix analysis is done first for a broad picture of key issues and later a detailed analysis using the template approach is used (King, et al., 2007).

This study takes a deductive content analysis approach as the cultural context assessment composite model formulated in chapter 3 uses many context and cultural elements that may be perceived as a priori template content for analysis. Each of the cultural elements is considered as a theme for analysis and is used for within case and across case analysis. It also uses an inductive content approach as data is gleaned for patterns, themes and categories that may not necessarily be part of the priori category.

Computers and software are tools that assist analysis however software do not really analyse qualitative data. They only facilitate data storage coding retrieval comparing and linking but human beings do the analysis (Patton, 2002). This is because qualitative analysis involves creativity, intellectual discipline, analytical rigor and hard work that may only be provided by humans. Technology, may, however facilitate by use of computer software in locating coded themes, grouping data into categories and comparing passages in transcripts. Tesch (1990) advises that computer aided analysis should be considered by researcher as it can reduce analysis time, cut drudgery, make procedure more systematic and explicit, ensure completeness and refinement and permit flexibility and revision in analysis procedures.

Durkin (1997) further indicates that qualitative data programmes improve our work by removing drudgery in managing qualitative data in areas such as copying, highlighting, cross referencing, cutting and pasting transcripts and field notes, covering flows with index cards, sorting and resorting card piles, finding misplaced cards among other tedious tasks.

Computing can move studies beyond handicraft production that has characterised much qualitative research (Ragin and Becker, 1989). Fielding (2000) distinguishes three types of software that qualitative researcher may opt to use. He cites the use of text retrievers that assist with text use, codes and retrieve packages and theory builders that may assist in some abstraction and grouping of codes. Patton (2002) advises that the decision to use software to assist in analysis is partly a matter of individual's style and comfort with computers, amount of data to be analysed and personal preference as it is absolutely not necessary as it may interfere with the analytic process.

This study embraces the use of qualitative analysis software NVIVO due its ability and power in managing text. The researcher attends NVIVO training, purchases the software and codes each question in the open-ended qualitative guide or schedule in NVIVO and organises the raw data under the various questions (themes) for ease in analysis.

The last process of content analysis is reporting. In reporting, Patton (2002) suggests various approaches of organising and reporting qualitative data that researcher may use. He suggests the use of storytelling approaches that may be based on chronology and history, flashbacks that work from outcome to the story, case study approaches that may focus on people, critical incidents, settings and lastly analytical framework approaches that may be based on: processes, issues, questions and sensitising concepts. In qualitative reporting (Graneheim and Lundman, 2004) suggest the need for clear description of the context, selection characteristics of participants, data collection and process of analysis all aimed at helping readers understand how the researcher reached their conclusions from the data available (Geertz, 1973; Graneheim and Lundman, 2004).

There is the need for a narrative that tells readers how findings answer the research question rather than merely providing a descriptive summary of the themes (Braun and Clarke, 2006). They further suggest that extracts used need to be embedded within analytic narrative that compellingly illustrates the story the researcher is telling about their data. The quotes chosen should highlight the nature of the theme, be easily understood and should possibly give some sense of the character of a respondent. Authentic citations should be used to increase the trustworthiness of the research and show originality (Patton, 1990).

King and Horrock (2010) suggest the need to organise a report by describing and discussing each overarching theme. The theme-by-theme report presentation, however, makes it difficult to gain much sense of how individuals' accounts are shaped since it does not preserve the holistic nature of accounts. The alternative method is to discuss case-by-case and relevant themes within each one of them with its limitation being that it's only feasible with few cases to avoid repetition and very long analysis.

Theme by theme reporting (King and Harrock, 2010) is used for reporting in this study. These themes emanate from the analysis of the collected data.

### **5.9. Validity and reliability**

Reliability focuses on how accurately and consistently any variable is measured while validity focuses on correctness or whether a particular form of measurement actually measures the variable it claims to measure (Kings and Horrock, 2010). LeCompte and Goetz (1982) argue that qualitative research is intrinsically placed to ensure high validity, because of how seriously it considers the context of study and how it develops concepts in close relation to the data. External reliability in the sense of the ability to duplicate the study using the same methodology as another researcher may be problematic and difficult to achieve in qualitative studies unlike quantitative studies. Murphy, et al. (1998) suggests that internal reliability referring to the extent to which a set of previously generated concepts can be matched with the data by new researches may be achievable.



Lincoln and Guba (1985) argue that even from a relativist point of view, it is possible to have general quality criteria for qualitative research just as the quantitative one. They suggest four criteria for achieving quality in qualitative research. Firstly, credibility, in the place of validity, referring to the extent to which, the researcher's interpretations are endorsed by respondents. Transferability instead of generalisability, based on the ability of the researcher to provide sufficient rich detail that a reader can assess the extent to which the conclusions drawn in one setting can be transferred to another.

Thirdly, trackable variance in place of reliability by demonstrating that they have taken into account the inherent instability of the phenomenon under study either based on the research context or that which, they have introduced through the research process. Lastly, conformability in place of neutrality, where researchers should provide sufficient detail of the process of data collection and analysis so that readers can understand how conclusions may have been made. The quality criteria is, however, challenged by post-modernist who argue that there are no limits or foundations to the way language can be used to construct reality, making an assessment criteria for assessing value of any version of reality illogical (Willig, 1999).

Other general procedures for analysing quality in qualitative studies include the use of independent coding and expert panels like the ones used in quantitative content analysis (Boyatzis, 1998). It may help researchers think critically about the thematic structures they are developing and the rationale for their coding decisions. It entails the use of code defining or code confirming strategies with the help of independent coders. This study uses a code defining strategy based on the robust cultural context assessment composite model formulated in chapter 3 after a vigorous literature review on culture.

Secondly, qualitative quality may be achieved by the use of respondent feedback as a quality measure of confirming the results of the analysis (Seale, 1999). Ashworth (2003) however cautions on the problems that may arise from using respondent feedback as individuals may deny accurate or agree with inaccurate interpretations for whatever reasons they may have. Thirdly, the use of triangulation that relates to the

use of multiple methods of data collection and multiple sources of data to study a particular phenomenon (Mays and Pope, 2000).

Denzin (2009) suggests different forms of triangulation including data triangulation that uses variety of data sources within a study, methodological triangulation that uses different methods to address the same research problem, investigator triangulation that uses different researcher to collect and compare data and theory triangulation that uses different theoretical models to make sense of same data. Methodical and data triangulation are claimed to enhance validity of qualitative research (Patton, 1990), while investigator triangulation is viewed with scepticism due to questions of integration of views (Mays and Pope, 2000).

This study uses methodical triangulation using qualitative interviews and open-ended question schedules. It also uses data triangulation by use of programmers and literature review from secondary sources of information to understand the various cultural aspects of the Kenyan tribal groups, and to further understand social marketing concepts.

Theory triangulation is inherent in this study as the study takes a multi-disciplinary approach, borrowing from various disciplines as marketing, sociology, communication, psychology, and health studies among other disciplines to enrich the study. Indeed, Social marketing is multidisciplinary in nature helping meet the theory triangulation aspect and further, different theoretical aspects are used to discuss the research findings in chapter seven. The next logical step is reporting on the findings after the implementation of the research methodology and methods.

## **5. 10. Chapter summary**

The study is grounded on the qualitative research paradigm. Ontologically qualitative approach is based on critical realism and relativism, while epistemologically on interpretivism that broadly describe aspects of the social world by offering a detailed account of the social settings, processes or relationships. This study aims to deeply understand the cultural and contextual realities that social marketers target HIV/AIDS in a multi-cultural setting as Kenya have to contend with. Cultural, contextual and HIV/AIDS elements are subjective issues that may be experienced differently by various Kenyan tribal groups thus endearing the study to interpretivism, relativism and subjectivity related issues that characterise qualitative studies.

Sampling is based on geographical mapping based on the eight provinces of Kenya in order to include the different tribal groups found at various geographical mappings within the country. In each province, six programmes are selected, each representing different demographic characteristics such as children 0-12 years, teenagers (13-19 years), young adults both male and female (20-59 years), grandparents (60 years and above and special interest groups such as gay, lesbians, commercial sex workers, drug addicts and people living with HIV/AIDs (PLWAS), giving a total of at least forty eight programmes for inclusion in this study although more qualitative open ended question schedules are sent to each province as a backup measure.

Programmes are chosen based on judgemental and purposive sampling methods to ensure data diversity and inclusion of various tribal groups of Kenya. Content analysis is the chosen approach for data analysis due to its flexibility in data analysis. Data collection instruments are qualitative open-ended question schedules and qualitative interviews as they are well-suited to capture rich detail programme officers' accurate experiences of their audiences' cultural and contextual realities.

Thematic content analysis is used to understand and analyse data and lastly, the report is structured along thematic lines, to provide a deep understanding of how cultural and contextual realities are engaged with by programmers working in the area of HIV/AIDS in Kenya. The next step is the reporting on the research findings after the implementation of the qualitative research methodology and methods.

## **Chapter 6: The Research Findings**

### **Introduction**

This chapter presents the research findings from the two qualitative open-ended question schedules used as research instruments in this study. The findings are presented based on the themes emanating from the programmers' responses.

Data is collected from all the former administration provinces of Kenya: Nairobi, Central, Western, Coast, Eastern, North Eastern, Nyanza and Rift Valley (North Rift Valley and South Rift Valley). The respondents are mainly programmers involved in HIV/AIDS related programmes at the community grass root levels. 45 open-ended question schedules A are collected. Respondents range from social workers, project chairmen/ladies, programme secretaries, programme managers, programme officers, health workers, field officers, peer educators, religious leaders, counsellors, outreach workers, teachers, volunteers and religious leaders. They have been in their positions for lengths ranging from 3 months to 11 years, with the mode being 3 and 5 years. Time with the organisations, range from 1 to 22 years, with the majority indicating 3 and 5 years. Most the respondents are men and the minority women-10, although there are those who did not indicate their gender. Their ages range from 30-39 age group, with the highest respondents of 20 of them, followed by 20-29 age groups that had 13. 40-49 age range had only 7 respondents while the 50-59 groups has 5 respondents. Most respondents were high school O level graduates; 16 of them, college diploma graduates 16 of them, then primary school has 7, university graduates are only three and post graduates only 3.

Forty-three (43) open-ended question schedule B are collected. Thirteen (13) females and thirty (30) males responded to the open ended questions, with their age range distribution being: 20-29=(12), 30-39=(13), 40-49=(13), 50-59=(4), 60-69=(1). Respondents were as follows: Western (5), Rift Valley (5), Nyanza (7), Central (3), Eastern (7), Coast (5), Nairobi (5) and North Eastern (6). Their education attainments are as follows: Post graduate level-8, Undergraduate-7, College diploma-15, secondary education- 6 and Primary education-7.

Programmes focus on different demographic groups such as the children (0-12 year), teenagers (13-19 years), young adults (20-59) the elderly (60 years and above) and special groups like the disabled, lesbian, gay, bisexual and transgender (LGBT), people living with HIV/AIDS (PLWAS) and the commercial sex worker (CSWs).

## 6.1 Infrastructure

Firstly, Pubs seem to be an issue pointed out by several programmers: In Nairobi a programmer says that *'in slum settings bars have mushroomed everywhere, so idlers spend most of the time taking cheap illicit beers like senator, keg, osama among others,'* male 30-39 years. In Western, a programmer says *'many small pubs strewn all over the province make cheap alcohol available to the youth and other ages and contribute to HIV infections'* male 40-49 years. Rift Valley and Coast *'increased bars pose danger to moral values in the society as most of the youth have sunk in alcohol due to pubs and local dens and cases of people losing sights and lives by drinking contaminate local brews are on the rise'* female 40-49 years.

Secondly, programmers point out lack of health and education amenities and slums. Programmers in Nairobi cite that *'absence of hospitals and schools characterise the slums'* male 30-39 years. *'Absence of health facilities in some locations makes it difficult for PLHIV to access their ARVS and treatment for opportunistic infections'* female 40-49, Western, Coast. A programmer in Eastern says *absence of hospitals and well-trained community health workers mean people die, where there are no schools, high illiteracy rates'* male 30-39 years. In Rift Valley, *'there are only two district hospitals that serve the whole county and people have to cover long distances to get attended'* female 50-59 years. In Nyanza, *'hospitals are approximately 7 kms away, most dispensaries lack equipment and many prefer district hospitals that lack skilled staff in HIV/AIDS causing fear to the audience, teachers and schools are not teaching pupils on HIV/AIDS'* LGBTI programme officer 30-39 years. In Northern Kenya, *'hospitals and schools are only found in the major town which are very few and not well equipped, pastoralists still have medical needs'* male 30-39 years.

Thirdly, there are lack of youth recreation and reproductive health facilities. A programmer in Nairobi says *'there is a need to invest in public libraries with all the facilities where the children will get information, learn and have fun,'* male 30-39

year. Another from Western cites *'there is a need for recreational facilities to engage the youth positively'* male 40-49 years. Someone from Eastern cites *'there is a need for church centred youth friendly centres'* male 30-39 years. Nyanza cites *'there is a need for counsellors for the youth and working forums for the youth and women to initiate income generation activities to deal with poverty'* female 30-39 years.

Fourthly, need for clean water for domestic and agricultural use and education on better agricultural methods. A programmer in Western cites *'There is rough terrain in the rainy seasons and springs dry up in dry season resulting in scarcity of good and water forcing people to travel far in search of water. Weather patterns are changing, disrupting timings for planting, and destroying crops and harvest'*, male 40-49 years. He goes on to say that *there is need to teach farmers, appropriate ways of planting like contour planting, digging terraces and educating the target audiences on disaster resilient crops.*

*'No cultural training is provided for programmers'* Central, male 50-59 years, Coast, Female 50-59 years, Nyanza, female 30-39 years. *'Only relevant trainings such as community based programming, community participation, monitoring and evaluation but no cultural training,* Western, male 40-49 years.

*'Need for mobile VCT facilities for use in HIV/AIDS related campaigns'* Eastern, female 40-49 years.

## **6.2 Prostitution/commercial sex work and the Fishing Communities**

A programmer in Coast cites that *'childhood prostitution is high'* female 40-49 years. *'Other children especially in Mombasa are forced by their parents to indulge into sexual activities with tourists to get money for the family upkeep'* Coast, female 30-39 years. *'We have young children as young as twelve fully involved in prostitution and many of them are HIV positive, however, we can't help them as our project only targets the adult population'* Rift Valley, male 40-49 years. Another programmer cites that *'Age 13 onwards, there is a period of sexual discovery and boys are fond of prostitution and promiscuity which considerably impacts transmission of HIV/AIDS'* Nyanza, male 40-49 years. A programmer in Coast cites that *'boys are being sodomised by male tourists'* Coast, female 30-39 years.

Another programmer says that *'Working with sex workers is a challenge because these groups are not afraid of promiscuity, for them, it is a human right issue and they claim 'my body my right' and engage in careless sex life as we encourage safe sex or abstinence'*, Nairobi, female 40-49 years.

Programmers cite that *'fishing presents various challenges such as lack of modern fishing kits, government regulations that means they can't export fish and fishing is clearly a risky occupation in relation to HIV/AIDS'* Male 30-39 years, Nyanza Province. Another one cited that *'fishing has its own challenges since most fishermen go fishing in the night and there are beach ladies who wait for them to acquire fish in exchange for cash or body'* male 30-39 years, Nyanza. *'Transactional sex for fish is very common in our region'* male 40-49 years, Nyanza. *'Fishing is common due to access to Lake Victoria and exchange of fish for sexual favours by fishermen is common'* male 30-39 years, Western Province.

### **6.3 Illicit Brews, alcoholic drinks and drugs use**

Programmers point out that there is *'high rate of local brew abuse especially coconut brew (mnazi)'* Coast, female 40-49 years. *'Leisure time is alcohol time mainly for men and abuse of local brews'* Central male 40-49 years. *'Commercial marketing of alcohol on TVs that glorifies alcohol while, it is a real problem to behaviour change'* Eastern, male 20-29 years. *'Ending local brews is difficult as chiefs and sub chiefs are bribed by local brewers'* Nyanza, male 30-39 years. *'Funeral discos held overnight-disco matanga', where people drink alcohol and engage in casual sex and drug abuse which is also common'* Nairobi, male 40-49 years. *'Alcohol during festivities is mandatory while others engage in marijuana/bhang abuse'* Central, male 40-49 years. *'Cultural nights where dances and alcoholic drinks are served, promote irresponsible sexual activities and pressure on drugs and unprotected sex for young people'* Eastern, male 30-39 years. *'Traditional brews abuse are common during burials and harvesting seasons'* Nyanza, male 40-49 years.

Programmers cite that *'drugs and local brew abuse are rampant'* Coast, male 40-49 years. *'The high use of drugs among youth with high rates of cocaine, heroin and bhang use'* Coast, female 40-49 years. *'Age 13 onwards, there is a period of sexual discovery and many boys are under pressure to engage in premarital unprotected sex and drugs taking'* Nyanza, male 40-49 years, Western, 30-39 years. *'13 years*

*onwards, many boys start selling khat and it is difficult to retain them in schools'* North Eastern, male 40-49 years. *'Individuals idle around chewing khat (miraa) without engaging in any useful activities'* Eastern, male 30-39 years.

#### **6.4 Secrecy surrounding sexuality and sex**

Programmers point out that *'words related to sexuality and sexual organs are challenging to use due to the secrecy surrounding sexuality and using them is considered insulting'* Eastern, Male 40-49 years. In Central, *'due to the association of HIV/AIDS and sex, people find it difficult to openly admit that they are infected'* male 40-49 years. In Western, *'programmers need to understand a coded language used by fishermen and the beach ladies in order to communicate with them'*, male 30-39 years.

*'HIV, itself, is viewed as a taboo and as a transgression of the strongly held morals associated with sex norms'* Nairobi, male 30-39 years. *'Tabooed issues such as sex, homosexuality, incest, rape can't be discussed because the audience will walk away'* Nairobi, Male 40-49 years. *'The community ignores sexual violence because it is a taboo to talk about it and therefore the victims are not treated appropriately'* Eastern, male 30-39 years. *'It is challenging and considered unethical engaging audiences in the culturally tabooed sex talks, encouraging parent and children discussion on sexual matters and discussing any sexuality issues in the public domain, as they are treated as insults and shrouded in secrecy'* Eastern, male 30-39 years.

#### **6.5 Illiteracy**

Programmers point out that *'illiteracy in the society presents language barriers as we are forced to use native languages'* Eastern Male, 40-49 years. *'Illiteracy means that understanding Kiswahili or English terms is difficult necessitating the need for translators'* +Nyanza, male 40-49 years. In North Eastern, *'you have to be a native to run a programme as many people don't even understand the basic Kiswahili national language'*, female 30-39 years.



*'High illiteracy among children and grownups limits informed choices and presents the need for competent caregivers to monitor ARV drugs regime adherence on PLHIV', Eastern, female 40-49 years. 'The gap between the knowledge and action that is caused by ignorance has been a factor in ARVs defaulting posing a challenge of defaulter tracing to the programme' Eastern, female 40-49 years.*

*'Most of the target groups are illiterate and therefore, it is difficult to educate them since they value income generating activities to knowledge' Nyanza, male 40-49 years. 'The illiterate audience are short of measures for prevention of HIV and the solution to take after contracting the virus', Nyanza female 30-39 years. 'Illiteracy is a big challenge as the materials being issued for instruction is quite difficult to read and translate into local languages', Nyanza, male 40-49 years. 'We find that literate population is easy to deal with especially in understanding the training content, more so when science issues are explained. We try to suit all our participants by using both English and Swahili spoken by most Kenyans', Nairobi, male 40-49 years.*

*'There are higher illiteracy rates in the rural areas compared to the urban areas, making health promotion difficult in these areas', Central, male 40-49 years. 'The understanding of most of our audiences is very low, ignorance is high and myths surrounding HIV is still an issue and of course culture aspects are hard to break' Eastern, male 40-49 years. 'Most of the people here are illiterate because they did not attend school or went and dropped early due to poverty' Central, male 40-49 years.*

*'A great number of the adults in the community are illiterate in terms of education and are very devoted to culture and religious teachings' North Eastern, female 50-59 years. 'Most of the members have studied up to primary level making their understanding very low. Also finding trained personnel who can assist in various positions in the programme is not very easy' North Eastern, male 40-49 years.*

*'Lack of sanitary towels is an issue that makes most girls miss schools that translates to poor performance, poverty, prostitution, high school dropout rate and poor intake of health education amongst girls and women' Central, male 30-39 years and Coast Female 40-49 years.*

*'Many boys have low education attainments as some are forced to drop out of school to earn money for the family and are involved in child labour', Eastern, Male 40-49*

years. *'Many boys drop out of school at early age and are taught herding and cattle rustling and to view girls as sex pets'* Rift Valley, female 40-49 years. *'Boys are relied on to look after animals at the expense of their education, hence the youngest boys do not go to school, they are mostly involved in religious teachings'* North Eastern, male 40-49 years.

## **6.6 Sexual violence**

A programmer points out that *'provocative dressing is believed to encourage rape cases'* Eastern, male 30-39 years. *'We have cases of parents who send their girls to the streets to look for food at the age of 10-12 years increasing sexual abuse of minors'* Eastern, male 30-39 years. *'Pornographic materials from local cinema and video dens are blamed for sexual abuse'* Nairobi, male 50-59 years. *'There is early sexual debut at 9 years increasing infections, silence and unreported rape cases and many STI and HIV infections at such an early stage'* Nairobi, female 30-39 years. *'Boys are being sodomised by male tourists and family related rapes'* Coast, female 30-39 years.

*'There is a belief that girls above 13 years are more fertile and can bear healthier children than when they are older. This has led to men forcing young girls into sexual acts and also abducting, raping and marrying those who refuse their demands'*, Rift Valley, female 40-49 years.

*'Some view HIV as a curse and believe that having sex with minors can cleanse them and cure them'*, Central, male 30-39 years. *'The community ignores sexual violence because it is a taboo to talk about it and therefore the victims are not treated appropriately'* Eastern, male 30-39 years.

*'A lot of rape suspects have gone unpunished as not many blame the rapist, but the victim, since they believe they must have provoked what befell them by mode of dressing or refusal to certain things like marriage proposal'*, Rift Valley, male 40-49 years.

## 6.7. Stigma and discrimination

A programmer points out that *'appearing thin or slims is associated with being HIV positive and increases stigma to the slender individuals'* Nyanza, male 40-49 years.

*'The children we rescue are mostly as a result of neglects, as their mothers abandon them because they do not want to be associated with unwanted pregnancy. Some of these children are HIV+ and without parents, making it difficult to integrate them with other children without discriminating against them'*, North Eastern, male 40-49 years.

*'Stigma and being ostracised, as once a young unmarried girl's virginity is broken she is viewed as an outcast'* North Eastern, female 40-49 years. *'Children and their infected parents are declared outcasts and given out to old men to take care of their animals'*, North Eastern, female 30-39 years.

*'Girls are isolated during their periods and many can't afford sanitary towels'* Eastern, male 30-39 years. *'There is lack of parental guidance on maturation and girls are isolated for one week because they don't have sanitary towels and there is widespread ignorance around sexuality'* North Eastern, female 40-49 years.

*'Men have often been excluded from a lot of health services and are not targets for reproductive health initiatives as these tend to target women'* Nairobi, male 40-49 years.

*'Religious people consider sex workers immoral and there is discrimination against women as they are not allowed to lead men in any gathering or activity especially among the Muslims and Catholics'* Eastern, male 40-49 years.

*'Churches scare members that HIV/AIDs is a curse from God because it is sexually transmitted and view it a disease for prostitutes and sinners'* Nairobi, male 40-49 years.

*'Fear of stigmatisation and discrimination make many refuse to test, preferring herbal treatment,'* Rift Valley, male 50-59 years. *'People fear going for ARVs due to stigma, they believe camel urine is a cure for all diseases'* North Eastern, female 50-59 years.

*'PLWAS are viewed as cursed and unworthy to associate with due to the fact that HIV is an STI'* Nairobi, Male 40-49 years. *'PLWAS are viewed as outcasts and as good as dead though still alive. They are isolated and have specified household stuff like cups and sleeping material for fear of contaminating others, and minimal attention is given to these individuals'*, Coast, female 50-59 years. *'Stigma and discrimination are rife based on ignorance on modes of transmission and earlier media campaign that used skinny people to illustrate infected PLWAS'* Eastern, male 30-39 years.

*'Some view the victims as a disgrace and a curse to the community and isolate, stigmatise and discriminate against them. This fuels denial and fear of testing and poor uptake to ARVs; contributing to new infections, depression and early deaths and fear of disclosure, especially by widows for fear of being disinherited'*, Nyanza, male 40-49 years. *'Plwas are held as immoral and cursed, and are stigmatised and they also stigmatise themselves; they are discriminated against and people fear associating with them'* North Eastern, female 50-59 years. *'HIV/AIDS related deaths are twisted to look like victims were bewitched to avoid stigma to the family'* Central, male 40-49 years, Western, male 40-49 years, Eastern, male 30-39 years.

*'Many hold that HIV/AIDS deaths are not honourable, others never reveal the cause of death but instead undertake secret burials instead of public ceremonies'* Rift valley, female 50-59 years. *'Individuals known to have died from HIV/AIDS related causes are not accorded burial rites because they are viewed as immoral, outcasts and cursed by God'* North Eastern, Female 50-59 years.

*'We are an organisation of HIV+ people for HIV+ people by HIV+ people. We fight stigma by openly and successfully managing our organisation and openly demanding for our rights in society'*, Nairobi, male 40-49 years.

*'Rape cases are reported to the authority but victims never accept due to the associated stigma'* North Eastern, male 30-39 years. *'Family and friends are the worst stigma spreaders denying the infected acceptance'*, Central, female 30-39 years. *'Some health care providers stigmatise and discourage PLWAS making them turn to herbalist and faith healers that accommodate them'* Western, male 30-39 years, Coast, female 50-59 years. *'Many health facilities are manned by locals making many clients shy away from going there to avoid stigma and discrimination'* Eastern, female 50-59 years.

## 6.8 Myths and beliefs

A programmer says that *'most people prefer plump girls or women as they associate them with health and being free from disease'* Nairobi, male 40-49 years. *'The bigger the heaps and breasts, the more sexually attractive the women are'* Nairobi, male 30-39 years. *'Our people believe that unprotected sex is the best, sweet and adorable than protected sex, and believe that women with big buttocks are the best and healthy while slim women might be sick. They both believe in smartly dressed partners'* Coast, female 30-39 years.

*'Girls between the ages of 9-12 years are regarded as mature and ripe for sexual debut because it is believed that they can't get pregnant at this age, others believe that at such age is the best for a man's sexual gratification because she is a virgin, while others believe it is the right age to be married as fertility is high'* Nyanza, male 40-49 years, Eastern, male 30-39 years.

*'Boys are more valued and feel more superior than girls'* Eastern, male 50-59 years, Rift Valley, male 40-49 years. *'Culturally men are brought up with the believe that promiscuity is acceptable for them and they have control over the women in their lives, a perception that places women at a high risk of HIV'* Nairobi, male 40-49 years.

*'After 13 years onwards, men demonstrate power, masculinity and have huge responsibilities, they are the most respected members of the society and their word is final whether right or wrong, nobody is allowed to question their decisions and actions. This has led to men feeling on top of the world and always making selfish decisions to benefit them financially. They decide when to marry off their daughters and to whom and this has hampered our fight against early marriages and HIV transmissions'* Rift Valley, female 40-49 years.

*'Churches scare members that HIV/AIDs is a curse from God because it is sexually transmitted and view it as a disease for prostitutes and sinners'* Nairobi, male 40-49 years. Central, male 30-39 years. *'Others hold that HIV is a result of witchcraft, especially, if one was rich, denying the fact that it is mainly sexually transmitted'* Nairobi, male 40-49 years, Coast, female 30-39 years. *'Some don't believe in its existence, while others believe that HIV/AIDS is for those that are not circumcised as*

*circumcision protects those 100%. Others believe that is a conspiracy by white people to finish the black by introducing the virus to Africa'* Nairobi, male 40-49 years, Western, male 40-49 years. *'Some believe that HIV has its genesis from green monkey (sooty manyabey) by effort of dare devil scientists to be used as a biological weapon to depopulate Africans because they are too many'* Eastern, male 30-39 years. *'Some view HIV as a curse and believe that having sex with minors can cleanse them and cure them'*, Central, male 30-39 years, Western, male 40-49 years, Eastern, male 30-39 years.

*'Some believe that it is bad omen and a curse for breaking traditional taboos that can be cleansed away for a widow to be inherited or widower to be left free to remarry'* Nyanza, male 50-59 years. *'Others believe that it can be cured by drinking camel's urine,'* North Eastern, male 40-49 years.

*'I do hear some old people saying that HIV is like 'Nyawawa' (evil spirit) that they chased away by beating drums as it feared a lot of noise, which we categorically deny'* Nyanza, male 40-49 years.

*Other school of thoughts exist that some medicine men and witchdoctors can cure HIV by special abracadabra to appease gods'* Eastern, male 30-39 years.

*'Some believe that sex with virgins will cure them while others believe in prayers and fasting for miracles to cure them of HIV/AIDS,* Rift Valley, female 30-39 years.

*'Some PLWAS believe that once infected, they will die shortly, therefore, have sex with as many as they find'* Nairobi, male 40-49 years. *'Others see HIV/AIDS as a death sentence and curse from God hence low access to VCT services'*, Central, male 40-49 years.

*'HIV/AIDS related deaths are associated with lack of morals and curses and believe that witchdoctors must cleanse the family from such occurrences and curses passed on by forefathers. Others deny that kin's died of HIV and contract the virus while preparing the body for burials while others inherit their wives and girlfriends'* Coast, female 40-49 years.

*'In Luo community, every activity must be officiated with ritual sex, this applies to wife inheritance and cleansing of the widowed women so that they can be inherited by use of ritual sex'* Nyanza, male 40-49 years.

*'Tabooed issues such as homosexuality, incest and rape can't be discussed because the audience will walk away'* Nairobi, Male 40-49 years.

## **6.9 Early sexual debut and childhood marriages**

A programmer cites that *'early childhood marriages cause/lead to increased levels of illiteracy and poverty, leading to immorality (prostitution) thus increasing chances of HIV/AIDS infection'* Eastern, male 20-29 years. *'Some parents don't value a girl's education. We, at times, earn enemies when we involve the police to intervene in cases of forced early marriages. In some occasions, we have to refund dowries already paid, in order to bring harmony amongst the affected families'*, Nyanza, male 30-39 years.

*'There is early sexual debut at 9 years increasing infections, silence and unreported rape cases and many STI and HIV infections at this early stage'* Nairobi, female 30-39 years. *'Early sexual debut and lack of parental guidance on sexuality are common'*, Central female 30-39 years. *'Children are forced to early marriages to wealthy polygamist'* Coast, female 40-49 years.

*'In this region, there are a lot of early childhood marriages, this has greatly contributed to child molestation especially when a girl refuses to be married off, they are mostly abducted and raped to teach them a lesson'* Rift Valley, male 30-39 years. *'The Maasai still endorse childhood marriages despite efforts by many NGOs to stop the behaviour'* Rift Valley, female 30-39 years. *'The girl child in our target audience is viewed as an object that will bring fortune to the family. They are rarely sent to school as they are married off at tender ages of 10 years after undergoing FGM'* Rift Valley, female 30-39 years.

*'Girls are married by the age of 12 and exchanged for animals'*, North Eastern, female 40-49 years. *'When animals die, you marry off the girls to wealthy people, they take them and make them their wives at ages 14-15'*, female 30-39 years.

*'Due to lack of information, the youth blindly engage in early sexual debut in search of money and get STI infections, while others have to result to abortions, early deaths forced early marriages and early parenthood at 13 years greatly increasing poverty levels and many use contraception as protection from HIV'* Nyanza, female 40-49 years. *'Many youths aged between 13 onwards are engaged in sexual practises and many have children out of this practice'*, Central, male 30-39 years.

*'This being the most sexually active group, they have the highest numbers of those engaging in unsafe sex, most believe that by engaging in this practise early, they will be able to please their partners or spouses in the future, this has led to increased infections and unwanted pregnancies'* Rift Valley, female 30-39 years. *'Boys are regarded as mature and involved in early sexual relationships after 13 years'* Nyanza, male 30-39 years. *'After circumcision most boys believe that they can freely get into sexual activities'* Central male 40-49 years.

*'Age 13 onwards is a period of sexual discovery and boys are fond of prostitution and promiscuity which considerably impacts on transmission of HIV/AIDS'* Nyanza, male 40-49 years.

#### **6.10 FGM and male circumcision**

A programmer cites that *'FGM is practised quietly'*, Nairobi, male 40-49 years. *'FGM is practised by the Mungiki followers and other traditionalists,'* Central, female 30-39 years. *'It has been a great challenge trying to educate the parents, traditional circumcisers and the community in general about the dangers involved with FGM and their effects and complications during child birth. They also predispose the girls to infections since they use rusty knives and blades or even broken pieces of glass. They believe this operation transforms and prepares girls into womanhood and makes them eligible for marriage. The audiences are simply resistant to change especially in the Kalenjin community'*, Rift Valley, male 30-39 years.

*'They still believe that by practising circumcisions, the girls will grow disciplined and their libido lowered to avoid reckless sex and marrying early will help them make good wives respectful to their husbands'*, Rift Valley, male 30-39 years.

*'Girls and boys must be circumcised in this region; girls' circumcision is a must and is highly practised'*, North Eastern, female 30-39 years. *'They don't want us to*



*circumcise girls, that is why there are sexual problems because of high libido', female 50-59 years. 'Girls circumcision is compulsory among the Maasai and Turkana, while the Turkana's and Luos don't circumcise their boys' Rift Valley, female 40-49 years.*

*'Male circumcision is contrary to community's cultural values' Nyanza, male 50-59 years. 'Traditional circumcision of boys involves the use of un-sterilised equipment on different boys, leading to STIs and related infections' Eastern, male 40-49 years, Western, male 30-39 years. 'Circumcision using un-sterilised equipment at 12 years is common, while for Muslims it is between 0-10 years', Coast, male 40-49 years.*

### **6.11 Extra marital sex and polygamy**

A programmer points out that *'the society treats extra marital relationships as a normal practice making unfaithfulness normal. This results in children being born out of wedlock that are stigmatised by family and community, family break ups and discordant couples'* Eastern, male 30-39 years. *'Extra marital sexual practices among the married couples are so far the predominant mode of HIV and STI network', Eastern, male 30-39 years. 'The cost of extra marital sexual affairs is unacceptably high, it costs the programme a lot of resources, it reverses the gains made in the fight against HIV/AIDS by rising the prevalence rate of the entire population, not to mention the personal and emotional toll it takes on individual, families and children'* Eastern, male 30-39 years.

*'It is an ingrained activity and poverty is seen as a contributory factor', Nyanza male 30-39 years. 'The majority of the married couples have what we call in Kenya 'mpango wa kando' which means one is married but still has other families or relations outside the legal marriage' Nyanza, male 30-39 years and Nairobi, Male 30-39 years. 'It is difficult to control sexual relationship outside marriage. They start relationships outside marriages and, mostly, are not concerned about the partners' HIV status; this increases chances of HIV even in marriages' Nyanza, male 40-49 years.*

*'Part of the challenge is a consequence of migration for work whereby you find men often migrate from the rural areas leaving their families in the rural areas. Consequently, they often end up having several 'wives' in the urban area posing the risk of getting infected with HIV and STIS, which they spread to their wife back home when they go for a visit'* Nairobi, male 40-49 years.

*'Extra marital affairs are a problem and are driven by various economical, financial or social reasons. The married men run to the young girls and go back home to their wives, while the girls run back to their peer boyfriends. This is the largest chain that has led to many infections. The girls find it hard to resist the cash rewards that come from sleeping with the married men due to high poverty rates'* Rift Valley, male 30-39 years. *'A man has to marry a lady in the African context, hence, the LGBTs do it for formality as they have their partners secretly of the same sex'*, Nyanza, LGBTI 30-39 year.

*'Churches are against polygamy and early marriages, but it happens and when we question them, they give reasons such as, they don't have children from the first wife, some have same sex children from the first wife and are looking for a different gender of children'* Nairobi, male 40-49 years.

*'Most of our members come from communities that believe in polygamous marriages. This has led to the dissatisfaction of women in various marriages; hence, they decide to find consolation from elsewhere, leading to the spread of HIV/AIDS in marriages. This has made the programme not able to fight the spread of the virus as required'* Nairobi, male 30-39 years.

*'For Tesos and Luos, we still have a long way to go, they believe a real man must have multiple wives as a sign of strength'*, Nyanza, male 40-49 years. *'Nothing can be done about polygamy'* Nyanza, female 30-39 years. *'Many audiences take the practice of polygamy as a mandatory cultural practice and though some practice monogamy, they are not faithful to their partners'* Nyanza, male 40-49 years.

*'The society regards men as naturally polygamous. Monogamy is considered as a sign of poverty'* Eastern, male 30-39 years. *'Polygamy is a must, where do you want the excess women to go'* North Eastern, female 50-59 years.

*‘Wife inheritance, indiscriminate search for children by the childless or for the valued boy child in spite of their status or in cases of discordant couple, are challenging values and practices’* Nairobi, male 30-39 years, Central, male 30-39 years, Coast, female 50-59.

*‘Symbols like Njuri Nceke (Meru council of cultural elders) shrine and institution that advocates for polygamy and wife inheritance among its members’* Eastern, male 30-39 years.

## **6.12 Taboos- homosexuality, rape and incest related issues**

*‘Taboos are good and should not be altered as they have been guiding people in matters regarding sexuality’*, Rift Valley, female 40-49 years. *‘Taboos minimise the spread of HIV/AIDS and homosexuality is not practiced’* Rift Valley, female 30-39 years. ‘

*‘In North Eastern, rapes are common during conflict, sometimes it’s the government’s army members that rape us’*, North Eastern, female 50-59 years. *‘The community ignores sexual violence because it is a taboo to talk about it and therefore the victims are not treated appropriately’* Eastern, male 30-39 years. *‘HIV, is itself, viewed as a taboo and as a transgression of the strongly held morals associated with sex norms’* Nairobi, male 40-49 years.

*‘Homosexuality is prohibited in Kenya by law and culturally, hence running programmes to target them becomes hard due to fear of being exposed. We conduct forums to the general community on sexuality in order for them to appreciate the LGBTI, as a means of reducing the prevalence rate of HIV/AIDS transmission, Nyanza, LGBTI male 30-39 years.*

*‘Homosexuality, incest and bisexuality are hardly mentioned in the African context and because of the secrecy applied in these practices, they could be a very serious mode of HIV transmission in the community’* Nairobi, male 30-39 years.

*‘A man has to marry a lady in the African context hence the LGBTs do it for formality as they have their partners secretly of the same sex’*, Nyanza, LGBTI male 30-39 years.

*'Many think that they are safe from HIV if they practise homosexuality'* Central, male 40-49 years. *'Incest is common and this is hampering programming because it is usually hidden and the young girls and boys are threatened with dire consequences if they 'shame' the family'* Central, male 40-49 years.

*'We have problems addressing issues of homosexuality because they don't believe these people among us, although they do exist and this has made it difficult to apply some interventions. Homosexuals marry among the general population without the notice of the family'* Coast, female 50-59 years.

*The issue of gays and bisexuals is a subject they would rather turn their back on, nobody wants to admit that these practices take place and they believe they only happen in Western countries. This hinders our efforts to reach out to these groups of people who practise in the dark, we believe this has increased the spread of the virus since they don't have the information that they can easily get infected by engaging in anal sex too'* Rift valley, male 30-39 years.

*'Homosexuality is very high, this is our key population we are working with'* Nyanza, LGBTI male 30-39 years.

*'Culturally, it is believed that LGBTIQ are a cursed society and cannot offer anything to the society; hence, neglected in key implementation programmes, making our target group feel unappreciated and suffer from low self-esteem. This can be changed by empowering professional LGBTIQs to come out of the closet and prove that we are like any other person. This is working out well for my organisation (Third Race), which is a purely LGBTIQ medical students' practitioners CBO out to make a statement and a difference'* Nyanza, Male LGBTIQ, 40-49 years.

### **6.13 HIV/AIDS related treatment and religion**

A programmer points out that *'it is a challenge for the parents to disclose to their children that they infected them with HIV, so children are put on treatment and are told that they are suffering from a different disease (homa or flu), making adherence very difficult among children'*, Rift Valley, male 40-49.

*'Most PLWAS are informed and for those that choose to take, they do take the prescribed medication. However, occasionally this is in tandem with taking herbal preparations which are not necessarily declared'* Nairobi, Male 40-49 years. *'They often rush to the herbalists in Loliando or Tanzania for the herbs and in most cases, the virus overtakes the herbal treatment and people get sick and die'*, Nairobi, female 30-39 years.

*'Use of herbal medicine is often marketed by the herbalists as a 'cure' for HIV and often preferred due to the various ARV's side effects and common view that the modern ARVS don't cure the virus'*, Nairobi, male 40-49 years.

*'Lack of a cure frustrates our programme and it's difficult to stop the spreading of the virus among members'*, Nairobi, female 40-49 years. *'Finding ARVS for the already infected is difficult due to lack of funds'* Nairobi, male 40-49 years.

*'Some churches will rather pray for the infected and expect a miracle or at times declare them healed'* Central, male 40-49 years. *'Faith healing and taking of herbal drugs are a real problem to HIV/AIDS management'* Central, male 40-49 years. *'Either of the witchdoctor or herbalist must be involved in whichever way before any other treatment'* Coast, female 30-39 years.

*'Some believe that ARVS are killer medicine and refuse to take them, while others hold that if you are on ARVS, you can't transmit HIV'* Coast, female 50-59 years. *'Other school of thoughts exist that some medicine men and witchdoctors can cure HIV by special abracadabra to appease Gods'* Eastern, male 30-39 years.

*'Most still believe in traditional herbs until they are compelled by infections when they seek medical services. However, ARVS are viewed as expensive and unaffordable and many don't follow the medical instructions of ARVS'* Rift Valley, female 40-49 years.

*'Except the ones in the urban areas, most of the community members have no information about HIV/AIDS infection and treatment. The poor have no access to information'* North Eastern, female 50-59 years.

*'There are sometimes incompatibility of medicine with patients and many ARVs side effects'* Nairobi, male 50-59 years. *'Many health care providers lack in counselling skills and many lack training on handling HIV/AIDS matters as it is a new infections'* Nairobi, male 40-49 years.

*'There is a shortage of health care givers especially doctors, shortage of ARVS and many PLWAS lack funds to access modern medicines'* Nairobi, male 40-49 years, Central, female 30-39 years. *'There is the pill burden due to various tablets for patients like four at a time, poorly equipped facilities discouraging PLWAS and some health care providers stigmatise and discourage PLWAS making them turn to herbalists and faith healers that accommodate them'* Western, male 30-39 years, Coast, female 50-59 years.

*'There is a language barrier where medics use medical jargon and many health providers don't communicate effectively leaving many unanswered questions'* Eastern, male 40-49 years. *'Many health facilities are manned by locals making many clients shy away from going there to avoid stigma and discrimination'* Eastern, female 50-59 years. *'Corruption exists in government hospitals that make drugs disappear mysteriously and health funds are misappropriated'* Eastern, male 30-39 years. *'Health care providers harass PLWAS if they miss visits but the facilities are very far, understaffed as many health care workers don't like working in hardship areas as Northern Kenya and there is a lack of nutritional support for PLWAS and lack of medicine in government hospitals'* Northern Kenya, male 40-49 years.

*'Belief in faith healing makes people stop taking ARVS after prayers in the belief that they have been healed and have turned HIV negative'* Nairobi, male 40-49 years. *'We have problems with Evangelical churches preaching faith healing as such misleading the HIV positive people to throw away their drugs. The Catholic Church has come to accept the use of the condoms presently. We, however, find it hard dealing with households that are of Muslim backgrounds due to their belief in polygamy'*, Nairobi, male 30-39 years.

*'Some, like the African traditionalists, do not believe in taking their sick people to hospitals and also don't see the need for schooling'* Western, male 40-49 years. *'Religious people consider sex workers immoral and there is a discrimination against women as they are not allowed to lead men in any gathering or activity especially*

*among the Muslims and Catholics’ Eastern, male 40-49 years. ‘Many audiences accept religious leaders’ teachings without questioning their values and relevance’ Eastern, male 40-49 years.*

#### **6.14 Cultural enablers**

*‘Taboos, intermarriages to avoid associating certain tribes with HIV, the hospitality and fellowship of members have facilitated programme work’ Nairobi, male 50-59 years, Central, male 30-39 years. ‘Community volunteers, voluntary male circumcision, alternative circumcision approaches for girls, long mourning periods among the Luhyas and Luos give access to audiences during 4-8 days mourning period after burial for HIV/AIDS sensitisation’ Western, male 50-59 years. ‘Cooperation of target audiences, cooperative administrators like elders, chiefs and sub chiefs and the fact that polygamy is slowing down’ Coast, female 40-49 years.*

*‘Strong family and kinship networks that help in the social support of orphans, cultural artistic sculptures and bead making act as income generation activities in support groups and hospices for the aged’, Eastern, male 30-39 years. ‘Involvement of traditional herbalist in HIV/AIDS interventions as well as tabooed prohibitions on rapes, homosexuality and bisexuality are helpful’ Rift Valley, female 50-59 years. ‘Hard working audiences to fight poverty and voluntary sterilised male circumcision helps’, Nyanza, male 40-49 years. ‘Madrasa and sharia law in the Holy Quran help teach morals such as saying no to sex before marriage and no to drugs, practise of strict Muslim culture also helps’ North Eastern, Female 50-59 years.*

#### **6.15 Political, Legal, Donors and funding related issues**

Programmers point to the *‘government misappropriation of national resources resulting in lack of basic utilities such as hospitals and schools and government legalising of pubs’*, Nyanza, male 50-59 years. *‘Elections related violence’*, Eastern, male, 30-39 years. *‘Terrorism by alshahaab and insecurity are key challenges, the government needs to deal with’* Coast, female 50-59 years. *‘Poverty, famines, low education based on the marginalisation of North Eastern province’* North Eastern, female 50-59 years. *‘Some chiefs, sub chiefs and MPs hold on to cultural practices and mislead the target audiences’* Rift Valley, female 50-59 years.

*'Friendly Kibaki's government with programmes like Total war on AIDS (Towa) where communities were encouraged to apply for funds and run programmes on HIV/AIDS prevention'* Nairobi, Male 40-49 years. *'There is good will from government agencies like NACADA, NASCOP, NACC among other regulatory bodies in targeting vices such as local brews, training programme officers and funding HIV/AIDS related initiatives'* Western, male 40-49 years. *'Some members of parliament help with hospital bills, food and education for the OVCs and some promote HTC in their meetings and discourage idleness and alcohol consumption'* Coast, female 50-59 years.

*'Most laws are on paper and law enforcers break them'* Nyanza, male 40-49 years. *'Drug trafficking laws lack enforcement, especially, when it concerns the well-connected big fishes and confidentiality law on status are not reinforced, leading to discrimination, Coast'* male 40-49 years. *'Sexual offences Act came into force in 2006, and is not enforced challenging gender violence'* Eastern, Male 30-39 years. *'Legal protection for employees that protect them against compulsory testing before employment and losing of jobs based on the HIV/AIDS status and legal firms that defends PLWAS disinherited after the death of their spouses'* Nairobi, male 30-39 years. *'Homosexuality is illegal, making LGBTIs hide and not get involved in programme work, Nyanza'* male 30-39 years.

*'Organisations like Kenya Human Rights Commission (KHRC) that has helped with capacity building on human rights on issues of discrimination, administrative justice and human rights violations and others like FIDA for women, Kituo cha Sheria, Cradle for children among others that offer pro bono services to the less fortunate have all helped'* Eastern, Male 30-39 years. *'HIV/AIDS tribunal, currently sitting and hearing human rights abuses and violations, has contributed positively to the fight against HIV/AIDS discrimination'* Rift Valley, female 50-59 years.

Programmer point out that *'The government releases donor funding so slowly hurting programmework and controlling licences and permits limiting programme meetings and work'* Nairobi, Female 30-39 years. *'Donors engage in periodic funding that is not sustainable'* Nairobi, male 40-49 years. *'Strict funding demands before funding approval'* Western, male 50-59 years.



## 6.16 Chapter summary

Programmers' responses represent fifteen main themes. Infrastructure is a major issue in Kenya, with related issues such as; pubs being linked to immorality and HIV spread, lack of health and education facilities, lack of youth recreation and reproductive health facilities, lack of clean water and cultural training for programmers as well as mobile VCTs to impact testing and managing of HIV/AIDS related infections. Prostitution is another theme and common among children, adults, married men and the fishing communities. It presents real challenges to HIV/AIDS prevention and management. Illegal brews, branded alcohol and unchecked drug use are also blamed for many HIV/AIDS cases and families' misery. Secrecy, surrounding sexuality and sexual matters, is also identified as a major hindrance to programme work.

Illiteracy is blamed for poor uptake of HIV/AIDS related information and poverty, while sexual violence is also blamed for many HIV and STI related infections. Stigma permeates many areas of life ranging from self-stigma by PLWAS, family members, health providers, the society, churches and religious circles all impacting negatively on PLWAS. Myths and beliefs also permeate all aspects of life in Kenya and greatly impedes sobriety in dealing with HIV/AIDS related programme work.

Early sexual debut and childhood marriages expose young girls and boys early to the HIV/AIDS virus as well as un-sterilised male circumcision. The cruelty of female genital mutilation and the scars, it impacts on the victims, is also a major portal for the HIV virus. Extra marital sex, practised with impunity by many Kenyan tribes together with polygamy, may explain the many HIV infections among the married and the non-married individuals in Kenya.

Taboos on homosexuality have negatively impacted reaching out to these outlawed groups, while taboos on rapes and incest may explain the silence by victims and lack of any justice they suffer. Herbal treatments take centre stage and preference in HIV/AIDS. Although they do not really work as well as faith healings, exacerbating HIV related infections and deaths. Political and legal factors may present positive and negative impact on programme work and programmers are experiencing tougher donor and funding requirements and lack of donor funding sustainability, negatively impacting on programme work. Lastly, Cultural enablers do exist that programmers should tap on for more successful programme work.

The next step is to discuss the findings while corroborating them with existing evidence and knowledge.

## **Chapter 7.0 Discussion of Research Findings**

## **7.0. Chapter introduction**

This chapter is a discussion based on the findings presented in chapter 6. Fifteen themes identified in the research findings chapter are discussed, compared, contrasted and corroborated with previous findings.

### **7. 1 Infrastructure**

#### **7.1.1 Slums and Informal Settlements**

Programmers point to slums as hot beds for HIV/AIDS, poverty and describe them as toxic neighbourhoods lacking in social amenities in the research findings in chapter 6.1. Slums mainly found in the urban areas in Kenya are a significant man made settlements in the context of HIV/AIDs. In Nairobi, Oti, et al, (2013) suggests that between 60-70% of the urban population in Nairobi Kenya reside in slums. Many of the residents live in congested areas that are characterised by makeshift structures. The majority of structures are rented on a room-to-room basis; meaning privacy is limited due to congestion. Residents of these areas also have high levels of unemployment and insecure incomes that limits their access to health, education and opportunities for self-development (Foeken and Mwangi, 2000).

Slum areas are underserved by social amenities such as water, sanitation and limited access to quality preventive and curative health services and characterised by high levels of poverty, unemployment and insecurity (Ross and Mirowsky, 2001; UN Habitat, 2003). The risk of HIV/AIDS infections is, indeed, very high owing to congestion, illicit brews, several sexual networks due to high prostitution rate, several rape cases and casual sex for survival driven by high poverty that characterise slum life.

Van Donk (2002) found that South Africa townships and informal settlements of Soweto, Walmer Estate and Cape Town had higher HIV/AIDS prevalence rates compared to the other parts of the same urban areas. Ziraba, et al. (2010) suggests that slum dwellers in Nairobi have a higher HIV/AIDs prevalence compared to national or city level estimates.

The government certainly needs to address the informal settlement issue by possibly looking at the push and pull factors. Poverty is a huge driver of these slums as well as

illiteracy and low educational attainments that reduce individuals to casual labourers earning meagre wages. Rural urban migration as individuals seek better lives and casual jobs and the presence of informal cheap settlements, all drives slum population and HIV risk factors (Van Donk, 2002). This has led to split families with frequent movement among cities, towns and the 'home' village remaining the norm for many urban migrants in Kenya (Gould, 1988). Men and women working as casuals or in other formal jobs in the city away from their spouses are prone to casual sexual relations out of loneliness as suggested by Packard and Epstein (1992). These sexual networking means greater exposure to the HIV virus to both the rural and urban dwellers due to occasional or frequent movements between these areas. Slums are areas social marketers must never ignore in the context of HIV/AIDS pandemic.

### **7.1.2 Pubs and alcohol serving dens**

The ecosystem's social economic aspect includes the built environment and the people (Gaudet, et al., 1997). The built environment constitutes the physical man-made environment that certainly impacts positively and negatively on health and HIV/AIDS related programmes. Programmers cite various challenges in relations to pubs and bars such as the presence and increasing numbers of bars/pubs serving local brews and branded alcohol. These structures seem to be driving many other social evils such as prostitution, irresponsible sexual behaviour, family problems that may predispose the audiences to the HIV virus. Alcohol serving venues are associated with risky behaviour due to the associated psychological effects of intoxication on decision making, such as inhibition of protective actions and the interactions between drinking and risk taking personality characteristics (Cook and Clark, 2005), that may all work in tandem to increase risky sexual behaviour.

Generally, alcohol consumption has been associated with increased sexual risk (Stall, et al., 1986; Parker, et al., 1994; Bryant, 2006). However, LaBrie, et al. (2005) suggests that alcohol is associated with unprotected sex with a casual partner but not with a primary partner. Conversely Graves and Leigh (1995) suggest no significant relationship between intoxication and unprotected sex, when they compared unprotected sexual encounters under the influence of alcohol to those without alcohol, although they agree that there is an association between heavy drinking and

unprotected sex. Alcohol intoxication may lead to reduced perception of risk (Kalichman, 2010) and affect personal judgement resulting in regrettable actions such as unprotected sex with possibly HIV positive individuals.

Programmers recommend that the pubs should not be built near school or hospitals and cite the need to institute and enforce laws restricting their operating times and age limitation on patronage. These issues certainly need upstream marketing to engage the government and policy makers to pass relevant laws, although programmers seem to be logically dealing with them at a downstream social marketing level by distributing condoms and having condom dispensers in pubs. They also engage local authorities in matters of pubs locations, engage community health workers and use of support groups and outreach programmes to especially reach men in pubs. However, they need to work more on upstream social marketing too.

Kalichman (2010) suggests the need for alcohol venue based interventions such as firstly, the use of popular opinion leaders (Kelly, Murphy and Sikkema, 1997), that can help provide appropriate HIV/AIDS information within the informal alcohol serving venues and use of trained peer educators to again educate their peers as they socialise in those venues. He also suggests structural intervention that mainly relate to the law and policy such as mandatory testing of commercial sex workers and lastly and most importantly, a combination of both the social influences and structural intervention.

Certainly, much as of social marketers in Kenya need to complain about mushrooming pubs, they need to train peer workers that can venture into these alcohol dens to diffuse appropriate HIV/AIDs prevention and management information and skills to bar patrons and employees, as part of downstream and in stream social marketing. They also need to lobby at upstream level for changes in policy and laws especially relating to commercial sex workers. It would be safer if they were tested and carried their certificates just like they do in Nevada in America (Hausbeck and Brents, 2000).

### **7.1.3 Reproductive health services for the youth and men**

Programmers in the findings, chapter 6 point to the fact that reproductive health services are mainly for the married in Kenya, and that this greatly hampers access to reproductive health services by the youth. This is, unlike in the West like England, where teenagers have access to reproductive services and are free to access them at their will. In the past, in Kenya, grandparents and not the parents were mostly responsible for sex education and to date many parents find it difficult to fill this gap. This vacuum creates a lot of problems as parents rarely discuss sexual matters with their children; yet expect them not to engage in premarital sex. Myths, media and false information relating to growth and sexuality mainly fill their knowledge gap. The sexual taboo of not discussing sexual matters probably explains why many young people are today ignorant of how to protect themselves against sexually transmitted diseases including HIV. Unfortunately, many girls consider getting pregnant as the main risk of premarital sex rather than getting the HIV virus (Ahlberg, et al., 2001).

This vacuum of information may explain why programmers cited that girls believe that they are sick during their periods and fail to attend school (Nyanza, Coast, North Eastern). Other believe they cannot get pregnant with the first or second sexual encounter because they have not matured yet (Eastern). Others use contraception as protection (Nyanza and Nairobi) with their main concern being pregnancy as opposed to prevention of STIs including HIV/AIDs. The girls and boys then indulge in unprotected sexual practices blindly (Nyanza and Coast), resulting in a myriad of consequences such as many sexually related infections including HIV/AIDs, cross generational marriages, unwanted children, back streets and do it yourself (DIY) abortions resulting in many reproductive related problems such as sterility and even deaths.

Programmers acknowledge that individuals between thirteen years and above are the most sexually active groups, yet many engage in unprotected sex (Rift Valley). Much as counselling, preaching abstinence, educating them on leisure use, life skills clubs in schools and peer education are logical measures taken by programmers; there is a need for the government and NGOS to create reproductive health centres specifically for the youth with youth friendly employees and health carers.

Tylee, et al. (2007) contends that the youth in Africa face substantial barriers in accessing reproductive health services, within the context of proscribed premarital

sexual practices. These barriers include age and marital status access restrictions barriers, lack of confidentiality from health care providers, fear of mistreatment by providers, inconvenient hours and locations of facilities, high costs of services and limited knowledge of available services. They further suggest that youth friendly health facilities have potential to ensure that services reach young people and that their unique health needs are met.

However, there is need for policy and resources to address youths' reproductive health needs appropriately and the need for health providers to be trained to deal specifically with the youth, without culturally judging them. Certainly this calls for an upstream social marketing approach to lobby the government and ministry of health to invest in such youth friendly centres.

Programmers also cite challenges related to the exclusion of men and boys in health related activities. Carlos and Dialo (1986) suggest that men have effectively been excluded, whether deliberately or by default from participating in many family planning programmes. This is worse in patriarchal societies as Kenya where husbands have absolute decision-making power over their wives (Mbiti, 1969; Onyango-Omuodo, 1984). Steinfeld, et al. (2013) suggest that women have variety of options in family planning, while males have limited options, insufficient knowledge about contraception methods compounded by fear of side effects, fear of social approval and myths surrounding fears of infertility, that all act as barriers to male related reproductive health services.

They allude that men are keen on male reproductive services and there is the need for more integrated services targeted specifically at men and couples, especially the PLWAS within the Kenyan context, where they can get HIV care and family planning services at the same time. More so the discordant couples that still wish to fulfil their marital duties and have children without infecting their loved ones.

Programmers use various means of reaching the hard to get men such as use of public media, football tournament, alcohol dens, chiefs' barazas (meetings) and religious leaders. These are all commendable methods, however catching them early via school based curriculum and the use of youth reproductive health centres may be more practical options. Omondi-Odhiambo (1987) suggests that educated men are more likely to encourage and cooperate with their wives on contraception use. Indeed, these

youth centres can also offer modern circumcision and educate the young boys as they heal their wounds, to empower them with the right information and attitudes in relation to sexuality and dealing with girls and women. Social markers should really be at the forefront in lobbying and soliciting funds for such youth friendly centres and male reproductive health integrated centres and ensuring that they are well managed to achieve their goals and objectives.

#### **7.1.4 Cultural training**

Much as cultural competence is crucial for programme work, the responses from programmers' in chapter 6 evidence that many do not indeed undergo any formal kind of cultural training. Responses range from none, not applicable (Central, Eastern, Coast, Rift Valley, and Nyanza provinces). Others cite that they employ local residents who do not necessarily need cultural training (Nairobi, Rift Valley and Eastern). Others just list the trainings undertaken that certainly exclude cultural trainings (North Eastern, Nyanza, Rift Valley, Western).

Cultural training is certainly not given the seriousness it deserves. Cultural training is relevant to programmers regardless of whether they are local residents or not. Cultural competence cannot be subsumed on local residency or similarity in tribe, nationality or language to the target audiences. Indeed many individuals may not be aware of their own cultures as well as the culture of other target audiences. Cultural awareness and cultural proficiency are completely different domains.

Cultural competence involves professional attitudes and skills and the ability to combine them with the knowledge of cultural systems, to understand their effects on behaviour and opportunities (Chrisman and Zimmer, 2000). It begins with a self-awareness and acknowledgment of the effect of culture on the individual self, on professional practice and also the knowledge of how to adapt to these influences in the context of intercultural relations. Cultural capabilities are mainly hindered by self-referencing criterion (SRC), a term coined by Lee (1966), that explains the fact that individuals evaluate other cultures based on their own cultural lenses, that may result in cultural biases.



Winkelman (2009) suggest that the ability to deal with cultural issues can be conceptualised as an interaction of three major levels. Firstly, capacity level that range from cultural awareness, cultural sensitivity and cultural competence. Secondly, specialty area, that may include cultural mediation, assessment, treatment, research, communication, intervention and policy formation. Thirdly, specific cultural group level, that refers to abilities in relating to particular cultures. This requires a long time to develop and may be possibly seen in some native members of a culture. However, it can be argued that it is also true that natives of a culture may be alien to their own cultural beliefs, attitudes, values and practices, possibly due to outward migration or acculturation to other cultures or simply based on sheer ignorance.

Social marketing programmers and donors should arguably be operating at the cultural proficiency level and given that few natives work in programmes, it is important for them to undertake cultural training and not assume that they are culturally competent to engage in programme work.

Most health interventions in the developing countries are western led and financed under the dictates of Euro-Americans that mainly subscribe to individualistic cultural lenses that are obviously different to collectivists' cultures. This often results in insistence on policies, strategies and rules, founded on ethnocentric and universalistic biases on collectivist communities, rendering programmes doomed to fail (Castrol, 1998; Skaff, et al., 2002). A good example is the USA PEPFAR- (Presidential Emergency Plan for AIDS Relief Prevention Funds) that dictates that one third (1/3) of the funds must be spent on youth abstinence campaign, while the reality in Kenya is that most the youth are sexually active with early sexual debut.

It would be indeed logical for the funds to be directed appropriately to providing safe reproductive health services to the youth, rather than excluding them from lifesaving interventions that could empower and protect them from the HIV virus (Njue, et al., 2009). Santelli, et al. (2006) submits that the USA government policy has indeed become a source of misinformation and censorship not only in the USA but in Africa, the Caribbean and Asia, as its emphasis on abstinence and may limit countries abilities to design prevention programmes specific to their needs. This is indeed quite true within the Kenyan context.

The USA donor policies also prohibit funding for programmes involving the homosexuals, drug users and commercial sexual workers; whereas in reality these are the riskiest groups, that are in dire need of all forms of interventions to protect other members of the society. Cultural competence should indeed drive programme research, decision-making process, implementations and evaluations and programme stakeholders should be free or cognisant of their limiting self-referencing criteria (SRC).

Cultural adaptation may only be possible via culturally driven research that can help programmers understand and working effectively with the cultural nuances of a target group. Indeed, the cultural context assessment composite model presents all programme stakeholders with a great opportunity to learn deeply the contextual and cultural aspects of their target audiences, that ideally should guide their planning, implementation, control and programme evaluations.

## **7.2 Prostitution**

Programmers in chapter six point to the fact that childhood prostitution is common especially in Coast due to poverty and tourism and is sometimes encouraged by parents that send out young girls in search for a livelihood. Prostitution by adults is also a challenge to programmers as most commercial sex workers believe that they can do whatever they like with their bodies regardless of the risks they expose themselves to.

Sex tourism along Lake Victoria and Indian Ocean are HIV/AIDs risk factors. Sex tourism promotes underage, adults, male and female prostitution and indeed it is a huge challenge to programmers especially in the Coastal region. Herold and Kerkwijk (1992) suggest that tourists travelling internationally lower their inhibitions and take greater risk than they would in their home countries, due to factors related to loneliness, boredom and a sense of freedom, while others travel internationally in search of sexual gratification consciously or subconsciously. Countries such as Thailand, Philippines, Brazil, Dominican Republic and Kenya are popular destinations for tourists seeking sex as well as Netherlands and Eastern European countries.

Mass tourism is a major factor in international transmission of HIV virus. This is mainly due to the casual sexual relationships between tourists and residents of the host countries, casual sex between tourists as well as the use of sex workers in the tourists' destination countries.

Kenya's tourism industry is heavily oriented towards the Coastal region. Peak seasons are November and March and off-peak are April and July, with the mid season being August and October. This seasonality means that jobs in hotel industries are mainly seasonal and attract both Coastal and migrant workers from other parts of Kenya, especially the business minded entrepreneurial Kikuyus and those tribes that like living in cities like the Luos and Luhya tribal members. The seasonality of jobs also mean that many men and women result in small time entrepreneurship such as selling curios while others result to commercial sex work pushed by poverty. Many parents send their young children out to beg from tourists and eventually they get into commercial sex work (CSW) with girls as young as thirteen being involved and later graduating to full time CSWs as they grow to be adults (Cohen, 1993).

Kibicho (2005) distinguishes between various drivers of prostitution in Kenya. Firstly, poverty related prostitution and many of these CSWs would be willing to leave the trade should they find better prospects or jobs in life. Secondly tourism services related prostitution is driven by the sheer need to serve tourists. This group is never motivated to look for alternative career to fend for themselves. Thirdly pleasure-seeking prostitution that is mainly practised by well-educated individuals, mainly motivated not by cash but by erotic fantasies such as adventure with foreigners. Other drivers of prostitution include children seeking motives especially the need to get beautiful and handsome mixed race children with white tourists and prestige in being involved with whites instead of black partners based on the colonial mentality (Kibicho, 2005).

The law that criminalises commercial sex work in Kenya is ambiguous as it criminalises the earning not the acts or perpetrators themselves (Sindiga, 1999). Kenyan police usually harass the CSWs because loitering or vagrancy and not really on prostitution and usually the male patrons are never harassed. United nations call for decriminalisation of punitive laws against prostitution worldwide and the need to recognise prostitution by countries; for easier regulation and on the basis of the need to reach the most in need and most affected by the HIV/AIDS pandemic (UNDP, 2012).

Controversially, perhaps social marketers in upstream social marketing should push for the legalising of this oldest profession in the history of mankind and learn from states such as Nevada in the USA. Nevada has put protective laws in counties where prostitution is legalised. These laws included issues such as: all prostitutes should be above 18 years old, all prostitutes working in brothels should register with the county sheriffs for permits, they should have regular medical check-ups such as weekly check-ups for gonorrhoea and Chlamydia and monthly blood check-ups for syphilis and HIV, mandatory use of condoms for all forms of sexual acts by patrons and brothel owners are liable should their clients contract HIV or other STIs (Prostitution.procon.org, 2013). Such regulations would serve to protect the commercial sex workers, children, patrons and probably bring some order in this lucrative industry in Kenya.

### **7.2.1 Fishing communities**

Programmers, in chapter 6.2, point to prostitution in relation to the fishing communities and say that transactional sex for fish by fishermen with female fish mongers present a real risk pertaining to HIV/AIDS.

In relation to fishing as a risky occupation, Kissling, et al. (2005) in their cross-country analysis of the prevalence of HIV/AIDs among the fisher folk, suggest that the fisher folk are among the most at risk groups to HIV. They attribute the high risk, firstly, to the nature and dynamics of the fish trade and fishing lifestyle related to factors such as the age group involved as they are mainly between 15 and 35 years and most susceptible to STIs as they are sexually active. Secondly, many fish folks are mobile and their migratory structure does not constrain their sexual behaviour to

the home context. Thirdly, fishing is a high-risk occupation that may lead to a display of bravado and risk taking in the social and sexual area.

Fourthly, fishing folks are often socially marginalised and have low status that may lead to exaggerated forms of masculinity that may include expectations of multiple sexual partners. Fifthly, alcohol abuse is widespread among fisher folks to help cope with the stresses of their occupation further compounding their vulnerability to HIV and sixthly, inadequate prevention, treatment and mitigation measures compounded by limited access to sexual health services. Certainly, social marketers need to do more to mitigate HIV/AIDS among the fisher folk in Kenya along the Lake Victoria and Indian Ocean.

### **7.3 Illicit brews and Branded Alcohol**

In theme 6.3 in the previous chapter, programmers point to the problem of local brews served in numerous occasions and abused by local residents in the guise of leisure time. They also note that chiefs and local administrators are amenable to bribes and thereby turn a blind eye on the brewers. They further point out that branded alcohol is promoted in the local media while it also presents the risk of casual sex.

Leisure relates to experiences most likely to occur during an engagement that is freely chosen for the intrinsic satisfaction inherent in participating in an activity (Rossman and Schlatter, 2000). It can, however, be argued that extrinsic motivation or a combination of both intrinsic and extrinsic motivations can lead to choices of activities engaged in during this unobligated time as suggested by Neulinger (1981). Kelly (1996) points to the emancipatory actions undertaken during leisure time, distinguishing them from the routine and obligatory activities individuals undertake. Edginton, Hudson and Scholl Kathleen G., (2005) suggests a holistic view on leisure and argues that work and leisure cannot be separated, as they are interrelated. Critical to leisure, though, are the activities undertaken during leisure time as part of recreation that may be either positive or negative and that may impact an individual's health and HIV/AIDS infection or management.

Branded alcohol is costlier as compared to local brews. Alcohol seems to be mandatory in cultural festivities such as circumcisions, harvests, births, marriages, funerals, bull fighting, village discos and in disco - matangas (funeral discos). Excess alcohol consumption may inhibit the choices, individuals make, leading to a higher likelihood of indulging in irresponsible and unprotected sex, a key risk factor in relation to HIV/AIDs. Pubs, bars and alcohol joints in Kenya are mainly associated with prostitution and many sex workers indeed patronise such joints for easier access to clients.

Alcohol use leads to dis-inhibition through its overall psycho depression actions on the brain (Valenzuela, 1997), leading to a false sense of excitement, bravely and increased libido that may lead to unprotected sexual behaviour. Branded legal alcohol is quite expensive in Kenya and due to poverty, many individuals prefer to drink the cheap illegal alcohol (*changaa*). Unfortunately, these illicit brews are mainly prepared illegally and under unhygienic conditions, sometimes with potentially harmful ingredients such as industrial alcohol methanol, dead bodies embalming chemicals such as formaldehyde and ethanol, ARVs among other chemicals, all meant to make local brews potent.

In 2010, in the slums of Nairobi, '*changaa*'-(local brew) containing alcohol methanol led to many hospital admissions, 23 deaths and 10 men went blind (BBC News Africa, 2010). On 6<sup>th</sup> May 2014, 61 individuals from Eastern province areas of Embu, Kitui, Makueni and Central province areas of Muranga and Kiambu died after consuming contaminated illicit brews (Nyawira, 2014). Addictions to these illegal brews have caused much suffering and ills related to sexual abuses, domestic violence, disintegration of families, loss of jobs and income, destitution and hopelessness as individuals drink themselves to extreme poverty and deaths.

The PLWAS that abuse alcohol risk increased liver toxicity when alcohol interacts with anti-retroviral drugs. They also risk non-adherence to their medication and high probability of re-infection due to higher chances of engaging in casual unprotected sex.

Othieno, et al. (2012) suggests reasons why PLWAs engage in alcohol abuse that range from; stigma, the need to gain confidence and find social acceptance among drunk peers, a coping mechanism to deal with their psychological problems related to denial, hopelessness and worse of all revenge and guilt as they indiscriminately spread the virus. There is also a wrong perception that the brews have medicinal value and that *changaa* is strong enough to kill the HIV virus.

Generally, alcohol abuse in Kenya is high (Willis, 2002). Roadside testing for drivers and higher prices could be effective measures to control drink driving and its related hazards. However, Chisolm, et al. (2004) argues that taxation could be counter effective in Kenya, as making branded legal alcohol more expensive would push many individuals to the cheaper and potentially harmful illegal alcohol pushing their demand and supply up. Unfortunately, in spite of so many individuals abusing alcohol in Kenya, there are a few services for detoxification and rehabilitation. Papa, et al. (2011) suggests that cognitive behavioural therapy (CBT) could be effective in treating alcohol related problems, although its use is not widespread. It indeed blends well with the orature learning method prevalent in all Kenyan tribal groups. Perhaps, this is another avenue, social marketers could explore to invest and use in their downstream social marketing interventions targeting harmful alcohol use.

### **7.3.1 Drugs use and substance abuse**

Programmers in 6.3, point to the fact that drug abuse is rampant in cities like Coast, Nairobi and Kisumu with common drugs mentioned as heroin, cocaine, bhang/marijuana and in the North Eastern and Eastern province 'khat'.

Drug users are generally at a greater risk of HIV infection than the general population (Holmberg, 1996 and Centre for Disease Control and Prevention- CDC, 2009). Beckerleg (2004) suggests that in Malindi, in Coast province, heroin use associated with drugs and sex trafficking, is common with European tourists.

Reid (2009) suggests that injecting drug use is more common among males in Kenya compared to women. It is, however, also common among female sex workers. Relevant to HIV/AIDs is the fact that sharing of needles and syringes, a popular practice among drug users, is a significant risk factor to acquiring and spreading of the HIV virus. This is because a significant amount of viable HIV viruses can survive for more than two hours outside the human body, whether on sharp surfaces exposed to air or surfaces within used needles and syringes (Tjotta, et al., 1991).

Another common and dangerous practice is blood flushing, where drug addicts share their blood with fellow users that cannot afford drugs (Williams, et al. 2007). This practice directly introduces the virus into the blood stream of the uninfected individual. Should any of the parties be HIV positive, this increases the risk of infection or re-infections. Injection drug use is associated with inhibitions that make individuals engage in risky sexual behaviour, compounded with the risk of acquiring other blood related pathogens such as hepatitis B and C apart from the HIV virus. Selling syringes and needles to a drug user is illegal in Kenya and consequently, many share a lot of equipment. Others use and reuse them even when rusted or when needles are bent. Disposal is also a big problem as some throw them outside through their windows or leave them carelessly endangering other individuals' especially innocent children (Beckerleg, Telfer and Hundt, 2005).

Unfortunately, access to drug addiction rehabilitation services in Kenya is difficult. There are a few privately-owned facilities serving only those who can pay for the care, leaving out the majority of the poor who cannot afford. The drug issue is a hot political bed that may need the international society as well as a clean government to deal with. Programmers, may indeed, find themselves in precarious situations with politicians in upstream social marketing in relation to drug issues; however, there is need for them to condemn drug barons.

Miraa (Khat) chewing is considered a mild drug. It is mainly grown in the Meru Eastern province region and it is a major export and source of income for the farmers. The Somali, Ethiopians, Arabs and other Muslims around the world mainly consume it. Miraa (khat) has been banned in the USA and European Union. The advisory committee on drug misuse advised Teresa May of England that the low harms associated with khat cannot justify its criminalisation. They, further, claimed that the



ban could criminalise as many as 90,000 members of the British Somali, Yemeni and Ethiopian communities that use it as part of their social lives in England. Teresa May (Home Secretary in 2013) asserted that failure to take decisive action and change UK's position on khat, would place it at a serious risk of becoming a single regional hub for the illegal onward trafficking to northern Europe (Travis, 2013).

Khat contains cathinone, a psychoactive chemical known to affect the nervous system; although, it is also rich in ascorbic acid (Graziani, et al., 2008). Basker (2013) discusses some of the effects of abusing khat such as gastrointestinal problems related to constipations, gastritis, duodenal ulcers, loss of appetite due to tannins and other harmful chemicals contained. It may also lead to dental problems due to plaque accumulation and oral cancers.

Khat is also related to psychiatric disorders such as lethargy, aggressive behaviour, hopelessness, insomnia, hypomania and psychosis (Pantelis, Hindler and Taylor, 1989). It also causes liver injury, urine retention, ophthalmological problems, diminished sexual performance, lowered libido, reduced semen volume, sperm malformation, impotence and low birth weights for the babies born by women that abuse khat. (Mossie and Mekkonen, 2002). However, on a positive note, they suggest that it leads to elevated diastolic blood pressure leading to increased alertness, energy, imaginativeness and communication abilities, explaining why many individuals choose to indulge in khat, especially long distance drivers, students and those that work during night hours.

Khat is significant to HIV/AIDs as some varieties may lead to diminished sexual performance and lowered libido. This may lead to family breakups that may push individuals to seek sexual gratification elsewhere, increasing their risks of acquiring the HIV virus. Elmis (1983) suggests that 60% of Somali and Djibouti men that are impotent have histories of consuming khat. Conversely, some varieties of khat also are known to enhance sexual arousal (Basker, 2013), again leading to family breakups and use of prostitutes that are a high HIV/AIDs risk group. Consumers of khat spend most of the day and night chewing khat severely affecting resting, working hours and family incomes. Indeed, social marketers need to educate the publics on the harms caused by khat.

#### **7.4 Secrecy surrounding sexuality and sex education**

Programmers in the previous chapter theme 6.4, point that words related to sex and sexuality are challenging to use, as the whole issue of sexuality is shrouded in secrecy and that people are generally not open to engaging in such discussions. They mainly prefer to use coded language on these matters. They further cite that due to secrecy and taboos around sexuality, HIV infected individuals find it difficult to disclose their status. This may be explained by the association of HIV to immorality and the stigma attached to the infection.

On the issue of teaching and discussing sexuality with children and teenagers, many parents in Kenya rarely provide their teenagers with sex education mainly due to the taboo surrounding sex education, as culturally it was meant to be the responsibility of the extended family mainly grandparents (Kayongo-Male and Onyango, 1984). In 1999, the Government of Kenya through the ministry of education developed a HIV/AIDs curriculum for use in primary and secondary schools. The curriculum, however, only covers the bio medical aspects of HIV transmission, prevention and care and is integrated into other subjects such as geography, history, ethics, science and Religious Education at the primary school level, and only infused within Biology at the secondary school level.

At the crucial secondary school level, biology is not a compulsory subject in most schools, meaning that many youths are not reached by AIDS curriculum. Njue, et al. (2009) argues that the curriculum is mainly factual, teaching morals and abstinence while not focussing on sex, sexuality, reproductive organs and contraceptives including condom use. It does not equip students with skills to implement behavioural self-protection nor does it address the social, sexual, gender or maturity issues that should be relevant to HIV/AIDs. They further argue that there is no adequate time given to HIV lessons due to the crowded work schedules and HIV is mainly discussed in extra curriculum activities, while others schools use medical professionals and other external agents to discuss HIV matters and attendance to these forums is usually not compulsory.

Parents and religious leaders in Kenya further argue that sex education increases immorality, however the truth is that many youths are already sexually active and the best that can be done, is to equip them with factual information so that they can

protect themselves and their networks. Results from studies in both developing and developed countries show that comprehensive sex education programmes delay the onset of sexual activities and reduce the number of sexual partners and serve to increase contraceptive use especially the condoms (Kirby, 2002; Gallant and Maticka-Tyndale, 2004).

Social marketers need to lobby the government on a more comprehensive sex education curriculum. Certainly school based HIV/AIDs education has the potential to reach almost every child and this potential should not be underutilised especially within the Kenyan context.

### **7.5 Illiteracy**

Programmers in chapter 6.5 cite that illiteracy poses many challenges to their programme work. They assert that they are forced to use native languages in their work and this presents translation problems, as some English words are difficult to translate. Illiteracy also limits informed choices their target audiences can make. It also forces programmers to monitor ARV adherence, as many audiences cannot follow simple instructions. They also mention the positive relationship among illiteracy, ignorance, myths, culture and religion, as they claim that many illiterate audiences are ignorant of HIV/AIDS related information, believe in myths and adhere strongly to culture and religion. They claim that girls' illiteracy is also fuelled by menarche and lack of sanitary towels, forcing girls to miss classes during their monthly flows, while boys' illiteracy rate is fuelled by child labour, as boys are forced to work after circumcision. They also note that generally illiteracy rates are worse in rural areas compared to urban areas and worse in North Eastern province, a highly marginalised area in Kenya.

The education theme seems to be a key driver of other issues and themes such as communication, information uptake, myths, ignorance, informed choices, uptake of ARVs, technology, development initiatives and participation and seem to obviously drive poverty, that is behind a myriad of other HIV/AIDS related risk factors.

Primary school education was never free in Kenya and only became free under the leadership of President Kibaki in 2003. This may explain the high adult illiteracy levels cited by programmers and high poverty level especially among the women, as

many parents prefer investing in the boy child and marrying off the girl child. Fortson, (2008) asserts that HIV/AIDS prevalence is spatially correlated with socioeconomic factors like female literacy rate and poverty. Free primary education however, well intended, has brought many challenges such as lack of trained personnel, IT skills and learning resources, and class overcrowding, learning under trees due to lack of classrooms, high student to teacher ratio among other problems that the current government has not dealt with yet. Much as free primary education is a step forward in fighting illiteracy, secondary education is not yet free.

The secondary education fee is usually beyond the affordability of many Kenyan families that live below the poverty line. Secondary education is part of the formative years of young Kenyans and therefore there is certainly a dire urgent need for the government to invest and introduce free secondary education to raise educational attainment levels among all Kenyan youths and adults.

Educational attainments have been associated with lower risk of HIV/AIDs (Gregson, Waddell and Chandiwana, 2001; Michelo, Sandoy and Fylkesnes, 2006). Conversely, Smith, et al. (1999) suggests that educated individuals are more likely to contract HIV due to their higher incomes and the resulting lifestyles. This has mainly been attributed to higher disposal income, increased leisure time, increased geographical mobility, access to different sexual partners and for some individuals, more access to commercial sex workers mainly due to affordability (Berkley, et al., 1989; Dallabetta, Miotti and Chipangwi, 1993; Quigley, Munguti and Grosskurth, 1997).

Gregson, Waddell and Chandiwana, (2001) suggest that after HIV infection, the educated are better able to protect themselves and change behaviour, reducing their chances of re-infection and spreading of the virus. This is because education affects knowledge, communication skills, attitudes regarding male dominance and gender roles, spousal characteristics and choices that all ultimately impact decisions taken in relation to sexual behaviour (Admczyk and Greif, 2011).

Education helps increase the human capital of women (Becker, 1993) and gives them access to financial resources thereby reducing their chances or need for transactional sex (Zulu, Dadoo and Ezech, 2003). However, the relationship between education attainments and sexual behaviour is complex as it boils down to personal choices that are difficult to predict with precision as individuals may be influenced by many cultural, personal and societal factors.

Overall evidence suggest that educated individuals are at a greater risk of HIV infection in the early stages of an epidemic but they tend to adopt less risky sexual behaviours and possibly a healthier seeking lifestyle in response to the epidemic (Blanc, 2000; Chesney, 2000). The suggested high correlation of HIV risk with higher education attainments, may suggest that cultural beliefs, attitudes and values contribute more to HIV/AIDs risk evaluation rather than intellectual and educational related evaluations.

Overall higher educational attainments are instrumental to financial freedom. Knowledge grants individuals the power and ability to understand and critically questions other related complex life issues including cultural issues. In the absence of any medical vaccine against HIV/AIDs, the only present tool is the educational vaccine (Minujin, Vandemoortele and Delamonica, 2002), however for it to be effective within the Kenyan context, the educational vaccine needs to change its content, methods and approach to empower boys, girls, men and women.

Education is a major policy issue that social marketers should be lobbying the central and county governments in as well as lobbying donors to invest more in, to at least reduce poverty.

## **7.6 Sexual and gender related violence**

Programmers in chapter 6.6 point to the challenge of sexual violence to their programme work. They claim that provocative dressing by females, easily available pornography, sexual silence culture, myths, early marriages and poverty all drive sexual related violence. Victims are usually blamed and perpetrators protected or never punished due to the sexual silence prevalence in Kenya.

The boy child was traditionally and is still culturally preferred by all the Kenyan tribal groups as compared to the girl child. Kenyan tribes are patriarchal and lineage is carried along the male child (Mayer, 1972; Mwambia, 1973; Monica and Parkin, 1973). Male children, however, face several challenges. Firstly, the fact that they are more valued than girls, they are culturally socialised differently from girls and mainly not allowed to carry out feminine chores. They develop superiority complex right from childhood and view girls and women as inferior to them.

Some programmers cite that they are taught to view girls as sex objects and are mainly given a cultural licence to sex after circumcision. Some tribal groups also encourage them to engage in gender violence as a means to satisfying their sexual desires, should girls or women resist or turn down their sexual advances. There is a need for downstream marketing to encourage respect for girls and women's rights by boys and men. School based programmes and curriculum should challenge these stereotyped beliefs right from nursery school all the way to university level.

Youri (1994) in a Kenyan study of 10,000 female secondary school pupils found that 25% (2,500) of sexually active girls reported forced sex as their first sexual encounter. Kiragu and Zabin (1993) in a study on contraceptive use among high school students in Nakuru in Kenya, suggest that 10% of 2,059 males and females in 29 urban and rural schools of Nakuru in Rift Valley province reported not using a contraception method at last intercourse because they had been forced to have sex. Eruklar (2004) in a Nyeri central province study of 2,712 married and unmarried young people study showed that sexual pressure starts at an early age with 30% of girls and 20% of boys aged 13 years and below reporting one or more episodes of sexual harassment.

Sexual crime is under reported in Kenya due to the fear of shaming family members, culturally imposed sexual silence and covertly culturally allowed sexual violence. Prior to 2006, there was no concrete legal framework in Kenya that addressed sexual violence. In September 2004, a motion was tabled in a male dominated parliament by a female member of parliament Njoki Ndungu, the famous but contentious sexual offence Act (2006).

The Act was instrumental; in that, it clearly spelt out sexual violence, included offences related to gang rape, sodomy, child pornography, trafficking for sexual exploitation, criminalised deliberately infecting other individuals with HIV, allowed for DNA data base related to sexual offences and spelt out related punishments for such sexual related crimes (Kilonzo, et al., 2009).

93% male members of the parliament, however, disallowed three important issues to be included in the Act. Firstly, they refused to recognise marital rape and argued that marriage implies sexual consent and that marital rape is alien in African culture. Secondly, they rejected the inclusion of female genital mutilation (FGM) in the Act and argued that it is a culturally accepted practice and lastly rejected the use of male medical castration as a punishment for related sexual violence arguing that it is inhuman. Certainly, these issues point to gender hegemony and great interference by cultural beliefs and practices in the legal framework. It sends the wrong message especially in relation to FGM that it is acceptable and not punishable by law, greatly disadvantaging the girl child due to its inherent and related dangers and health related complications. The Act is however a step in the right direction as before, no such concrete reference to sexual violence was present within the Kenyan legal framework.

Much as sexual violence is criminal and an abuse of women's rights, it increases HIV/AIDS risk to the girl or women due to forced sex probably by an infected partner, interferes with negotiation of safer sex and treatment access and limits communication about safe sex or positive HIV status (Champion and Shain, 1998; Wingood, DiClemente and Raj, 2000; Garcia-Moreno, 2005; WHO, 2008; Dichter and Gelles, 2012). Implementation, certainly, is the bone of contention on the Sexual Offences Act 2006 in Kenya, and it is up to the programmers to encourage and promote the reporting of sexual related offences and to ensure that the law is enforced accordingly.

Many traditional societies ascribe to closed sexual scripts, characterised by sexual cultural practices founded on patriarchal beliefs. These beliefs include gender inequalities, sexual violence, multiple sexual partners among men, negative attitudes towards condom use, fatalistic attitudes and myths based on magic and supernatural explanations of both diseases and risky sexual behaviour and pressures to prove fertility (Caldwell, Caldwell and Quiggin, 1989; LeClerc-Madlala, 2002). These

closed sexual scripts certainly contribute to a high-risk environment for girls and women, as their choices and decisions on issues such as wife inheritance, child bearing and dealing with sexual violence are often mediated through a host of social and cultural norms and practices, even in the light of HIV risks.

Hatcher, et al. (2013) in their study of intimate partner violence in Kenya, had respondents suggesting that marital violence is a normal timeless tradition and is as common as medicine or prayer before going to bed. They further suggest that sexual coercion and forced sex is part of a married relationship norm. Violence is used to consolidate or reassert male sense of power and control (Miller, 2003). Turan, et al. (2011) suggests that women that anticipate male partner stigma or violence are more than twice as likely to refuse antenatal HIV testing, explaining reasons for refusal to test for HIV by many pregnant women, as they fear being beaten up or being sent packing back to their natal homes, if they disclose their positive status to their spouses.

A woman may place more value in securing food and shelter for herself and her children than on safer sex practices. This may be driven by poverty fuelled by land inheritance beliefs and values, which dictate women access to land is only via marriage or wife inheritance in patriarchal societies. Negotiating for condom use by girls and women mainly implies perceptions of immorality and may lead to outrage, violence and rejection by boys and men (Muturi, 2005). These closed gender scripts prevalent among most of the Kenyan tribal groups may explain the disparities in male and female HIV prevalence rates, with girls and women's HIV rate being four times that of boys and men (UNAIDS, 2006). There is a need for the government and social marketers to strengthen legal and social structures to deal with culturally allowed gender related violence in order to stump it out completely.

The trend is, however, changing and more women in Kenya are now abusing men. Sivakumaran (2007) suggests that male sexual violence is frequent than is often thought and is perpetrated at home, in communities, prisons, by men and women, during conflict and in times of peace, but is rarely reported due to shame, confusion, guilt, fear and stigma. Violence against men is incompatible with masculinity, particularly where men are discouraged from talking about their emotions (Stanko and Hubdel, 1993). Violence against men is obviously not an excuse and should also be



firmly dealt with. Social marketers should lobby upstream for robust structures and policies to eradicate all forms of gender related violence and put in place structures to support the vulnerable members of the society regardless of their gender, age or sexual orientation.

### **7.7 Stigma and discrimination**

Programmers in chapter 6.7 suggest that HIV/AIDs related stigma and discrimination are huge challenges that affect their programme work. Stigma permeates many areas of life such as body size, as thin individuals are associated with HIV infections, growth and maturation as girls and women on their periods are isolated and viewed as dirty and unclean during their monthly flows. Sexual related violence rarely reported due to the associated shame and stigma on the victims, while in religion, women are not allowed to participate or lead worship especially among the Muslims and Catholic due to gender related discrimination. In death, HIV/AIDS related deaths are treated with disrespect, as those infected may not be accorded a burial or a decent burial due to the related stigma.

Programmers also point out to the consequences of stigma and discrimination such as many women refusing to test for HIV simply due to gender related violence and being divorced. Stigma has also led to PLWAS refusal to take the lifesaving ARVS as they are scared of being seen going to pick them, it has also made many turn to herbal drugs to avoid dealing with judgmental health care workers and also led to self-stigma, early deaths and suicides by PLWAS.

Programmers notably point to the causes of stigma and discrimination. They suggest that religion, fuelled by the belief that HIV is a curse by God on the sexually immoral and sinful individuals, ignorance around HIV/AIDS causes and management and cultural myths and beliefs surrounding sexuality, all drive stigma.

Stigma is indeed a major challenge in relation to HIV infection. Goffman, (2014) suggests that stigma relates to an attribute that a person possesses that marks them as different from the other members in a community. He described two types of stigma, felt stigma experienced by the stigmatised person and enacted stigma that is a prejudicial reaction from other community members to the person marked as different.

Foucault, Rabinow and Faubion (1997) uses the term heterotopias or other spaces that individuals, within a community, force individuals into that may be perceived as different from themselves for whatever reason. They suggest two forms of outer spaces the heterotopias of deviance, which relates to those that do not fall within the norms of the society such as the mentally ill. Secondly, the heterotopias of crisis that relates to illnesses or other forms of crisis that befalls on societal members. HIV positive sero-status is certainly not an easy outcome to deal with and individuals suffer from both the self and enacted forms of stigma. Since stigma is a social construct, individuals from different cultures construct it differently. Kenyan context leans more on collectivism and cultural heterotopias are indeed inevitable.

The patriarchal nature of Kenyan tribal groups means that HIV positive women experience more stigma compared to the positive men. The women are labelled as prostitutes, blamed for immorality and infidelity regardless of how or who infected them, even if it is the husband or partner's fault. The society shuns many of them, others experience physical violence from their spouses, while others are thrown out of their matrimonial homes, gossiped about, stigmatised and discriminated upon, resulting in loss of livelihood and loss of status in the community, all leading to desperation, more poverty and isolation (Turan, et al. 2008; Mwaura, 2008; Kako and Dubrosky, 2013). Stigma, therefore, results in many negative outcomes related to physical, psychological and emotional ill health and unfortunately the Kenyan context lacks adequate health facilities and practitioners to help them cope (Mwaura, 2008).

Many HIV positive individuals cope by keeping their HIV status secretive, migrating to new areas away from communities that are not acquainted with them. Some fail to seek and access health facilities that could help them manage their conditions, leading to untimely and unnecessary deaths. There is, therefore, the need to look for relevant ways and strategies of dealing with HIV/AIDs related stigma at community level as well as at an individual level to help PLWAS cope.

Other contentious strategies of dealing with HIV infections may mean that Programmers perhaps need to lobby the government to ensure that clinics make the testing of pregnant mothers' compulsory and legal to reduce mother to child infections, and probably pass laws criminalising the refusal by mothers to test and treat while pregnant, at least to save the children from the HIV/AIDS burden.

Compulsory antenatal testing may bring ethical issues as mothers have the right to refuse to be tested. However, the ethics of bringing into the world HIV positive children and burdening them with the complications HIV/AIDS presents, is also an ethical dilemma that stakeholders need to consider. Indeed, policy and laws may work better to affect this kind of change rather than a voluntary approach. This would need a more coordinated approach as many mothers also give birth at home via the help of Traditional Birth Attendants (TBA). The government and social workers would need to work together to affect this change while collaborating with traditional birth attendants and other gynaecologists, medicine men and paediatricians to ensure they catch mothers and children early and put them on treatment. This approach would indeed be justified and supported by Rothschild (1999) and Donovan and Henley (2003) assertion that since humans are flawed, there may be the need for coercion to protect individuals from their destructive tendencies and to protect other vulnerable societal members.

There may also be the need to share results of positive children with concerned agencies such as schools to ensure appropriate support for them, and to ensure that good practices are followed to avoid infecting others. Certainly, this again may be contentious, as it may be perceived as enhancing stigma and discrimination. However, it is arguably necessary for support and follows up strategies. It is also contentiously critical for the medical personnel to ensure the involvement of spouses in treatment to reduce cases of re-infections however difficult this may be, given the patriarchal Kenyan context and low place of a woman in the Kenyan society.

Home based care training should be well-supported at local and national level to avoid carers getting infected, and there is an urgent need to provide protection guidelines together with resources for those that cannot afford. Grandparents have literally been overburdened with the caring role, as they look after their grown up HIV positive children together with their grandchildren. They are devoid of caring role's resources and information on how to handle the infected generations and consequently they get infected. Upstream social marketing to lobby for resources and training for home based care as well as downstream measures to ensure support and get the information gaps filled are certainly necessary.

There is also a need to educate the public more on HIV/AIDS modes of infection and management to counter the ignorance that drives stigma and discrimination and intensify counselling services for those infected together with their families to discourage stigma and encourage uptake of ARVS and HIV related management. The media may need to intensify anti HIV/AIDS stigma campaigns to normalise HIV/AIDS related infections. Religious leaders also need targeted information on HIV/AIDS as well as politicians and health workers to enable them become champions of anti HIV/AIDS related discrimination.

### **7.8 Myths and beliefs**

Programmers in theme 6.8 suggest that myths and beliefs surround all spheres of life. Myths are tales usually sacred and set in the distant past or other worlds or parts of the world, involving extra human, inhuman or heroic characters believed to be true (Bascom, 1981; Leeming, 1990). They mainly offer explanations related to cosmogony, cosmology and other social realities and phenomena encountered by a cultural group involving heroic characters. The programmers' responses to HIV/AIDS related myths denote three themes. Firstly, religious explanations revolve around; HIV is caused by transgression of social norms associated with sex and it is a punishment from God or ancestors for immorality. It is also believed to be a curse mainly caused by unfaithful wives to husbands, by witchcraft, evil spirits (*Nyawawa*) and a disease from prostitution. The second theme relates to colonial and racial oppression such as HIV is a creation of some scientist using green monkeys (sooty manyabey) and chimpanzees, that is to be used as a biological weapon to depopulate Africans as they are over populated. The third theme is related to cynicism, used to justify the denial of the existence of the HIV virus.

Religion was traditionally used to explain rare and mystical phenomenon thus explaining various religious related myths cited by programmers. The colonial masters were seen as intruders that brought untold suffering to the Kenyan people and disrupted their ways of life, thus explaining the colonial link to HIV/AIDS. Myths certainly impact the subsequent actions taken by the infected and their families as well as perceptions held on risky behaviour. Denial of the existence of the HIV/AIDS virus means that individuals continue engaging in risky behaviour without

considering the need for protection. Myths related to witchcraft and evil spirits mean that individuals seek medicine men and diviners to deal with the relevant spirits and witchcraft. The curse myths only serve to encourage cultural cleansing by witch doctors, as well as encouraging stigma and discrimination of the PLWAs and their families.

Responses given by programmers on HIV/AIDS held beliefs cluster around three main themes. Firstly, they relate to causes of HIV/AIDS such as witchcraft, unfulfilled cultural dictates, punishment by God and white man's conspiracy to finish the black man. These beliefs mainly centre on religious explanations, colonial sentiments as well as scepticism and denial just like the myths discussed above. Secondly, the beliefs relate to the management and treatment of HIV/AIDS, such as it can be cured by sex with minors, by divorcing of the infected wife, use of herbs and use of camel milk. Thirdly, certain beliefs also suggest fatalism, such as acceptance as God's will for an individual's life and it's an accident that cannot be prevented. These beliefs are significant to programmers because just like myths held, beliefs drive the subsequent actions taken by PLWAs and their families in relation to management of the virus and its related infections.

In fact, some of these beliefs drive risky behaviour such as belief in divorcing the infected wife, as this may mean that the woman and man both get into other relationship, perhaps without knowing the status of their new partners, thus increasing their risk of HIV infection or re-infections. Belief in sex with minors, incest and early marriages all increase the risk of STIs and HIV infections to minors. Acceptances of HIV as God's will for an individual's life may positively promote active engagement with ARVS to cope or negatively promote fatalism and the avoidance of ARVs in order to die as a fulfilment of punishment for sexual related sins. It is important for programmers to understand the beliefs held on to by their target audiences in order to tactfully and appropriately challenge them and guide PLWAs and their families to the right direction in relation to managing the virus. Probably, HIV/AIDS related factual information to different segments of the target audiences, particularly the older ones may help change these beliefs and myths. Educating the youth in schools may also help counter these dangerous myths and beliefs.

## **7.9 Early sexual debut**

Programmers in theme 6.9 suggest that early sexual debut is a real challenge to their HIV/AIDS related programme work. It is mainly driven by factors such as boys from 13 years and above after circumcision are expected to experiment sexually in the context of lack of information on protection and safe sex. Again many girls are also oblivious of contraception and protection methods, blamed on lack of parental guidance on their maturation and sexuality.

Early sexual debut especially for boys after ritual circumcision, practiced and allowed by all Kenyan tribal groups is a key concern. Mwambia (1973) in reference to Meru groups suggest that during circumcision related seclusion, boys were encouraged to ‘sharpen their swords’ and keep them ‘sharp’ in reference to euphemism related to engaging in sexual practices. Kettel (1973) in reference to the Kalenjins, suggests that many young men had to have sexual relations with girls before they married them and many of them ended up having many sexual relations whilst falsely promising the girls a hand in marriage. The Maasai ‘Ilmurans’ had cultural exclusive rights to ‘play’ with young girls (Talle, 2007). It is clear that the adolescent boys were covertly and overtly granted a cultural licence to premarital sex; especially, after initiation yet some tribal groups traditionally encouraged female virginity.

In the context of HIV/AIDs, early sexual debut is risky because early age of first sexual intercourse is associated with a long period of exposure to sexual activity, a higher propensity to accumulate sexual partners and increased chances of contracting sexually transmitted diseases (Dixon-Muller and Wasserheit, 1990; Konings, et al., 1994).

Many youths lack factual information on sexually transmitted infections (STIs) and lack protection, as there are no centres for reproductive health that mainly focus on the youth in Kenya. This is a major issue considering the fact that most of them are sexually active and devoid of appropriate sexual information and protective measures, leaving them at the mercy of the myths held in relation to sexuality and conception (Ahlberg, Jyklas and Krantz, 2001).

There is, certainly, a need to invest in youth reproductive health services to empower boys and girls on these crucial life matters to enable them make informed decisions that affect their lives. Nzioka (2001) suggests that much as adolescent boys are aware of the societal notion that premarital sex is immature and immoral, many of them continue to engage in it. He points to the need to recognise that young people have their sexual needs and rights, hence the need for private and confidential sources of advice, contraception, condom supply, counselling and referral facilities that assures them of confidentiality and anonymity. This echoes many of the responses given by programmers in this study. Njoroge, et al. (2010) suggests the need for female condoms to empower teenage women and to provide them with comprehensive reproductive health infrastructure suited to their needs.

### **7.9.1 Childhood marriages**

Programmers in theme 6.9 also suggests that early marriages are a challenge to their programme work. The girl child culturally faces many challenges in Kenya. Programmers cite that among some tribes, a girl is viewed as an object that will bring good fortune to the family in the form of dowry; some are mainly married off after circumcision at around 10 years to old polygamous men and rarely sent to school. Huntingford (1973) citing the Kalenjins of Kenya, explains that childhood marriages were common, where young girls without breasts were given off to old men, in exchange for cattle that was used to pay off the bride price for their brothers' wives. Older wives looked after the young girls until they got circumcised in order to begin sexual relations with the aged husbands.

Cultural practices such as early forced marriages thwart educational opportunities for girls, impacting on their economic dependence and dangerously expose young girls to cross-generational risky sexual behaviour (Sobo, 1995). Much as childhood marriages are outlawed in Kenya, the practice is rampant among tribes such as the Maasais and Samburus of the Rift Valley. Social marketers and the government need to do more to save the girl child and the education sector needs to be more accessible to both girls and boys via free primary and secondary education to provide opportunities for both gender, so that parents do not have to choose between educating boys or girls.

## 7.10 FGM

Programmers in 6.10 suggest that FGM is a challenge to their HIV/AIDS targeted programmes. Female genital mutilation (FGM) is covertly and overtly practised by many Kenyan tribal groups. In Northern Kenya, programmers cite that FGM is a must among the Somalis of Kenya. It is also rampant among the Maasai and Samburu groups in spite of a clear law outlawing the practice in Kenya. FGM was culturally meant to tame a girl's libido, accentuate virginity before marriage and as part of rite of passage to adulthood (Lewis, 1972; Mwambia, 1973; Talle, 2007). However, different groups subscribe to different types of FGM with some groups such as the Luos culturally, only practicing body tattooing to evidence menarche, while others practise the most severe forms of genital mutilations such as the Somali's of Kenya that involves the partial or total removal of the clitoris, labia minora and labia majora, leaving less than one centimetre orifice for passage of urine and menstrual blood (McCaffrey, 1995 and Johansen, 2002).

FGM carries a hoard of challenges that include infections, as circumcisers use rusty knives or broken piece of glasses, discomforts and pain, loss of blood, loss of sexual drive, complications while giving births and sometimes leads to deaths due to related infections and bleeding (Dirie and Lindmark, 1991; Almroth, 2000). Hardy (1987) and Brady (1999) argue that female genital cutting also may increase a woman's risk of HIV infection by elevating her risk of physical trauma during sexual encounter. More severely cut women may experience greater trauma during coitus which may cause injuries to and the alterations in the vaginal surface that enhance transmission of the HIV virus.

In a study in Egypt and Sudan, men expressed preferences for sex with uncut (uncircumcised) women and reported experiencing discomfort when having sex with cut (circumcised) women (Wassef and Mansour, 1999; Almoroth, et al., 2001). Thus normative expectations to marry a cut woman may make men marry cut women, however they may have uncut extramarital partners for their pleasure, a factor that elevates their own risk and that of their wives of acquiring HIV infection (Kapiga, et al., 1994).



Men may also avoid using condoms with cut women if condoms heighten their discomfort or if men associate female genital cutting with virginity, either way increasing their risk of exposure to the HIV virus to themselves and their sexual networks.

Thuy, et al. (1998) conversely suggests that more severe female genital cutting like infibulation may reduce the frequency of sexual intercourse by the woman, thereby reducing their exposure to the HIV virus. This suggestion may be arguably controversial as the main reason why these infibulated women avoid sexual relations is largely due to the pain associated with the tearing of their culturally inflicted scars, pushing their spouses away from them to other uncut women. Social marketers need to do more to protect young girls from FGM and enforce the law that protects them from such body harm.

#### **7.10.1 Male circumcision**

Most Kenyan tribal groups practise circumcision apart from the Luos and Turkhanas. Male circumcision may present a risk factor to HIV especially when carried out in unhygienic and unsterile conditions. Sharing of circumcision knives was a practice that was traditionally meant to instil brotherhood among initiates of the same age set. The use of sterile equipment for circumcision is certainly important and the need to avoid sharing of any objects that can transfer blood from one person to another, to avoid HIV and other blood related pathogen contamination risk (Brewer, Potterat and Brody, 2007).

Epidemiological studies have reported a strong association between lack of male circumcision and risk of HIV infection (Moses, et al., 1990; De Vicenzi and Merten, 1994; Weiss, et al., 2000). In an interesting study done by Bailey, et al. (2002) on circumcision among the Luos, they suggested that the high HIV prevalence among the uncircumcised men is mainly related to the fact that the penile foreskin is considered susceptible to physical scratches, abrasions, cracking and tearing during intercourse, resulting in tearing at its base. This fraenulum trauma provides an entry portal for germs, sexually transmitted diseases (STDs) as well as HIV infection. Besides, the foreskin is also perceived as a harbour for dirt, germs and viruses making penile hygiene difficult and consequently resulting in the ease of spread of sexually transmitted infections (Patterson, et al., 2002).

Despite the acknowledgement of the preventative and curative benefits associated with male circumcision, many individuals still prefer not to undergo the cut. Interesting reasons that have been suggested in support of not getting circumcised includes; fear of pain especially when it is done to a fully grown adult male, fear of infections related to circumcision, lowered sexual pleasure due to the loss of the foreskin, stigma by other in-group members, costs associated with circumcision, loss of penile size and an increase in sexual libido (Bailey, et al., 2002). For the communities that do not traditionally practise male circumcision, upstream and downstream social marketing is necessary to encourage voluntary male circumcision (VMC).

### **7.11 Extra marital sexual affairs and Polygamy**

Programmers in 6.11 suggest that extra marital sex presents one of the greatest challenges to their programme work as it is the predominant mode of spreading HIV and STI related infections, as many individuals do not bother to know the status of their partners or to use protection. It is driven by factors such as: it is treated as a normal and culturally ingrained practice, rural urban migration with separation of families and spouses, poverty in search of cash for basic and vital resources, boredom in marriage, search for children or male child among others issues cited by programmers. The problem is that most unfaithful spouses get back to their wives and refuse to use any form of protection.

French (1996) suggests that generally there is a very low use of condom protection among married people, greatly exposing the involved individuals to the risk of HIV/AIDs. This is mainly due to the general association of the condom use with extra marital sexual activities, especially with commercial sex workers, meaning that suggestion of condom usage within the marital set up leads to conflicts and a sense of mistrust (Knodel and Pramulratana, 1996). Many Kenyan men that sire children outside their marriages generally do not take responsibility over their off springs, further contributing to single mother families, further compounding poverty and its related challenges such as prostitution, engaging in illicit brewing businesses among other vices.

Polygamy is a culturally ingrained practice among many Kenyan tribal groups driven by several aspects suggested by programmers in 6.11 such as search for children in cases of sterility, search for a boy child, perceptions of true masculinity wealth and strength; as monogamy is equated to poverty. It is also encouraged by wife inheritance as a cultural practice meant to take care of the widowed women.

Wife inheritance done openly or secretly in most tribal societies is significant to HIV/AIDs. It exposes the inherited wife to the HIV virus that the inheritor might have contracted from other sexual networks, and also exposes the male inheritor to the virus as the deceased spouse probably may have died from an HIV related complications (Caldwell, Caldwell and Quiggin, 1989).

Consistent and correct use of protection may be the only hope and way forward in the fight against HIV/AIDS in Kenya, especially among the sexually active adults. Programmers need to do more to empower women by availing female condoms and other ingenious forms of prevention to reduce their HIV/AIDS and STI burden within the patriarchal societies that normalise; trial marriages, extramarital affairs, wife inheritance, polygamy, sexual violence as well as sexual silence. Campaigns on correct and consistent use of condoms, HIV testing as well as ARV treatment counselling should be intensified as these may be the only way of helping individuals in these complex and diverse sexual networks found in Kenya.

#### **7.12 Taboos- rape, incest and homosexuality**

Theme 6.12 is on taboos. Programmers cite that many tribal groups in Kenya regard discussions on sexual matters in public as taboos. This perception explains the secrecy and the silence culture surrounding sexuality in Kenya and further explains why an HIV/AIDs diagnosis is regarded as a taboo in itself by some individuals, as it is associated with transgression of strongly held moral code associated with the sexual norms. Unnatural sexual practices such as homosexuality, incest, bisexuality and bestiality are all tabooed and violations of any form culturally attracted hefty fines, penalties, being ostracised and at times resulted in punishment in the form of death sentence. This cultural trend is reflected in the Kenyan laws that criminalise such acts.

Programmers however suggest that incest, although tabooed is common but hidden and rarely reported for the fear of ‘shaming’ the concerned families. Rape is also common but rarely reported under sexual violence as some tribes covertly accept it as a cultural norm. Rape is, however, tabooed in various contexts such as raping a close relative like mother, sister, auntie or a child, although surprisingly within marriage it is presumed that it never occurs.

In many cases, rape victims are blamed and victimised. They are blamed for refusing marriage proposals, turning down sexual advances, looking or staring at perpetrators suggestively and dressing inappropriately among other flimsy reasons, and consequently many of the perpetrators go unpunished. In the Northern Eastern part, inter clan conflicts result in revenge rapes that also mainly go unreported. Minors’ rape cases are also common due to the false belief that sex with a minor or a virgin can cleanse and cure a PLWA from the HIV virus.

An issue of dire concern though is the issue of homosexuality. Some programmers seem to deny its existence in the false belief that it is a Western practice and not an African one. Other programmers falsely deny its existence, yet programmers targeting the LGBTI groups acknowledge the existence of a high population of lesbians, gays, bisexuals, transgender and intersexual (LGBTI) among most Kenyan tribal groups.

Homosexuality poses a high HIV/AIDS risk as firstly, many of the homosexuals prescribe to the social norms and marry among the general population, while still practising homosexuality with their same sex networks as acknowledged by the LGBTIs programmers. This indeed poses a serious risk to the married women that may or may not be faithful to their husbands, greatly increasing the sexual networks and spreading of the HIV/AIDS virus.

The fact that this group is also marginalised and outlawed makes them operate secretively; meaning that involving them in any prevention or management programmes is difficult. There seems to be a false belief also surrounding homosexuality, whereby some of the individuals believe that as long as they are homosexuals, they cannot contract HIV/AIDS. Scientifically, the large mucosal anal membrane makes homosexuals extremely vulnerable due to the direct and high absorption rate of any viral loads into the blood stream with anal sexual encounters.

Homosexuals in Kenya face a lot of stigma and discrimination. This is mainly due to the traditional family values that taboo the practice. Culturally they are stereotyped as evil and abnormal humans only fit to die. Cultural gender norms dictate that sex should be strictly heterosexual. Religious influences suggest that homosexuality is a sin that greatly angers God and an insult to ancestors based on African religions. Cultural and religious viewpoints all contribute to the deeply ingrained hatred, stigma and discrimination meted on LGBTIs (Okal, et al., 2009).

The general denial of the existence of homosexuality in Kenya has discouraged research, for fear of ridicule or questioning of researchers' sexual orientation (Tapsoba, et al., 2004). In most African countries with an exception of South Africa, same sex sexual behaviour is criminalised. Section 162-165 of Kenya penal code regards carnal knowledge of a person against the order of nature as unnatural offence, punishable by up to fourteen years in prison (Penal Code 2009, Cap 162, Kenyan Constitution). This discriminatory law has served to legitimise country wide homophobia and catalogues of human rights abuses against the LGBTIs, that include; verbal and physical assault, sexual violence, social marginalisation, extortion and harassment by corrupt police officers. Others include threats of imprisonment if bribes are not paid to law enforcers, families ostracising them, forced psychological and physical therapy to 'cure' them especially seen in raping of lesbians by men purporting to 'cure' them of their mental illness. Job dismissal, expulsion from schools for teenagers and stigma from health officers denying them access to medical care are also common unfair practices.

Research on homosexuality by Kiama (1999); Sharma, et al. (2008); Kenya Human Rights Commission –KHRC, (2011) and Geibel, et al. (2012) highlight various issues in relation to homosexuality in Kenya. They suggest that homosexuality is common among various demographic groups of Kenya; especially, the adolescents and young people, male sex workers are a sizeable population at the risk of HIV because they usually have multiple male partners, many of them also have female partners and some of them have female spouses and families. Majority of male sex workers' partners are Kenyans not white tourists as wrongly assumed, and many of LGBTIs' first experiences were during adolescence, while many are driven to commercial sex work by poverty. Many perceive anal sex as less risky compared to vaginal sex in relation to HIV, consequently engaging in unprotected anal sex. Condom use is also

not common unless clients request for them. Many gay men and commercial sex worker use petroleum jelly as lubricants resulting in condom tears, instead of water based lubricant and many experience lots of victimisation of physical and sexual violence from their clients just as normal CSWs.

There is certainly an urgent need for social marketers to engage with these groups firstly at downstream level using behavioural interventions that may involve: counselling, linking clients to services and media campaigns and condom education (Johnson, et al., 2008). There is a need for more use of in-stream social marketing interventions targeting the LGBTI group using biomedical interventions such as: male circumcision, rectal micro biocides and use of pre exposure prophylaxis (Padin, et al., 2008). Upstream social marketing level is also critical via structural interventions by addressing social, cultural economic and political factors impacting on HIV transmission (Altman, 2005). Support for human rights, help with health systems for men that have sex with men (MSM) and public health legislation are also crucial as well as decriminalising homosexuality (Sumartojo, 2000). Human rights violation against this group of people is inhuman and should not be tolerated, however when the law decriminalises their existence, it makes it hard to legally punish the perpetrators, as they perceive themselves as enforcing the unjust law.

Communication via well-trained peer educators, health providers specifically trained to deal with anal related STIs, counselling and treatment specifically targeting the LGBTs may all be urgently very necessary too (Giebel, et al., 2012).

### **7.13 HIV/AIDS related treatment and religion**

Healthcare systems may be viewed as consisting of the folk, popular and professional health care systems (Kleinman, 1980). It is important to discuss each one of them within the Kenyan context.

#### **7.13.1 Folk health care system**

Programmers in theme 6.13 suggest several challenges in relation to HIV/AIDS related treatment. The first challenges relate to herbal medicines. They suggest that herbal medications are the first point of call for many PLWAs before they get seriously ill and turn to modern medicines. Many herbalists market herbal medicines

as a 'cure' for HIV virus while in principle no cure exist. The second challenge relates to faith healing where PLWAS turn to prayers and refuse to take their ARVS falsely believing that they are cured of the virus. This is, indeed, a common practice among many churches, while traditionalist refuse to take their loved ones to hospitals due to their strong belief in herbal medicines.

Folk/traditional health care system involves the use of faith healing, alternative medicine and within the Kenyan systems this would also include the witchdoctors that all presents challenges to programmers. Faith healing in Kenya is also a controversial area. Many PLWAs believe in miracle healing and refuse to take their ARVS and eventually succumb to opportunistic infections. Father Antony of the Vincentian Catholic congregation is the director of Vincentian house in Nairobi where many Kenyans flock for faith healing. Many share testimonies of being healed of HIV/AIDS, Tuberculosis and other chronic conditions. When asked why only few but not all claim to be healed, he suggests that the Lord chooses whom to heal and when to heal them. He further suggests that the Lord heals especially those that come to him in full faith and have forgiven their enemies, as they are ready to receive inner healing and physical healing (Mwaura, 2010).

Tele-evangelists parade HIV/AIDs or cancer patients on Kenyan televisions to show how frail they look and later on showcase the same individuals as having gained weight, claiming that they have been cured of their terminal diseases and conditions. These revelations are certainly meant to send shockwaves in the congregation and viewers at home. However, many allegations still exist such as individuals being paid to stage manage these testimonies, in order to entice more followers to the churches and increase the watching ratings of their television programmes, while pastors and evangelists demand offerings and tithes as forms of payments for faith healing (Kiberenge, 2009).

From a psychiatrist's point of view, Atwoli (2013) suggests that most faith-based cures are practically unverifiable, as they concern illnesses for which objective evidence is difficult to obtain or rather involve symptoms that relate to hundreds of different largely benign conditions. He asserts that most patients that benefit from faith healing and alternative medicine suffer from psychological afflictions, whose

treatment even in the conventional settings involves psychotherapies that help patients deal with their problems using more adaptive means. He asserts that it is wrong to generalise the same healing to individuals with conditions that cannot be managed via psychotherapy, especially terminal conditions and HIV/AIDS. He challenges faith healers and herbalists to submit their cure claims to peer reviewed publications for validation and publication as currently there is no current spiritual, herbal or conventional cure for HIV/AIDs; rather than threatening doubting Thomas's with fire and brimstone on judgment day.

Atwoli (2012) suggests that when lives are at risk, it is crucial to question faith and herbal healing claims, as conmen hide behind religion and traditions to peddle dangerous ideas that result in death and disabilities of people. He further submits that the Kenya Medical Practice and Dentist Board (KMP&B) need to regulate all those that purport to practise all forms of medicine or that interfere with the working of conventional medication.

Herbal/traditional/alternative medicine is usually the first line of treatment for many communities and especially in the rural Kenya. It is the only form of health care they can afford and access with an estimate of over 80% Kenyans using this line of health care as suggested by Mathu-Senior researcher Kemri (Gemson, 2013). Indeed, traditional healers have made a positive contribution to health care especially in many herbal remedies and psychosomatic disorders (Lambo, 1974; Basch, 1990). It is estimated that 80% or more of the world's rural population relies mainly on traditional medicines for health care needs (Bannerman, Burton and Chien, 1983), as many of the western trained doctors in Africa prefer living in cities, leaving the rural folks to rely on traditional practitioners for their health care needs (Oyebola, 1986).

Many Kenyans turn to alternative medicine because health care services are expensive, with private and public hospitals charging high fees and detaining patients due to unpaid bills. PLWAs in slums turn to herbal medicine instead of ARVS due to many reasons; such as lack of meals that must be taken before ARVS due to abject poverty, while herbal medicines do not require meals, inaccessibility of conventional medicine due to travel costs, unavailability of ARVS in public hospitals, long wait times and queues in public health centres whereas herbal doctors and traditional birth are locally found and accessible in slums (Ayado, 2008).



The problem, however, is that many individuals in Kenya at the bus stops, street corners and slum areas all claim to be practising alternative medicine with impunity. There is the need to register herbalists, diviners, bonesetters and traditional surgeons for easier monitoring of their activities and the need to pass regulations for easier implementation, as suggested by Matoke-Chair National Traditional Health Practitioners Association (Mwakera, 2009). Medicine men are also associated with risky practices like bloodletting and scarification, where a practitioner/medicine man uses sharp instruments like a razor blade to make cuts deep enough to allow blood to flow freely and afterwards rubs ashes and leaves into the wounds, exposing himself and others to other patients' blood (Hardy, 1987). This practice may increase the spread of the HIV virus due to the use of un-sterilised shared sharp objects and exposure to contaminated blood.

In Kenya, herbalists use television, radio and newspaper for their adverts. These adverts defy conventional medicine, science and logic. They claim to cure all terminal and incurable diseases and sort out complex life issues ranging from; HIV/AIDs, cancer, small male organs, infertility, unfaithful spouses, joblessness, getting rich, jealous neighbours, madness, male impotence among others (Ndungu, 2012). Certainly, these claims are offences under Public Health Act and Kenya information and communication Act, that require all licensed broadcasters to ensure that adverts are not misleading either in content, tone or treatment and are not deceptive or repugnant to good taste. However, no one has ever been arrested or charged on the basis of these acts due to lack of regulation or apathy in implementation.

In contrast, conventional doctors in Kenya are barred from advertising their services in the media. Yumbya- chair Kenya Medical Practitioners and Dentist board (KMPDB) suggests that Kenyans could be exposed to dangerous concoctions in the name of medicine not subjected to lab testing by the pharmacy and poisons board. He claims that it is difficult to know the number of people that have died in the hands of these alternative medicine practitioners, hence the need to regulate all of them (Kiberoge, 2009).

Currently, there is some scanty regulatory framework for herbal industry under the ministry of Gender and social service, as this is the ministry meant to preserve culture and indigenous knowledge. It lacks the capacity on matters of health, making it

irrational for the department to identify, expose and punish quacks out to take advantage of gullible sickly poor Kenyans. To lump herbal industry under women groups and community-based groups is absurd, as it should rightly be under public health or medical services (Ndungu, 2012). The only people barred from practising herbal medicine are witches under Witchcraft Act cap 67. In 2009, Rarieda Member of Parliament Nicholas Ngumbo sponsored a motion in parliament asking the government, to establish a legal framework for herbal pharmaceutical industry and create relevant institutions and regulatory bodies to oversee standards and ethical practices, yet to date in September 2015, the bill has not been passed to law.

Several concerns have been raised in relation to herbal drugs in Kenya. Dr Chepkwony, Director of governments National Quality Control Laboratory (NQCL), after his group tested 18 samples of herbal drugs in the Kenyan national laboratories indicates that, huge number of Kenya's herbal medicines contain unacceptable high levels of disease causing organisms such as aflatoxins causing organisms that cause cancer and liver poisoning, E. coli and helicobacter pylori. He claims that their findings indicate that these herbs are contaminated with pesticides, lead, magnesium and mercury and have serious issues related to incorrect dosages, misidentification of plants, inappropriate labelling, hygiene concerns as packaging bottles are not disinfected but mainly rinsed with plain water and are not hygienically handled as they are sold on polluted streets or hawked in highly polluted and dingy places (Okwemba, 2010). These are serious health and safety concerns that may affect over 80% of the population, suggesting the need for urgent regulation to safeguard the poor Kenyans.

Regulating the herbal medicine industry would bring many benefits such as legitimising traditional medicine, attracting researchers to gather data to verify the impact of traditional medicine in relation to quality and safety, help in conservation of trees and plants used for health benefits and possibly make Kenya an international powerhouse in the industry, as it lies in the tropics with diverse plants and offer employment to many as suggested by Dr Njenga- Researcher Jomo Kenyatta University of Agriculture and Technology (JKUAT) (Gemson, 2013).

It is critical that this traditional medicine bill is passed to law and more cooperation is sought between traditional healers and professional medicine especially in the face of HIV/AIDs, to avoid unnecessarily spreading of the virus and also to help the PLWAs and certainly to improve the health care experiences of all Kenyans. This is an area that requires an upstream social marketing approach to lobby the government to pass this law, as well as in stream and downstream approaches to work with the established institutions to ensure safety is upheld in the herbal industry.

### **7.13.2 Popular Health Care**

Popular health care relates to the help and advice given by family and friends in relation to health. Programmers in theme 6.13 cite key issues such as stigma and discrimination meted on PLWAs by family and friends due to fear of contamination, lack of proper information, advises full of myths, lack of confidentiality, abuse of basic rights, rejection and isolation. The theme of stigma and discrimination seems to be heavily emphasised. This is a major challenge as usually families are meant to be the source of care and support, especially in traditional societies as Kenya. Some friends and families that believe in herbal medication lead PLWAs to herbalists. Others give wrong advice such as the need to drink camel urine was believed to cure all diseases, need for sex with minors to get cured of the virus, killing of albinos to drink their blood as it is believed to be potent enough to cure them from the virus, among other disturbing myth driven advices that may lead to criminal activities and endangering of other individuals.

Albinos in the rural areas are under great threat of being killed due to such misconceptions, while minors rape cases are on the rise due to such advices from ill-informed friends and relatives. The presence of such misconceptions and myths mean that there is need for proper-targeted education on HIV/AIDS to all people, starting from primary school to the aged villagers. This may ensure that correct and information is communicated to friends and family on the need to take the appropriate treatment and management measures to deal with the virus. It may also discourage the taking of suboptimal and criminal measures that endanger other societal members especially the vulnerable children and albinos.

### 7.13.3 Professional Health Care System

Programmers in theme 6.13 also suggest several challenges in relation to the professional health care systems in relation to HIV/AIDS management and treatment in Kenya. They point to problems related to ARVS drugs, popularly known as the Highly Active Anti-Retroviral Therapy (HAART) access such as: ARVS related side effects, pill burden, drug resistance and perception of ineffectiveness as PLWAs seek alternative traditional herbal medicines. In Kenya, over the 1.5 million people are estimated to be HIV/AIDS infected, but only around 600,000 receive ARVs, while over 900,000 require it but have no access to it. Disturbingly, over 85% of the ARV budget comes from development partners (Kariuki, 2013).

Access is certainly not the only reason that explains the huge number of PLWAS not on treatment, as self-stigmatisation also remains a major barrier to treatment. This points to the need to fight stigmatisation and discrimination to upscale testing and treatment (Korir and Njoroge, 2011). Some PLWAS do not qualify for medication, based on the WHO guidelines on when to begin the ARVS treatment. Ragi- chair Kanco suggests that uncertainty looms over the future of donor funding on fighting against HIV, Malaria and Tuberculosis, with over 85% of Kenya funds coming from donors and suggests that the government needs to chip in the treatment funding kitty urgently (Kibet, 2013). The United Nations also warns the country against the high dependency on donor sources and advises the government to invest in local manufacturing to simplify market access and reduce buying and logistic costs.

The few ARVS available need more safeguards from misuse. PLWAs register in several clinics to maximise their supplies, and sell them to those unwilling to register with local providers at a higher price and also sell to unscrupulous traders. These traders use them for bizarre uses that have been unearthed such as the use of ARVS to fatten chicken by poultry farmers in areas around Thika and Muranga, by mixing them with the broilers' feeds so that the birds can gain weight quickly, to enable farmers to sell them at only four weeks for quick gains (Obonyo, 2013). ARVS are also reported to be widely abused by illicit brewers who use them to increase the brews' potency in addition to molasses and formalin (a chemical used to preserve dead bodies) (Ngoiri and Mutambu, 2012). Some health workers also steal and sell

them in their private pharmacies at a profit, while others misappropriate funds meant to buy essential drugs, explaining the various shortages of ARVS and other essential medication reported in Kenyan health facilities. There is certainly a need for vigilance within government health care, especially among the employees, medical suppliers and health institutions (Kwendo and Mukunga, 2009; Aluanga, 2010; Wesangula, 2010; Muiruri, 2013).

Many developing countries such as Kenya are still using toxic ARV drugs such as stavudine belonging to the first class of ARV treatments formulated in 1987. These are banned in developed countries as they fall short of the recommendations of World Health Organisation- WHO. These toxic ARVS are used mainly due to their low costs and the unavailability of other less toxic drugs such as tenofovir (TDF) or zidivudine (AZT) (Okwembo, 2010; Gathura, 2011). Stavudine causes many side effects such as: lipodystrophy that refers to the loss of body fats with fats being disproportionately accumulated in some body parts, nerve disorders leading to numbness and burning pain, build-up of lactic acid, premature aging, dementia, cardiovascular disease among others (Wagura, 2008; Castelilif, et al. 2010; Gathura, 2011). The HIV burden also means that PLWAs struggle with other common ailments and opportunistic infections that need medication, increasing the pills burden to the cocktail of the combination ARVS.

Many PLWAS may also suffer drug resistance necessitating a change of ARVS; while in reality the second line and third line are not readily available in many developing countries including Kenya (Castelli et al., 2010). PLWAS also need regular monitoring of their viral loads and immune system levels, which require laboratory tests and frequent doctor appointments, which are a challenge within the Kenyan system, due to the poor health care infrastructure and inadequate health care professionals. Certainly the plight of PLWAS in Kenya requires social marketers to address these ARV, management, treatment and health care concerns using upstream methods to lobby for adequate medication perhaps by manufacturing them locally, adequate medical supplies and better health care systems. There is also the need for in stream and downstream social marketing approaches to address these concerns within the local counties and local health facilities.

#### **7.14 Cultural enablers**

Programmers in theme 6.14 suggest some cultural issues that have aided their programme work. There are indeed positive aspects of culture that programmers can engage in their programmes. Iwelunmor, Newsome and Airhihenbuwa (2013) suggest that health interventions encounter difficulties in sustaining behaviour change due to inadequate attention to the role and influence of culture. Indeed, all cultures have positive attributes that should be viewed as cultural assets. Cultural negatives need to be identified and placed within their cultural contexts, so that they can be clearly understood and engaged with. Dutta (2007) suggests the need to work within a culture to identify the health issues considered important to a community in order to incorporate them in health interventions.

Programmers in theme 6.14 cite many positive cultural issues in relation to their work. Some of them include voluntary male's circumcision (VMC) that has been shown to reduce chances of HIV/AIDS infection and enhance personal male hygiene. Intermarriages that promote tribal acceptance, understanding, promote peace, help to reduce stereotyping and associating specific tribal groupings with the virus. Taboos such as those against rape, bisexuality and bestiality are positive contributors, but not those against homosexuality. The socialisation and hospitality of the Kenyan people mean it is easy for programmers to approach different people and speak to them on the various issues concerning HIV/AIDS without much opposition and suspicion. This further explains the volunteering spirit found among many volunteers and the community spirit that promotes taking care of the HIV/AIDS orphans and widows.

Alternative circumcision methods for girls as a rite of passage means that programmers have ingenious ways for girls to graduate into adulthood without genital mutilation. This saves them so much from the risk and complications associated with FGM. Prolonged mourning among the Luos and Luhya give programmers' wide audience and longer times for HIV/AIDS awareness and sensitisation.

On the other hand, it is an expensive venture for the involved families to feed relatives and visitors for between four to eight days and really, social marketers should be discouraging such resource draining and impoverishing practices, rather than encouraging them. One or two days of burial rites are arguably enough; eight days is stretching it too far.

Cooperative local leaders such as chiefs and sub chiefs are some positive aspects as they help programmers assemble local people for their campaigns.

The slow death of polygamy should be accelerated although it has really transformed to extra marital affairs. More youth friendly forums to raise awareness on reproductive and HIV/AIDS matters should be promoted alongside reproductive centres for the youth. Strong family and kinship networks for supporting the orphans are positive aspects although more needs to be done to deal with family and kinship related stigma and isolation of PLWAS. The culture of separating sexes to avoid incest is practical although its feasibility in the urban and peri - urban areas is low, due to the tiny rooms available and high rent, in the context of poverty and poorly paying jobs. Programmers need to do more to lobby the government to at least take care of orphans and the disabled in matters of meeting basic needs such as food, housing, health care and education as part of social welfare programmes.

Use of artistic sculpturing and beadwork for income generation and recreation is positive. However, the government needs to do more to look for international markets for these and other related income generation activities, to alleviate youth and women's related poverty. Belief in God or practicing of religion is a positive aspect, to the extent that it offers individuals hope and faith. However, programmers need to work harder to deal with related stigma and discrimination and discourage faith healing myths. Much as the acceptance of ARVs is a positive aspect, the programmers need to lobby the government to ensure a steady supply and reduce the reliance on donor funding for these life supporting medication for the sake of PLWAs for sustainability.

Many of the above-mentioned themes have been discussed extensively elsewhere however social marketers need to engage with the positive aspects of culture and not view culture only from negative lenses. The positive aspects of culture can be conceptualised under social capital theory that characterises the relations and interactions between individuals and groups.

Pierre-Bourdieu (1985) views social capital within the logic of social ties, that enable a group to constitute, maintain and reproduce itself through mutual recognition and obligations, that allow access to resources held. He stresses the role of social capital in reproducing patterns of power and inequalities. He suggests that social capital is not a possession of an individual, but depends on one's social ties, size of social networks and volume of resources held by members or a network and network's durability. He views social capital as purposive, resourceful and facilitating individual action by the virtue of an individual's location within a social networks and groups created via social ties.

Coleman (1990) views social capital from the perspective of social structural resources, embodied in relations among people that facilitates actions of actors within the structure. These social structures take the forms of mutually acknowledged obligations and expectations, information potential, norms and sanctions, authority relations, appropriate social organisations and intentional organisation. Putnam (1993) locates social capital in the long-standing dense networks of voluntary association where norms of trust, reciprocity and civic engagement are encouraged.

The three views of social capital point to important aspects of culture and its inherent positivity that social marketers should harness in their HIV/AIDs related programmes. Social capital tenets such as social networks, social participation, social trust and social support are key cultural positives that programmers can use for the good of their programmes. They should consider how to work with social capital mechanisms such as norms and attitudes, psychosocial networks that increase access to health care and psychosocial mechanisms that enhance self-esteem (Kawachi, et al., 1999; Zukewich and Norris, 2005). The challenge however is dealing with social stigma that challenges the tenets of social capital, typical in health care institutions, work places, rural areas and among the general public.



## **7.15 Political, legal and donor funding**

Theme 6.15 relates to above three important issues that present challenges to programme work as pointed out by programmers.

### **7.15.1 Political Issues**

Programmers' responses in theme 6.15 on political related challenges point to its supportive/positive attributes and the unsupportive/negative attributes. Political challenges highlighted by programmers include corruption issues especially relating to the local chiefs and the sub chiefs that the programmers have to deal with at the grass root community level. Indeed, the chiefs need to be informed of any gatherings and meetings within their jurisdiction, however the taking of bribes for permits and demanding tokens of appreciation for the work they are paid to do is unacceptable and may be construed as petty corruption. Again taking bribes from local brewers to turn a blind eye to illicit brews is not acceptable and should be dealt with firmly by the county and central governments. Corruption by Members of Parliament (MPs) that handle community development fund, as they allocate cash meant for HIV/AIDS related work to their cronies is also unacceptable. Corruption is a sign of poor leadership and lack of accountability at all governance levels that need serious addressing in Kenya.

Transparency international (2013) perceives corruption as the abuse of entrusted power for private gain. However, this view focuses mainly on power abuse, while corruption, may be engaged in by anyone regardless of the positions they hold. Heidenheimer, et al. (1989) suggests three categories of corruption. Firstly, misuse of money or favours for private gain. Secondly, inappropriate exchanges of money or favours to achieve undue influence or power. Thirdly, the violations of public interest or norms of behaviour, mainly to get special advantages for self-serving purposes. These categories certainly give a wider coverage and meaning to corruption.

Transparency international (2013) also distinguish between various levels of corruption. Firstly, grand corruptions as corrupt acts at high level of government that distort policies or are central to the functioning of state, enabling leaders to benefit at the expense of the public good. Secondly, petty corruption that may occur every day

as abuse of entrusted power by low and mid-level public officials in their interactions with ordinary citizens trying to access basic goods or service in the public or private sector. Thirdly, political corruption that involves the manipulation of policies, institutions and rules of procedure in allocation of resources and financing, mainly engaged in by political decision makers that abuse their position to sustain their power status and wealth.

Kenya was ranked 136 out of 177, with a score of 27 (where 0 score is highly corrupt and 100 is very clean), in the Global Corruption Perception index by Transparency International (TI), 2013). This high corruption score has been attributed to lack of political will in tackling graft and slow pace of new constitutional reforms in key corrupt sectors. It is also attributed to the lack of legal enforcement, as many scandals see perpetrators go unpunished and interference from political and economic elites that obstruct enforcement institutions from doing their work (Kimeu-Director Transparency International, 2013).

When the political and economic environments are corrupt, it only means that corruption permeates the HIV/AIDs programmes environment too. Forms of grand and petty corruption are cited by programmers in areas such as chiefs and sub chiefs demanding token before issuing HIV/AIDs related meeting/campaigns permits, HIV/AIDs funds are being embezzled by politicians and programmers; corruption by local administration is turning a blind eye to illicit brews that enhance risky environments; lack of accountability in relation to HIV/AIDs funds and poor leadership to support development exist. Perhaps, social marketers can take a bold step and work with anti-corruption agencies in Kenya using the social marketing mind-set to fight graft at all levels, in order to impact positively on all sectors of the economy and subsequently in HIV/AIDs related programmes.

Political enablers cited by programmers relate firstly to support to programme work. Support by friendly chiefs and sub chiefs in mobilising their people to attend meetings and knowledgeable politicians who encourage behaviour change and discourage risky behaviour. Some NGOs fund and train programmers and audiences, and some government agencies like NACC coordinate with programmers from all over the counties as well as coordinating donor funding. Secondly, political enablers fall under friendly policies such as Total War on HIV/AIDs (TOWA) by president Kibaki, that

greatly support programmers and funding related policies. HIV/AIDS tribunals deal with violations of human rights for the PLWAS and the constitution upholds human rights of even the homosexuals and commercial sex workers.

Thirdly, the presence of peace and stability is necessary for programme work, enabled by a positive political will and lastly government efforts to provide basic services such as the free primary education an initiative introduced by president Kibaki, that enables literacy at least to the primary education level. There is, however, also the need to provide free secondary education to raise educational attainments of children from poor families. Social marketers would indeed capitalise on these positive political enablers to effect large-scale positive changes to their programmes for instance the use of the HIV/AIDS tribunals to fight stigma and discrimination.

### **7.15.2 Legal related issues**

Programmers' responses in theme 6.15, evidence that legal issues may have a positive or negative impact on programme work. Legal challenges cited by programmers are the government legalisation of the marketing of alcohol in the media and pubs, lack of enforcement of laws as many only exist in papers, lack of enforcement of the sexual offences Act 2000 that could engage gender related and sexual related offences and laws that criminalise homosexuality making them hide and not participate in HIV/AIDS related interventions. Some enablers include legal NGOs that help the poor and fight for human rights such as Kenya Human Rights Commission, Kituo cha Sheria, Cradle among others, HIV/AIDS tribunals that help fight stigma and discrimination against infected individuals and the occasional crackdown on illicit brews, although as cited earlier, chiefs and sub chiefs are amenable to corruption and mainly turn a blind eye on these vices.

The Alcohol Drink Control Act -ADCA, 2010 (International Institute for Legislative Affairs, 2014) commonly known as 'Mututho laws' after the member of parliament that pioneered it, was enacted to control the production, manufacture, sale, labelling, promotion, sponsorship and consumption of branded alcohol. Its impact has mainly been on branded alcohol sales, in that all alcohol outlets near schools and learning institutions have not been given licences, consequently reducing alcohol consumption near these structures. It has also served to control the purchasing of alcohol from

supermarkets and convenience sites, as the mandated hours are between 10.00 am to 8.30 pm and also served to lock underage individuals from purchasing alcohol from these sites. It has also impacted aggressive marketing and promotion of alcoholic drinks with messages targeting young people being discouraged, as well as promotional programmes such as Buy one get one free (bogof) and raffles banned that mainly encourage alcohol abuse.

Conversely, the ADCA 2010 Act has encouraged more illegal drinking sites and expanded businesses for illicit cheaper brewers, due to the increase in prices of branded alcohol and closure of many former licensed outlets. Certainly, the focus should be on how to tackle these mushrooming illegal breweries and drinking dens that mainly serve the slums, rural and urban areas.

Stigma and discrimination related issues are a major legal challenge especially to PLWAS, women and orphans. The HIV/AIDs equity tribunal was set up in 2012, supported by Joint UN Team on HIV/AIDs in Kenya through UNDP and UNAIDS. It is a unique tribunal and a first of its own kind in the whole world, mandated to implement HIV/AIDS Prevention and Control Act 2006. The Act generally deals with protecting PLWAS against all forms of discrimination and promotes provision of basic care and social services for them, as well as promoting utmost safety and universal precaution in practices and procedures that carry the risk of HIV transmission. There is certainly the need for the government to expand the HIV/AIDS equity tribunal, probably set it up as a special court in every county and pay its employees, in order to effectively fight against HIV/AIDS related stigma and discrimination.

Notable legal enablers cited by programmers include crackdowns on illegal brewers as well as girl child abductors and defilers and criminalising of FGM. Other enablers include police assistance, presence of law courts and police posts in rural areas, presence of peace and criminalising of deliberately infecting others with the HIV/AIDs virus.

Programmers also cite trainings on rights issues, friendly legal NGOS offering pro bono legal aid such as Kituo cha Sheria, Kenya Human Rights Commission, KELIN and community watch groups on crime. There are also friendly work place policies for PLWAS, health services provided for sex workers and the new constitution that spells out rights issues that protect all Kenyans regardless of their sexual orientation. Much as they are laudable enablers, more needs to be done.

Social marketers should lobby for all organisations to embrace work place HIV/AIDs policies that promote human rights and fight discrimination, lobby for more police presence and posts at grass root level and more legal aid perhaps championed by the government not just few donors funded NGOs. There is a need to lobby and deal with enormous issues such as constitutional reforms decriminalising homosexuality and search for ingenious ways to fight corruption within the government to promote transparency and good governance. In stream and downstream social marketing approaches should be embarked on to ensure that programmers build their capacity and networking in order to learn more on legal and rights issues.

### **7.15.3 Donors and Funding Related Issues**

Programmers in theme 6.15 suggest key concerns. Firstly, unrealistic donor conditions that relates to cultural ignorance and incompetence by donors. There is certainly a need for donors to understand the cultural nuances of the people they fund, to ensure that the funding conditions they give are realistic and in the best interests of the target audiences. The issue of lack of transparency and accountability by the programmers is a serious issue that they need to sort out by themselves. Coordinating agents and governments ought to take it seriously to avoid punishing the transparent and well run projects. Corruption issues should also be well investigated and dealt with by the courts efficiently to deter programmers from greed and to promote accountability. Donors too need to deal with corruption issues and promote transparency in their funding endeavours. They need to physically verify the programmes they fund, not just relying on agencies that report back to them.

A matter of concern is that over 80% of Kenya's HIV/AIDS programmes are externally funded, with largest donors being USA's Presidential Emergency Plan for AIDS Relief (PEPFAR) and USA Global Fund meant to fight AIDS, Tuberculosis and Malaria. In the event that USA stopped funding, these interventions could stall, drawing back gains so far realised (Kariuki, 2013).

The United Nations office for coordination on humanitarian affairs and other programmers in the country have called upon the Government of Kenya to allocate more funds towards HIV/AIDS treatment and prevention efforts (Kariuki, 2013; IRIN, 2014). It is indeed terrifying to imagine what would happen to the 1.2 million PLWAS in Kenya if USA stopped funding free ARV drugs that sustain them, while their own government doesn't invest much in these life-sustaining medicines.

Programme sustainability through funding is a real problem as donors are under no obligation to continually fund Kenya's programmes. Social marketers need to certainly deal with sustainability issues and lobby the government via upstream measures to invest more in HIV/AIDS programmes and look for strategies via both upstream and downstream social marketing to make these programmes survive beyond donor funding.

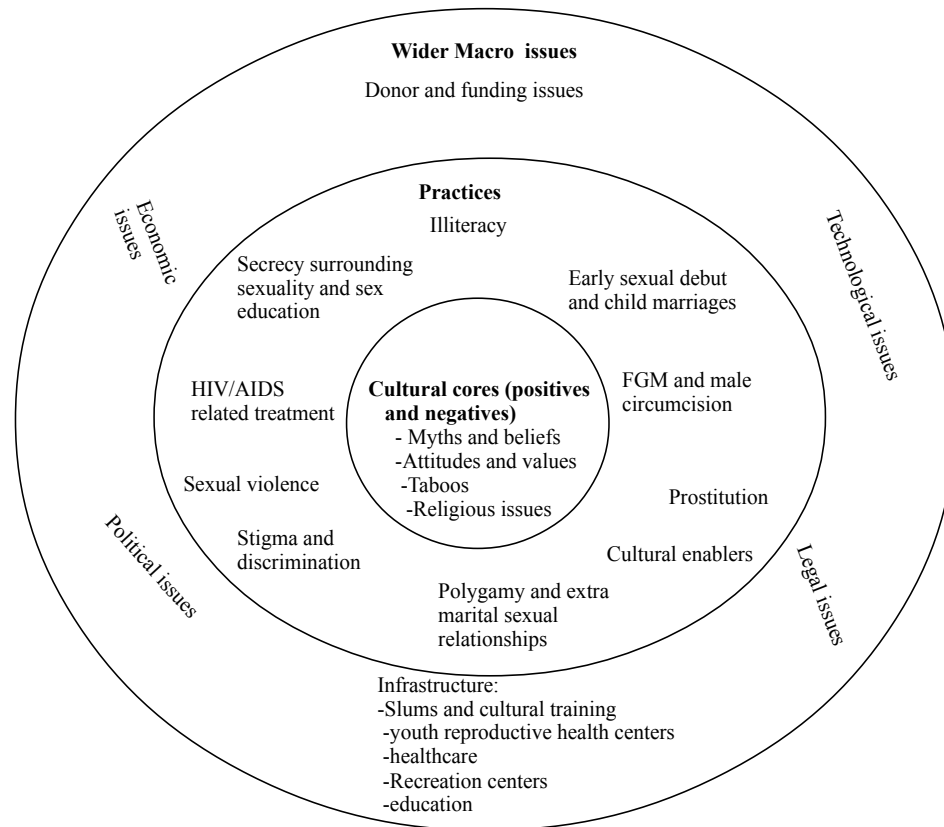
ARV patent issues are of key concerns as these drugs are the lifelines for the PLWAS in Kenya, though unfortunately they are mainly funded via donor funds. Kenya is capable of producing these ARVs, but the government really needs to deal with the patent issue to allow for local production. Much as the former President Moi declared HIV/AIDS, a national disaster in 1999, the pandemic was not gazetted but instead National AIDS Control Council (NACC) was created to coordinate a multi-sectoral response. Sixteen years later, without the gazetting of HIV as a national disaster, prevention and management products such as condoms, ARVs, TB medicine, reagents and testing kits for HIV/AIDS and related non-communicable diseases such as cancer and kidney dialysis, are not exempted from taxes duties and levies (Daily Nation, 2013). This taxation issue certainly hinders efforts to manufacture ARVs to meet the local demand and should be firmly and decisively dealt with.

The government should be investing in research and development of local ARVs just as India and Brazil for sustainability purposes. These are key issues social marketers should be lobbying upstream for, as part of programme sustainability focus and

certainly lobby against legal mechanisms such as the East Africa anti-counterfeiting draft bills that conflates quality assured generic ARVs with counterfeits, limiting their access. This is mainly an effort to safeguard existing Trade Related Aspects of Intellectual Property Rights (TRIPs) flexibilities. Free Trade Areas (FTA) agreements like India and European agreement pose a threat to affordable ARVS as India produces almost 80% of generic ARVS and other drugs for developing countries. Programmers need to fight against provisions such as data exclusivity, which may decrease access to these well-tested generic cheaper drugs used by developing countries. They should also be lobbying the government for more budgetary allocation on ARV and HIV funding.

A graphical representation of the above discussed themes, indeed create a cultural contextual model, that may help programmers in their social marketing interventions right from situation analysis, objectives development, developing of the marketing strategies and mix, implementation and evaluation of their interventions. These representative variables may help answer the research questions—what cultural and contextual opportunities and challenges do social marketers, involved in HIV/AIDS interventions, face in a multi-cultural environment like Kenya?

The model is a contribution to knowledge as it suggests key cultural and contextual themes that social marketers ought to deal with, in a multi-cultural context as Kenya. It may provide valuable insights to all the steps of social marketing initiatives from background situational analysis, objective formulation, planning, implementation and evaluation and guide programmers in order to understand their target audiences in an in-depth manner for more successful interventions.



Kendi-Mutugi (2016) Cultural contextual assessment model

**Figure 12 - Kendi-Mutugi (2015)- Cultural-context assessment model (2015).**

## 7.16 Chapter Summary

Fifteen themes inferred in chapter 6 that emanate from the programmers' responses in the qualitative instruments are discussed in this chapter. Infrastructure related issues such as slums, pubs, health and educational structures, youth recreation and reproductive health structures as well as cultural training of programmers may all have an impact on HIV/AIDS related programme work. Prostitution, illicit brews, branded alcohol and drugs abuse also impact the programme work negatively.



Secrecy surrounding sexuality drives myths, beliefs and sexual violence that all negatively impact HIV/AIDs related programme work. Illiteracy may explain poverty that drives a host of other issues such as ignorance, which in turn may explain childhood marriages and FGM practices. Polygamy and extra marital sexual relations present complex sexual networks where the HIV virus may thrive. Some taboos especially on homosexuality may drive individuals away from programme related benefits and explain stigma and discrimination against these individuals, driven by religious beliefs.

Political and legal issues may present barriers and opportunities for programmers, while donor and funding issues remain thorny to programme work due to sustainability issues especially in relation to HIV/AIDS related treatment. Lastly, programmers need to embrace the enablers culture presents to their programme work.

The next chapter is the final one on research conclusions, recommendations contribution to knowledge and areas for future research.

## **8. Chapter Eight Conclusion and Recommendations, contribution to knowledge and areas for future research work**

### **8.0. Chapter introduction**

This chapter revisits the research objectives, discusses the extent to which they are achieved and makes conclusions and recommendations based on the research findings. It also discusses the study's contribution to knowledge, the research limitations and finally proposes areas for further and future research work.

### **8.1. Revisiting research objectives and questions**

The study's main objective is to get a deep understanding of the contextual and cultural realities encountered by programmers that deal with HIV/AIDS issues using a social marketing approach in Kenya. The study explores context and cultural related challenges and enablers, how programmers deal with them and also gleans on how to appropriately engage these realities for the success of programme work.

The key research objectives of this study are to probe the Kenyan context in order to:

- Understand how culture is perceived in social marketing initiatives targeting various ethnic groups in Kenya.
- Understand the contextual realities faced by social marketers targeting different ethnic Kenyan groups.
- Understand context and cultural related barriers and enablers to social marketing initiatives targeting HIV/AIDS in Kenya.
- Understand how cultural context barriers and enablers have been engaged with, by social marketers that target HIV/AIDS in Kenya.
- Understand how context and cultural barriers and enablers could possibly be engaged with, using social marketing approaches within the Kenyan context.

These research objectives are indeed achieved. The study evidences that social marketers view culture as having both positive and negative influences on their programme work. The positives act as programme enablers while the negatives act as programme barriers. Secrecy surrounding sexuality and sex education-theme 7.4, cultural myths and beliefs - theme 7.8 such as HIV is an ancestral curse or divine punishment for immorality, drives self and societal stigma, while others like early sexual debut – theme 7.9, FGM - theme 7.10, extra marital sexual affairs and polygamy-theme 7.11 present challenges making programme work difficult. Some cultural taboos- theme 7.12 such those surrounding incest and rape cases deter and discourage risky behaviour, male circumcision-theme 7.10 when done under hygienic conditions, and cultural enablers-theme 7.14 may positively impact the programme work. The contextual realities faced by social marketers differ based on the geographical settlement areas of their target audiences that dictate their economic activities and risky behaviour. For instance, the Luo's live near Lake Victoria will have a large fishing community. Fishing has a high risk to HIV/AIDS due to the many women that trade sex for fish, increasing their chances of acquiring the HIV virus- theme 7.2.1 on fishing communities.

Social marketers engage cultural barriers logically, however the study evidences that they largely deal with downstream social marketing practices, mainly targeting target audiences with little use of upstream social marketing that targets policy makers. The study points to a gap in upstream social marketing measures that social marketers should use to influence cultural and contextual realities of their target audiences.

## **Research questions**

The main overarching research questions are:

1. *What are the contextual and cultural realities social marketers operating in the field of HIV/AIDs face, in a multi- ethnic context as Kenya?*

This question has largely been answered in the research findings. Figure 11-cultural assessment model (2015) represents a graphical summary representation of all the fifteen cultural and contextual themes/issues social marketers face within the Kenyan context. The cultural ones include: secrecy surrounding sexuality and sex education- theme 4, myths and beliefs-theme 8,

early sexual debut fuelled by childhood marriage-theme 9, female and male circumcision-theme 10, extra marital affairs and polygamy-theme 11, taboos-rape, incest and homosexuality-theme 12, HIV/AIDS related treatment in reference to folk and popular care systems and religion-theme 13 and some of the cultural enablers like strong family and kinship, cultural income generating programmes- theme 14, alternative rite for girls and male circumcision. Contextual realities include infrastructure-theme 1, prostitution-theme 2, illicit brews and branded alcohol as well as drugs and substance abuse, illiteracy-theme 5, sexual and gender related violence-theme 6, stigma and discrimination-theme 7, HIV related treatment-professional healthcare- theme 13 and political, legal and donor funding issue-theme 15.

The contextual realities largely depend on the tribal group's geographical mapping. For instance, the Somalis in North Kenya are prone to extremely hot weather conditions and drought just like the Coastal dwellers prone to hot and humid conditions and the realities of tourism. General realities may relate to poor professional health care- theme 13.2, poor educational infrastructure promoting illiteracy – theme 7.5 although the severity depends again on the geographical mapping, as urban centres cannot be compared to rural areas in relation to infrastructure and slums presence- theme 1.1.

The research points to the need to deal with each tribal group distinctly to address their unique cultural and contextual realities for more effective social marketing programmes targeting the HIV/AIDS pandemic.

## 2. *How do programmers deal with these contextual and cultural realities?*

The research findings point to the fact that programmers mainly engage in downstream social marketing with little attention given to up-stream social marketing approaches that target policy makers. In downstream approaches, education strategies are largely used to counter cultural myths, beliefs, values, norms and practices. There is a need for social marketers targeting HIV/AIDS in Kenya to look for ingenious ways to engage up stream social marketing approaches in order to realise large-scale social marketing impact. For instance, it is not just enough to advise Maasais against FGM and early marriages- theme 9 and 10. Social marketers need to mobilise and use the

legal apparatus appropriately, to root out the practice and save young girls' misery caused by unnecessary practices. Much as some contextual realities may be beyond their mandate such as educational- theme 5 and medical infrastructure-theme 13, they should still look for ways of lobbying the policy makers and donors to ensure that these vital structures are available for their target audiences.

3. *Are there any better ways of dealing with these issues that programmers can identify? Where are the gaps? How can they be filled or dealt with?*

The research findings again overwhelmingly evidence that programmers largely use downstream social marketing approaches. The gaping gap exist in that programmers do not engage much with upstream social marketing approaches and they really need to use them to effect large scale changes for the good of their target audiences. Social marketing is robust and should be used upstream, in stream and downstream for effective programme work. Appropriate ways of dealing with each challenge have been well explicated in chapter 7-discussion of the research findings.

## **8.2. Conclusions**

This study clearly proves that cultural and contextual realities of a market or target audiences cannot afford to be ignored by social marketers, especially in multi-tribal or multi-ethnic environments. The two (cultural and contextual realities) are extremely important and should be well researched to provide the underpinning knowledge that should inform the planning, implementation, monitoring and evaluating of social marketing programmes. This is indeed in line with Lefebvre (2011) clarion call for social marketers to embrace an understanding of determinants, context and consequences of current behaviour and desired ones from the point of view of audiences not from any set of theories and models.

Commercial marketers operating in many countries know that they cannot afford to ignore or assume the cultural and contextual realities of their operating environments, as these realities determine their success or failure (Ganon 1994; Cateora and Graham 2005; Katobe and Helsen 2011). Social marketers therefore also need to learn to probe and engage context and cultures meaningfully.

The study also clearly evidences that the cultural and contextual realities of each of the Kenyan tribal groups are unique. Programmers and donors should therefore endeavour to understand their target audiences based on their ethnic tribal groups, rather than blanketing their interventions as simply targeting Kenyans. Crucially, cultural competence, responsiveness and proficiency (Winkelman, 2009) is critical for stakeholders involved in social marketing approaches regardless of their origin or status, to avoid suboptimal and culturally incongruent decision making, especially the donor society.

The geographical realities of a target audience provide unique challenges to the dwellers while the urban and peri-urban areas also face unique challenges related to the tribal realities of the inhabitants. Much as times have changed, cultural beliefs, attitudes, values, taboos and practices persist as suggested by Brislin (1993). These cultural realities need to be tactfully and intelligently engaged with, if the war against HIV/AIDS is to be won in Kenya. Indeed, this calls for tribal specific segmentation and targeting or cultural specific segmentation as a distinct segmentation method in social marketing, alongside geographical segmentation.

Major and similar contextual concerns that cut across the many tribal groups in Kenya include: illiteracy and low educational attainments- theme 7.5, intergenerational high rate of poverty, endemic corruption that cuts across most public and private sectors and undermine development- theme 15.1. Other concerns include poorly equipped or non-existence health and educational infrastructure- theme 13.2, marginalisation of some geographical areas and their inhabitants, pollution issues and environmental concerns. Poor investment in technology, discriminative laws especially to the LGBTI groups, poor enforcement of laws- theme 15.2, poor investment in entrepreneurial education as many people prefer the limited white collar jobs based on an educational system that looks down on entrepreneurship and blue collar jobs, poor leadership and governance, greedy leaders, poor planning and misuse of the limited resources available- theme 15.1.

Major cultural concerns that cut across many tribal groups in Kenya include: notorious religiosity that make individuals complacent to almost all the other issues that affect them in life including poor governance, fatalistic attitudes in life especially in diseases management and generally in life challenges- theme 7.8. Gender violence

tolerated and encouraged in many tribal groups- theme 7.6, female genital mutilation (FGM) endemic in some tribal groups such as the Maasai, Somali, and Samburus-theme 7.10. Lack of male medical circumcision by some tribal groups especially the Luos and Turkanas. Traditional male circumcision with the sharing of knife among many tribal groups, cultural silence on sexual matters, wife inheritance practiced by almost all the tribal groups- theme 7.10.1. Premarital sexual practices encouraged by again almost all tribal groups especially among the boys while punishing the girls that fall pregnant- theme 7.9, culturally allowed extra marital sexual practices especially for men, cultural preference and search of male children-theme 7.11, culturally engendered superiority of men and inferiority of women.

Inheritance practices along the male children and not females, taboos that encourage discrimination especially of the LGBTIs-theme 7.12, cross-generational arranged marriages and childhood marriages practiced by some groups such as the Maasais and Samburus-theme 7.9.1. Early sexual debut encouraged by some tribal groups especially the Maasais- theme 7.9, belief in witchcraft found among all the tribes apart from the Maasais and Samburus, strong belief and preference of herbal medicine and practitioners to conventional medicine and inter-tribal animosity and hostility that fuels discrimination and tribal clashes leading to killing of innocent tribal members-theme 15.1.

Much as downstream social marketing approaches may be necessary to deal with these contextual and cultural realities; social marketers need to do more using in-stream and upstream social marketing approaches to effect large-scale impact on their programmes.

### **8.3. Recommendations**

Culture has long been neglected by social marketers and it is time they seriously engaged with it to avoid the failure of their programmes/interventions. Social marketers need to use the cultural and contextual composite model and cultural-contextual assessment model to deeply understand the contextual and cultural realities of their target audiences.

A deep scoping using these models is critical to inform the planning, implementation, control and evaluation of social marketing programmes. There is also the need for donors and other related stakeholders to be culturally informed, to avoid imposing unrealistic and culturally and contextually incongruent regulations or policies on the programmes they fund.

Culture has both positives and negatives attributes that may impact positively or negatively on social marketing programmes. The challenge is for programmers and relevant stakeholders to use the positive cultural aspects to enhance programme work, while tactfully engaging the negative aspects of culture for the success of their programmes (Airhihenbuwa, 1995). Ignoring cultural and contextual realities is not an option social marketers, donors and other relevant programme stakeholders can choose, if they envisage successful programme work.

Social marketers targeting HIV/AIDs in Kenya need to go beyond downstream social marketing approaches and engage more in upstream social marketing approaches, to be able to change the context of their environment in line with suggestions by Goldberg (1995). Upstream social marketing is dismal within the Kenyan environment. More needs to be done by social marketers and HIV/AIDS related networks to engage the government and other stakeholders on pertinent realities that face HIV/AIDs programming. Upstream, downstream and instream social marketing approaches could be effective in many areas. Key recommendations emanating from the previous chapter 7 include:

Based on theme 7.1.1 on slums and informal settlements, social marketers should work with the government and donors to address the slums issues. Upstream social marketing via policy could be used to lobby for living wages for casual labourers in Kenya and ensuring robust checks in their implementation, and to ensure investment in formal housing structures in slum areas is done under slums upgrading programmes. There should also be regional development to attract individuals back to rural areas and investment in infrastructure in these slums to provide essential services to the populace. Downstream interventions would target issues of providing medication and health support, schools, HIV/AIDs related education, income generating programmes and constructive recreational facilities for the slum dwellers.



In reference to theme 7.1.2 on pubs and alcohol abuse, there is a need to engage local authorities in matters of pubs locations to ensure pubs are built away from schools and hospitals. There is also a need for alcohol venue based interventions, such as the use of popular opinion leaders and trained peer educators to educate peers as they socialise in those venues. Structural intervention mainly relates to the law and policy such as mandatory testing of commercial sex workers, however there is need to combine both the social influences and structural intervention for a more robust response to the pubs problem.

Theme 7.1.3 is on reproductive health services for the youth and men. There is need for the government and NGOS to create reproductive health centres specifically for the youth with youth friendly employees and health carers in both rural and urban areas. There is also the need for more reproductive health integrated services targeted specifically at men and couples, especially the PLWAS, where they can get HIV care and family planning services at the same time.

Theme 7.1.4 relates to cultural training. There is a need for all the stakeholders involved in HIV/AIDS work to be culturally trained and for the decision makers and implementers to be culturally competent. Cultural adaptation should be in the form of programme content, where cultural knowledge determines what should be included in the programme. It should also be in the programme methods to ensure the strategies chosen are congruent with the culture of the target audiences and in the programme delivery, where culture determines the message provider, channel, chosen and locations of delivery.

Theme 7.2.1 is on prostitution. In relation to childhood prostitution driven by tourism in Kenya, programmers in Kenya and the government need to do more at the upstream social marketing level to police and provide surveillance to ensure that both the local and international perpetrators of child related sexual abuses are firmly punished in Kenya and abroad. Regretfully child abuse is not treated with the seriousness it deserves in Kenya compared to the west as in England, where perpetrators are put on a sex offenders' lists, jailed and shamed in the media. In Kenya, most of the perpetrators bribe the involved families and police force and the case gets forgotten and stopped.

UNICEF and other international child protection agencies need to do more to deal with paedophiles that sodomise young boys and abuse the poor young girls along the Kenyan Coast and in other Kenyan cities. Programmers dealing with children rights should police the Kenyan beaches to deter perpetrators. Stern actions need to be taken against tourists that abuse children together with their cooperating confederates such as parents and relatives of the young children.

In relation to adult prostitution, controversially perhaps social marketers in upstream social marketing should push for the legalising of this oldest profession in the history of mankind and learn from states such as Nevada in the USA on how to make the industry safe. This could help limit the trade to adults that are 18 years and above and restrict CSWs to routine STI and health checks as well as compulsory use of condoms to avoid infecting their clients.

In downstream social marketing, programmers should work with CSWs to provide them with both female and male condoms for protection and educate them on testing, treatment, drug and alcohol abuse and other forms of micro financing to help those interested in leaving the profession. Poverty is still the underlying push factor coupled with low educational attainments. Addressing educational attainments and encouraging entrepreneurship to provide employment in the tourist regions, may help.

Theme 7.2.2 is on prostitution among the fishing folk. There is a need for clear targeting of fishing communities in prevention care and mitigation and the need for key national and international fisheries policies on HIV/AIDs. Certainly social marketers targeting the fishing communities need to do more at upstream and downstream level to deal with these marginalised groups. They need to lobby the government to recognise the fishing folk as amongst the most at risk groups in relation to HIV/AIDS, for better resources allocation. Indeed, Nyanza province leads in regional HIV/AIDs prevalence rate at 15.1% compared to 5.6% national prevalence rate (NACC, 2013), probably explaining the urgent need to deal with this risky group.

Theme 7.3.0 is on illicit brews and branded alcohol consumption in Kenya. There is a need by social marketers to lobby upstream measures that seek to strengthen rehabilitation and alcohol related treatment structures, as there are very few of these facilities in Kenya. Downstream programmes need to target harmful alcohol consumption reduction especially at community and rural areas levels. Local chiefs

and administration need to do more to curb the menace of local brews, as they take bribes from brewers and let them endanger the lives of poor Kenyans. NACADA, the local authority that deals with alcohol need to also be firm on policies and implementation that will help stump out these illicit brewers and brews.

Branded alcohol also needs to be controlled. Drink driving needs to be controlled via roadside alcohol blows testing, policy issues such as higher taxation on alcohol and probably more use of cognitive behaviour therapy (CBT) methods that are indeed in line with the preferred oral media in Kenya. Social marketers also need to lobby for more control of alcohol and cigarette abuse and advertising, similar to European countries to counter their demand and supply.

Theme 7.3.1 is on drugs use and substance abuse. Among the injecting drug users, harm reduction strategies such as syringe and needles exchange programmes and building awareness on the dangers of HIV and needle sharing may be necessary. There is a need for the use of youth outreach programmes for the out of school youths, students, the homeless, unemployed and commercial sex workers to educate them on HIV/AIDS and involve them in harm reduction programme. Drug rehabilitation centres need to be availed to not just all those that can afford to pay. There is a need for programmers to do their best to work with government agents to at least lobby more on the issue of punishing and stopping drug lords.

Khat abuse is also common and social marketers should target the tribal groups that are known to abuse it such as: The Meru, Somali, Arabs, Asians, Ethiopians, Coastal dwellers among others, to educate them of the harms it causes. They need to mobilise imams, so that they can be empowered to educate the Muslim communities on the dangers of this herb as well. At policy level, there is need for upstream social marketing to lobby for laws that could regulate and control khat growing and selling and downstream approaches targeting the tribes that abuse it.

Theme 7.4.0 is on secrecy surrounding sexuality and sex education. There is a need for resources to be allocated to HIV/AIDS related studies at primary and secondary school levels. Teachers need to be trained adequately to tackle the HIV and STI topics. There is a need for electricity or energy sources to enable the use of audio-visual materials in teaching especially in the rural areas, and the need for youth friendly teachers and instruction methods, rather than fear instilling and punitive

instruction methods. There is also the need to change the curriculum content to focus more on sex, sexuality, contraception and reproductive organs rather than teaching abstinence and good morals only as a behaviour change focus to the youths.

Benefactors such as the USA need to reflect on their policies regarding funding abstinence to only related programmes in third world countries. They need to accommodate the realities of culturally accepted early sexual debut by teenagers and help invest in their reproductive health in order to protect them in more realistic ways. Youth friendly centres may be the only hope for the Kenyan youth. These are key upstream social marketing issues in relation to infrastructure and youth policy issues that programmers should be lobbying, as well as working in downstream interventions by actively working with the youth rather than culturally judging them and drumming abstinence to them. Certainly, those that can abstain should be encouraged to do so especially within the religious circles, however the alternatives should be available to help the majority that cannot abstain.

Theme 7.5 is on illiteracy. Low educational attainments among boys are a key concern, just as they are among girls. Probably free primary and secondary education in Kenya may help raise attainments, as many parents struggle with secondary school fees payments. However, more needs to be done at upstream social marketing level to lobby for free secondary education and deal with child labour issues. Downstream marketing may be used to encourage boys to attend schools and deal with the barriers that hinder their educational attainments.

The Kenyan education system is quite limited in the areas of access. It restricts individuals, as without a grade A to C KCSE qualification, entrance to meaningful professions and careers become difficult or impossible. They certainly need to learn much from the English education system in this area; especially in the provision of free or at least affordable adult skills and foundation courses. These would propel the youth and adults to the job market or entrepreneurial opportunities and reduce illiteracy levels.

There is also the need to invest more in nursery education for the younger children to help build a strong educational foundation. More investment in special education to cater for the disabled and academically challenged children in Kenya is also necessary.

Theme 7.6 is on sexual violence. There is the need to implement the sexual offences Act (2006), to ensure that sexual related offences are appropriately reported and dealt with to reduce sexual offences and protect the vulnerable girls, women and men. Gender related violence covertly and overtly encouraged in many of the Kenyan tribal groups need to be dealt tactfully with, in all socialisation institutions such as schools, churches and the media. There is a need to de-market cultural preference for the boy child and discourage the superiority complex bred in boys as they grow up, as it drives male chauvinism that further translates to gender related violence. Upstream measures such as firm policies and laws on gender related violence as well as downstream measures to educate the boy and girl child on their rights and the consequences of violating these rights, may perhaps help reduce gender related violence.

Theme 7.7 is on stigma and discrimination. HIV/AIDS related stigma is driven by religious and cultural beliefs as well as ignorance surrounding the infection. There is a need for social marketers to intensify HIV/AIDS related training and counselling on PLWAS and their families and friends to fight stigma, ignorance, discrimination and encourage ARV uptake. There is also a need for the media to engage in anti-HIV/AIDS stigma related campaigns to normalise HIV/AIDS management via ARVs. There is also a need to target religious leaders and their followers with targeted information again to fight stigma among these groups. Politicians and health workers also need to be retrained on issues of HIV/AIDS related infections and stigma.

Contentiously however, there may be the need to make antenatal testing for mothers' compulsory in order to offer infected mother early treatment to save future generations. Again contentiously, it may be necessary to involve spouses and families of infected individuals in HIV/AIDs management in order to avoid re-infections and cross infections. This is also crucial in home based care training and counselling for carers, to help them care for the infected without putting themselves at risk of acquiring the virus.

Theme 7.8 is on myths and beliefs that relate to HIV/AIDS. Many of them relate to male domination over women, witchcraft, religious beliefs, HIV infections and management. There is need for honest and informed dialogues on HIV/AIDS infections with especially the older generation to challenge these myths and beliefs, as

well as educating the youth to counter these false beliefs. Contentiously, there is a need for social marketers to engage with the witchdoctors and herbalist to enlighten them more on HIV matters and to point them towards sending their clients to hospitals for appropriate diagnosis and possibly ARVS. HIV related support groups and counselling sessions are important as they educate the PLWAS on their infection and also help to counter false information that they may hold especially from their friends and relatives.

Theme 7.9.1 is on early sexual debut that fuels early infections, unwanted pregnancies and compounds female poverty. There is a need for parental guidance on matters of maturation and sexuality for both boys and girls that should be encouraged by all socialising agents in Kenya such as churches, the media and schools. The learning curriculum also needs to comprehensively provide guidance on educating young people on maturation, contraception and HIV/AIDs matters to help them make informed choices. Comprehensive reproductive health centres for the youth in both urban and rural areas may also help.

Theme 7.9.1 is on early childhood marriages, a cultural practice fuelled by apathy for girls' education and preference to marry them off to wealthy polygamists at an early age of between 9-15 years. There is a need for the social marketers and the government to enforce the law that criminalises forced childhood marriages to protect the girl child. There is also a need for the government and donors to help provide free primary and secondary education to encourage access by both genders to education and avoid parents having to choose between educating boys' child over girls.

Theme 7.10.0 is on female genital mutilation practised by many tribal groups in Kenya such as the Somalis, Samburu and Maasais. There is a need for social marketers to make good use of the law that outlaws the practice and engage the elders of these communities to help stop it. The law needs to be hard on the perpetrators such as the circumcisers and their parents to stump it out. There is also the need for more shelter homes to house girls that escape from their families in fear of being cut.

Theme 7.10.1 is on male circumcision. When done under sterilised and hygienic conditions, it has the potential of reducing HIV and other STI related infections. There is therefore the need to encourage hospital cuts rather than traditional ones, carried out by knowledgeable medical personnel, under sterilised and hygienic conditions. There is also the need to encourage voluntary male circumcision among the communities such as the Luos and Turkhanas that traditionally do not have this rite.

Theme 7.11 is on extra marital sexual relations and polygamy. There are two culturally ingrained practices that present colossal challenges to programmers in Kenya. Social marketers need to normalise and educate sexually active adults on the need for correct and consistent use of condoms to protect themselves from HIV and STIs. They also need to encourage the use of female condoms as weapons of self-protection among women. There is a need to encourage HIV testing and counselling as well as ARV treatment, among married individuals, those that suspect their partners of unfaithfulness and those in polygamous relationships. This may help in early treatment and may help protect other members of the complex sexual networks from infections and re-infections.

Theme 7.12 is on taboos such as rape, incest and homosexuality. Much as the law is clear on rape and sexual violence issues, social marketers need to do more at upstream, in-stream and downstream social marketing levels, using appropriate approaches and tools to ensure zero tolerance level is achieved towards gender related sexual violence and the violations of minors. There is a need to ensure that facilities and personnel are available to offer counselling, rehabilitation and treatment of such victims. The law should ensure that stiff penalties and punishments are accorded to perpetrators to deter other societal members from such practices.

In dealing with homosexuals, there is an urgent need for social marketers to engage with these groups. Downstream level could include using behavioural interventions such as counselling, media campaigns and condom education. In-stream social marketing interventions targeting the LGBTI group using biomedical interventions such as encouraging the uptake of male circumcision, rectal micro biocides and use of pre-exposure prophylaxis.

Upstream social marketing level is also important such as support for their human rights to be upheld, help with health systems for men that have sex with men (MSM) and public health legislation as well as decriminalising homosexuality in Kenya to stop human rights related abuses.

Theme 7.13 is on HIV related treatment and religion. In folk health care system, there is a need to counter witchcraft related narratives on HIV/AIDS and educate the public that witchcraft has nothing to do with how individuals acquire the HIV virus or related infections.

On herbal medication, there is a need for social marketers to lobby for the registration and monitoring of those practising alternative medicine such as herbalists, traditional surgeons and bonesetters to ensure that they do not mislead or harm gullible publics. Herbal industry should not be managed under women and community based groups but under public health or medical services and there is a need for a legal framework for the herbal pharmaceutical industry to monitor their standards and uphold ethical practices and ensure health and safety issues are upheld.

In relation to popular health care system, programmers need to ensure that their target audiences have factual information on HIV/AIDS prevention, treatment and care, to avoid believing in myths fuelled by ignorance.

Social marketers need to do much more in relation to professional health care system. They need to lobby for local manufacturing of less toxic ARVS such as tenofovir and zidovudine. They also need to lobby the local production of second line and third line treatment medication for those that develop intolerance and resistance to the first line treatment. They also need to lobby the government and donors for more and better investment in health care personnel and infrastructure.

Indeed, many Kenyan hospitals suffer from chronic shortage of health care personnel and lack of laboratories that can help PLWAS monitor their viral loads and immunity levels as well as access help with opportunistic infections.



There is also a need for vigilance among health care employees, medical suppliers and health institutions to fight medication and equipment theft and related corruption in health care institutions. Downstream measures such as better counselling services to help PLWAS fight stigma and discrimination, as well as training health care providers on matters of how to handle PLWAS are also necessary.

Theme 7.14 relates to cultural enablers. Social marketers need to incorporate positive cultural aspects of their target audiences in their programme work. Positives such as strong family and kinship relations that help to reach out to the hard to reach audiences, investing in cultural specific income generation activities to fight female and male related poverty, working with and training herbalist in HIV/AIDS related matters to ensure a better response to programme work by their target audiences should not be ignored.

Theme 7.15 is on political, legal and donor related issues. Corruption is a major political issue fuelled by the lack of the political will to fight graft and lack of legal enforcement of laws to punish perpetrators. There is a need for the Kenyan government to do more to fight graft at all levels and social marketers need to put the government to task on corruption that has permeated all sectors of the economy. Politicians also need to be trained by social marketers on HIV/AIDS factual issues on prevention, care and treatment so that they can avoid misleading the publics. Peace is important for programme work and the government should uphold security by fighting corrupt security officers that compromise the security of ordinary citizens.

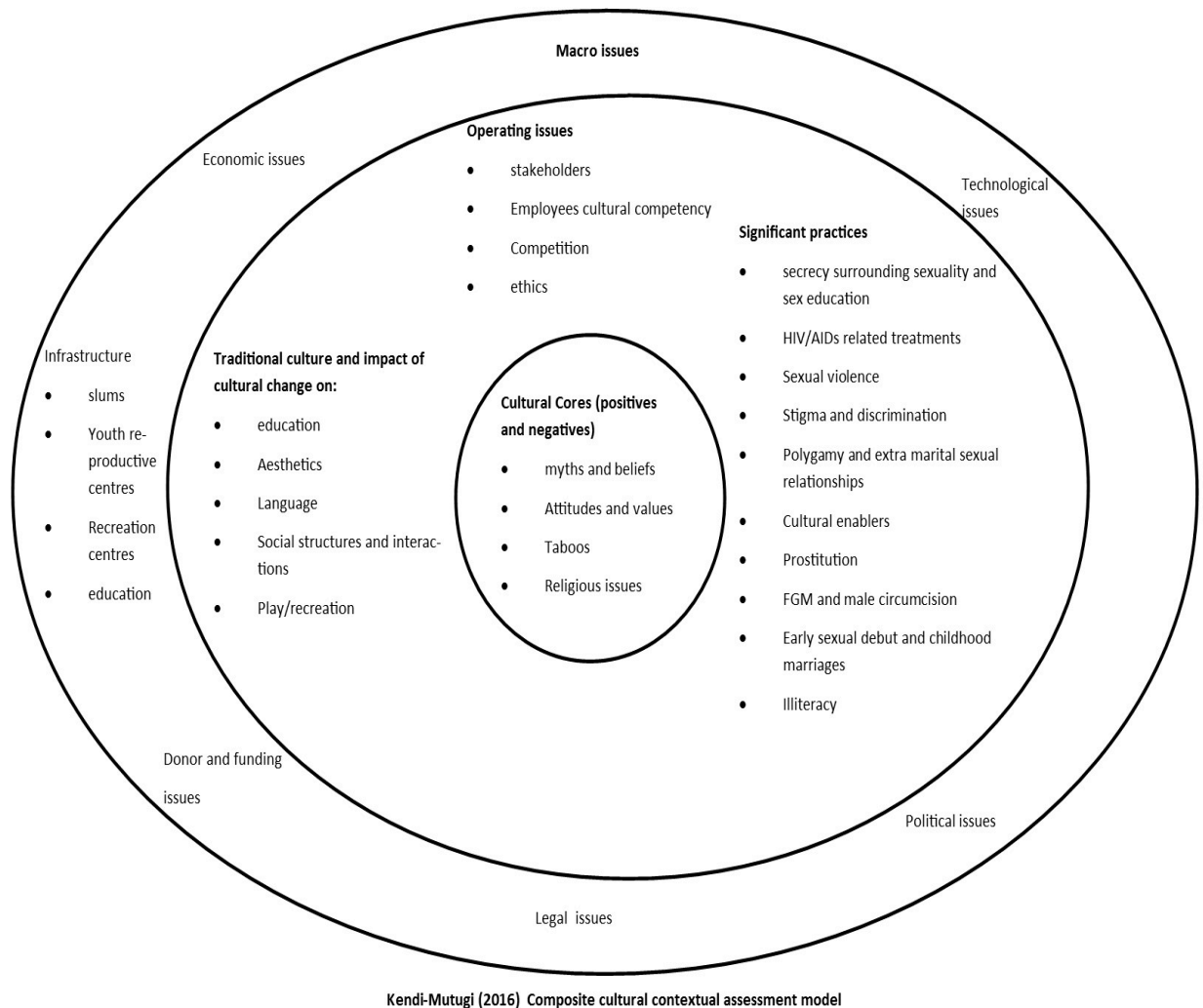
Legal challenges relate to HIV/AIDS tribunals, which need to be availed in the 47 counties of Kenya to avoid overwhelming the present existing tribunal. They should be given jurisdiction over criminal matters too. Social marketers also need to lobby the government to change the constitution especially the section that criminalise homosexuality to avoid human rights abuses against these groups.

In relation to donor funding, social marketers need to lobby donors and development partners on providing realistic funding conditions that considers the best interest of target audiences rather than unrealistic ones. There is also a need for programmers to be accountable for the funds received. The government should also invest in funding ARVS as they have a responsibility for their citizens, rather than only relying on donor funds. The government should endeavour to manufacture ARVS locally to cut down on costs and to make them more accessible to the local Kenyans.

#### **8.4. Contribution to knowledge**

A reflection of the two earlier models, the cultural context assessment composite model (2013) developed based on secondary literature review in chapter 3 and cultural-contextual assessment model (2015), based on research findings in chapter seven, necessitates a final synthesised comprehensive model that borrows from the two. The model is necessary as a contribution to knowledge and is shown below:

## Synthesised cultural-context assessment model (2016)



**Figure 13 - Kendi-Mutugi (2016)- synthesised cultural-context assessment model (2016).**

The model above features the cultural cores at the inner most central layer. They include: myths and beliefs. Myths encapsulate tales, usually sacred and set in the distant past or other worlds involving extra human, inhuman or heroic characters believed to be true (Lemming, 1990), while beliefs are opinions or convictions that we hold about different realities of the world (Wright, 2006). Other elements that form parts of the cultural cores are attitudes and values, taboos, and religious issues. In this context, attitudes refer to favourable or unfavourable evaluations of an object (Eagly and Chaiken, 1993); while values are enduring beliefs or concepts about

desirable goals and modes of action (Shwartz and Bilsky, 1987). Taboos relate to strict social prohibitions that call for severe negative reinforcement and as explained by Cosman and Cladis (2001), religious issues relate to beliefs and practices relative to sacred things and are surrounded by prohibitions, beliefs and practices that unite adherents. Myths, beliefs, attitudes, values, taboos and religious issues may explain many of the rational and/or irrational decisions and actions taken by the target audiences. These actions and decisions may in turn have positive and/or negative impact on programme work. It is therefore important for programmer to glean, understand and engage with them appropriately for successful programme work.

The second innermost centric layer in the model features operating issues. They include: Stakeholders that relates to individuals and groups that can affect or are affected by strategic decisions and outcomes of an organisation. Stakeholders involved in programme work need to be identified, understood and engaged with appropriately. Symbiotic relationships may be pursued, while parasitic relations' done away with or engaged with tactfully. Employees' cultural competency need to be assessed and addressed appropriately via training, as it may hugely impact on decision making. As shown in the model, competition may come from one or several actors in the market involved in the struggle for scarce resources; and those that produce very similar products or services that satisfy same target audiences' needs.

Competitors in social marketing interventions need to be identified, understood and engaged with appropriately, as they may impact positively and/or negatively on social marketing interventions. Ethics relates to what is perceived and judged as right or wrong; and may differ depending on interventions, contexts and cultures. Hence, social marketers need to glean, understand and engage with ethical issues that relate to their interventions appropriately.

The second layer also features significant practices. These practices may differ depending on the areas or problems targeted by the social marketing intervention. However, in relation to HIV/AIDS, significant practices include: secrecy surrounding sexuality and sex education, HIV/AIDS related forms of treatment, sexual violence, stigma and discrimination, polygamy and extra marital sexual relations, prostitution,

female genital mutilation (FGM) and male circumcision, early sexual debut and childhood marriages, illiteracy and cultural enablers. Social marketers need to research on the relevant and significant practices that may impact on their specific programme work, from the view point of their target audiences, and engage with these practices appropriately, for the success of their interventions.

Also in this second layer of the model are five major issues, whose traditional culture and impact of cultural change ought to be gleaned, understood and engaged with in programme work. Firstly, with education, it is vital to understand how formal and informal education has changed, to engage appropriately with target audiences' preferred instruction methods, instructors, content and place/venues for education, for effective communication and optimal learning by the target audiences. Secondly, aesthetics refers to concepts of taste, beauty, what is perceived as pleasant and desirable; and may refer to physical, intellectual, moral or literal aspects of beauty (Johnson, 1982). Aesthetics is a social construct, that may only be better understood from the perspective of the target audiences, hence the need for researching to appropriately engaging with it; as it may have evolved due to cultural borrowings and may provide insights in the planning and delivery of interventions.

Thirdly, language may be multi-faceted, as it may refer to different aspects and preferences such as: the spoken languages, those preferred for social interactions, for formal interactions and those preferred by specific individual groups among the target audiences. It is crucial for social marketers to consider the target audiences' language preferences, and engage with these preferences appropriately, even if it means investing in the learning of target audiences' preferred languages by programme employees, to communicate effectively with them. Fourthly, social structures and interactions are crucial in understanding the target audiences' behaviour, decision making processes and individuals of influence. This understanding can greatly help in the planning and delivery of social marketing interventions, as programmers can make good use of agents of change for faster diffusion of their interventions. It is therefore crucial for social marketers, to research, understand these social dynamics and engage with them appropriately.

Fifthly, play/recreation issues are vital as they provide avenues for social marketers to understand their target audiences better in their informal environment. Play may provide valuable insights into the social issue at hand and may also provide informal avenues for planning and delivery of successful interventions.

The outermost layer features the macro factors. Political issues relate to governance, power bases and elections to local and central government offices. Political environment may influence social marketing interventions due to their important roles in relation to legislation, , fiscal strategy, budgeting, targeting audiences' settings, enforcement of justice, enabling and empowerment of individuals, and provision of social amenities among others. These political factors may impact positively or negatively on social marketing interventions, hence the need for social marketers to tactfully engage with this environment.

Economic environment, relates to economic parameters of a country such as: employment, income, wealth creation, demand and supply factors, interest rates, inflation among others. Certainly, many of these economic factors may impact positively or negatively on different social marketing interventions, hence the need to tactfully engage with them. The legal environment relates to the laws and regulations that govern a country and the relevant sectors in charge. Laws of a nation may impact on programme work positively or negatively. Technology relates to the application of scientific knowledge for practical purposes in different industries. Different aspects of technology such as technological advancements, availability, diffusion, cost, may have an enduring impact on social marketing programmes. Infrastructure relates to the physical and organisational structures and facilities needed for the operations of a society. Different interventions may require different structures and organisation. Hence, social marketers need to understand how available and non-existing structures and facilities impact on their interventions and engage with them appropriately. Finally, social marketing interventions need financial resources, that could be from their organisations or donors.

Funding issues determine interventions availability, implementation, longevity and sustainability. So, it is imperative for social marketers to seriously engage with funding issues to address the biggest threat to their programme work, which is the issue of sustainability of their programmes and understand how funding impacts on their social marketing programmes/interventions.

Overall, the synthesised cultural-context assessment model (2016) is indeed a useful model that can guide and assist social marketers glean and understand their target audiences' cultural and contextual issues better; and provide them with valuable insights that can assist them in successful planning, implementation, evaluation and decision making in their social marketing interventions.

This study also further contributes to the social marketing field in several ways as detailed below:

- 1) It suggests a cultural-context assessment composite model (2013)- figure 11 and cultural-contextual assessment model (2015)- figure 12, which social marketers can use in all stages of social marketing. The models simplify social marketers understanding of the cursorily used terms culture and context, to aid deeper understanding of their target audiences. They are quite useful in the first stage of social marketing process- scoping or situation analysis; as they lead to a sound understanding of determinants, context and consequences of past, current behaviours and desired ones from the point of view of audiences, in line with the clarion call by Lefebvre (2011). The findings evidence that the models are robust and vigorous enough to scope the context and cultural realities of a target market, and efficient enough to suggest areas that may need upstream, in-stream or downstream social marketing approaches. Researchers' can also use the models for cross countries comparison studies and to further more research work in social marketing, HIV/AIDs and other related disciplines.

- 2) The study also provides a detailed contextual and cultural assessment of the use of social marketing in HIV/AIDS related programmes in an interesting multi tribal context as Kenya. Researchers, donors, programmers and related stakeholders certainly benefit from this study, as it gives detailed knowledge and discussions providing cultural and contextual realities of HIV/AIDS in Kenya. This knowledge could equip them with a better cultural understanding of their target audiences and may be used as part of their secondary research. This understanding may also be a basis for further research, policies and decision making and can help them design more effective and culturally congruent campaigns, to better fight the HIV/AIDs epidemic in Kenya and many other similar African countries.
- 3) The seven major and three minor tribes of Kenya: The Kikuyus, Luyias, Kalenjins, Luos, Kambas, Somalis, Kisiis, Mijikendas, Merus, Turkanas and the Maasai tribes, covering over 81.22% of the Kenyan population are discussed extensively in relation to their cultural and contextual HIV/AIDS realities. No other studies have taken such an extensive and rigorous approach to gleaning and understanding how cultural nuances impact on HIV/AIDS related programme work in Kenya as this one. Hence, this study is indeed unique, rigorous and extensive, coverings all the former eight provinces of Kenya in an interesting, comprehensive and robust manner. The whole research is a unique cultural evaluation of the use of social marketing programmes that target HIV/AIDS in Kenya from the programmers' perspective. It gives some detailed insights in the cultural and contextual realities of different tribal groups in Kenya in relation to social marketing efforts targeting one of the most important challenges facing Kenya, the HIV/AIDS social issue.
- 4) This research suggests and evidences that there is a close association between tribal belonging and HIV/AIDS risk, based on the cultural nuances practised by the group members. Chapter two summarises in table form the risky practices found among the various Kenyan tribal groups, which may increase their HIV risk, that social marketers can engage with and address appropriately. These practices are well corroborated in the research findings in the responses given by programmers.



- 5) The study aids in the understanding of the patterns of HIV transmission within the Kenyan context and explains the different prevalence rates found in the different regions of the country. The seven major tribal groups are extensively discussed as well as three minor ones, covering all the provinces of Kenya. Indeed, these patterns of transmission point to the need for tribal specific segmentation when dealing with multi tribal groups for effective social marketing programme work. It also cautions social marketers against blanket assumptions of cultural homogeneity based on nationalities and suggests the need for cultural specific research to inform programme planning, implementation and evaluation of interventions.
- 6) The study findings suggest that the use of social marketing in the fight of the HIV/AIDS virus in Kenya is effective to a certain extent. However, unless it engages with the cultural and contextual realities of the target audiences, it cannot realise its full potential. The study points to the need for tribal specific segmentation, due to the uniqueness of the cultural nuances of each of the Kenyan groups. Again the study evidences that social marketers mainly use downstream social marketing without using the full potential of social marketing, especially upstream and in-stream social marketing approaches. It is not enough to target the audiences; programmers need to target the policy makers and other stakeholders relevant to their programme work. The study also evidences that social marketing has mainly been restricted to the health domain in Kenya and there is need for programmers to use the social marketing mind set to address other social issues such as the environment, deforestation, afforestation, bad governance, corruption, education, substance abuse, domestic violence, gender related violence, child abuse among other problems that Kenyans face.
- 7) The social marketing chapter makes a robust evaluation of social marketing in relation to culture and evidences that social marketing has not been engaging with culture robustly. There is the need for the discipline to take the cultural concept with the seriousness it deserves, as culture may impact positively or negatively on programme work.

Indeed, cultural nuances underpin target audiences' attitudes, practices, behaviour, costs, price and competition and unless it is robustly engaged with, social marketing cannot realise its full potential in effecting social changes.

- 8) This study provides a beautiful understanding of how the macro factors impact on HIV/AIDS related social marketing programmes in Kenya. It evidences that macro environmental factors (PESTEL) may have either positive or negative implications on HIV/AIDS related programme work. The political environment underpinned by poor governance and corruption impacts poverty and unsound multi-sectoral policies. The economic environment is strongly linked to the political environment and the geographical realities of the target audiences. The technological environment may curtail technical knowhow that could realise economic and health benefits; while the legal factors may encourage homophobic and discriminatory policies and practices that may impact negatively on social marketing programmes. Failure to engage with environmental factors may impact food securities that hinder effective uptake of HIV related treatment. Indeed, PESTEL analysis is a part of the contextual understanding of the target audiences that social marketers need to fully embrace.
- 9) Indeed, all the important recommendations given in 8.3 are contributions to knowledge and policy making, as they are based on sound research findings. They address relevant stakeholders such as: social marketers, policy makers, coordinating organs, donors, the Kenyan government and others that could benefit by implementing these recommendations for more effective programme work and more fruitful fight against HIV/AIDS epidemic in Kenya.

### **8.5. Limitations of the study and areas of further research**

The study mainly focuses on Kenya, although a few other countries are used for the purpose of comparing pertinent issues mentioned in the study. For instance, the educational lifelong learning chances in Kenya, are compared to those of England. Attaining a D and E grade in secondary schools in Kenya usually condemns an

individual to no career and brands these individuals as failures. This is unlike in England that offers credible foundation courses and limitless opportunities to retake GCSEs to improve chances of getting to any career of choice. Homophobic issues in Kenya are compared to those in Uganda and Nigeria and contrasted with South Africa, England and America among other thematic issues. Perhaps, future studies can consider regional study such as an East African study or with good funding continental studies like the whole of Africa, Europe, Asia or other continents to test the models and contribute more to the understanding of how cultural and contextual realities influence the use of social marketing approach in programmes targeting HIV/AIDS and other social issues in different countries and continents.

The study also only concentrates on the programmes dealing with HIV/AIDs. Perhaps further research could focus on all or major sexually transmitted infections (STIs) and other chronic health conditions as well as other social concerns that social marketers deal with, to understand how culture and context influences the use of social marketing approach in dealing with these issues.

This study targets only the programmers, perhaps future researchers need to target more programme stakeholders including the target audiences, to get a more detailed and wider picture of the cultural contextual realities that affect social marketing related interventions, in the form of triangulation.

## **8.6. Chapter summary**

The research objectives of this study was to get a deeper understanding of the contextual and cultural realities encountered by programmers dealing with HIV/AIDS issues, using a social marketing approach in a culturally diverse context as Kenya. The study sought to understand: how social marketers perceive culture, the contextual realities they face, cultural barriers and enablers they encounter in relation to their programme work. The study probes into how they engage with these realities and seeks to gain insights into how they could better engage these realities for more successful interventions.

This study evidences that programmers view cultural and context as providing both positive and negative impacts on their programme work. Major contextual concerns relate to specific geographical realities of a tribal group, however some issues cut

across the many tribal groups in Kenya and include: illiteracy and low educational attainments, intergenerational high rate of poverty, endemic corruption that undermine development. Others include poor health and educational infrastructure, marginalisation of some geographical areas and environmental concerns. Poor investment in technology, discriminative laws especially among the LGBTI groups, poor enforcement of laws, poor investment in entrepreneurial education as many people prefer the limited white collar jobs encouraged by the educational system, poor leadership and governance, greedy leaders, poor planning and misuse of the limited resources available, all impact negatively on programme work.

Cultural issues are also unique to each Kenyan tribal group, however those that cut across tribal groups include: notorious religiosity, fatalistic attitudes towards misfortunes, gender related violence and female genital mutilation (FGM). Lack of male medical circumcision by some tribal groups especially the Luos and Turkanas, traditional male circumcision with the sharing of knives, cultural silence on sexual matters and wife inheritance practised by almost all the tribal groups. Premarital sexual practices encouraged by again almost all tribal groups especially among the boys while punishing the girls that fall pregnant. Culturally allowed extra marital sexual practices, cultural preference and search of male children, culturally engendered superiority of men and inferiority of women.

Others include inheritance practices along the male children and not females, taboos that encourage discrimination especially of the LGBTIs, cross-generational arranged marriages, childhood marriages and early sexual debut. Belief in witchcraft, strong belief and preference of herbal practitioners and medicines to conventional medicine, intertribal animosity and hostility that fuels discrimination and tribal clashes leading to killing of innocent outgroup tribal members.

Main recommendations relate to the need to address cultural and contextual realities of the target audiences. They include the need to reform the education curriculum to support: lifelong learning, enterprising culture, ICT skills, sex education and empower the youth to deal with risky cultural nuances based on factual HIV/AIDS knowledge. There is a need to provide free secondary education for all to alleviate poverty and improve literacy skills, micro financing to ease youth's joblessness and encourage entrepreneurship. Need to address regional imbalances, illicit beer brewing,

discourage faith healing, pass bills relating to making herbal medicine safe, legitimise homosexuality, vigilance and punishment of international tourists that molest children and rehabilitation of child prostitutes. There is a need for more health infrastructure, dealing with local and international terrorists as well as corruption and effecting good governance. There is need to expand HIV equity tribunals to deal with HIV related stigma and provide the youth with reproductive health facilities among other recommendations. Most important though, social marketers need to not only use downstream social marketing approaches but also make good use of up-stream and in-stream approaches.

In relation to contribution to knowledge, this study is unique and comprehensive in that it focuses on all the regions-provinces of Kenya. It focusses on major tribes of Kenya and a few minor ones, hence contributing to an in-depth understanding of the contextual and cultural realities faced by social marketers targeting HIV/AIDS in these regions. The study also suggests cultural contextual models that social marketers can use to understand their target audiences for effective planning, implementation and evaluation of their programmes. The study is however limited in that it only discusses the Kenyan context, however it recommends regional and continental studies using the models to contribute to cross counties and cross continental understanding of how culture and context impacts on social marketing approaches in the fight against HIV/AIDS and other social issues.

## References

### A

- Aaker, J. L. and Williams, P. (1998). Empathy versus Pride: The influence of emotional appeals across Cultures. *Journal of Consumer Research*, 25, pp.241–261
- Abdalla, R. (1982). *Sisters in affliction*. London: Zed Press.
- Abramson, P. and Herdt, G. (1990). The assessment of sexual practices relevant to the transmission of AIDS: A global perspective. *Journal of Sex Research*, 27(2), pp.215-232.
- Adler, J. (1991). *International dimensions of organizational behavior*. Boston, MA: Kent Publishing.
- Adamczyk, A. and Greif, M. (2011). Education and risky sex in Africa: Unraveling the link between women education and reproductive health behaviors in Kenya. *Social Science Research*, 40, pp.654–666.
- Agar, M. H. (1985). *Speaking of ethnography*. CA: Sage.
- Ahlberg, B. (1991). *Women, sexuality, and the changing social order*. Philadelphia: Gordon and Breach.
- Ahlberg, B., Jyklas, E. and Krantz, I. (2001). Gender construction of sexual risk-implications for safer sex among young people in Kenya and Sweden. *Reproductive Health Matters*, 9(17), pp.26-36.
- Ahlberg, B., Kirumbi, V., Kaara, L. and Krantz, M. (1997). The Mwomboko Research project. The practice of male circumcision in Central Kenya and its implications for the transmission and prevention of STD/HIV in Central Kenya. *African Sociological Review*, 1(1), pp.66-81.
- Ahmad, I. (2000). *Islam and female circumcision*. [online] Minaret.org. Available at: <http://www.minaret.org/fgm-pamphlet.htm> [Accessed 21 Aug. 2013].
- Ahmed, K. (1999). *The impact of HIV/AIDS on the Muslim community in the western Cape: A critical analysis of Muslim responses to the AIDS pandemic*. Thesis. University of Cape Town.
- Airhihenbuwa, C., DeClemente, R., Wingood, G. and Lowe, A. (1992). HIV/AIDS education and prevention among African-Americans: A focus on culture. *AIDS education and prevention*, 4(3), pp.267-276.
- Airhihenbuwa, C. (1995). *Health and culture*. Thousand Oaks, California: Sage Publishers.

- Airhihenbuwa, C. and Makinwa, B. (2000). *Communications for HIV/AIDS prevention, care, and support*. Philadelphia, PA: Taylor & Francis.
- Airhihenbuwa, C., Makinwa, B. and Obregon, R. (2000). Toward a new communications framework for HIV/AIDS. *Journal of Health Communication*, 5(supplement), pp.101-111.
- Ajiferuke, M. and Boddewyn, J. (1970). "Culture" and other explanatory variables In comparative management studies. *Academy of Management Journal*, 13(2), pp.153-163.
- Akwara, P., Madise, N. and Hinde, A. (2003). Perception of risk of HIV/AIDS and sexual behaviour in Kenya. *Journal of Biosocial Science*, 35(3), pp.385-411.
- Albaum, G., Strandkov, J. and Duerr, E. (2002). *International marketing and export management*. London: Prentice Hall.
- Albaum, G., Duerr, E. and Strandkov, J. (2005). *International marketing and export management*. Harlow, England: Prentice Hall/Financial Times.
- Allen, T. (1992). Taking culture seriously. In: T. Allen and A. Thomas, ed., *Poverty and development in the 1990s*, 1st ed. Oxford: Oxford University Press.
- Almroth, L. (2000). Male complications of female genital mutilation. In: *NORFA workshop on reproductive health research*. Gotland, Sweden.
- Almroth, L., Almroth-Berggren, V., Mahmoud Hassanein, O., Salah Eldin Al-Said, S., Siddiq Alamin Hasan, S., Lithell, U. and Bergström, S. (2001). Male complications of female genital mutilation. *Social Science and Medicine*, 53(11), pp.1455-1460.
- Altman, D. (2005). Rights matter: structural interventions and vulnerable communities. *Health and Human Rights*, 8(2), p.203.
- Aluanga, L. (2010). *Public hospitals run out of basic supplies*. [online] Standard Digital News. Available at: <http://www.standardmedia.co.ke/business/article/2000001579/public-hospitals-run-out-of-basic-supplies?pageNo=2>. [Accessed 15 Jan. 2015].
- Andreasen, R. (1994). Social marketing: its definition and domain. *Journal of Public Policy and Marketing*, 13(1), pp.108-114.
- Andreasen, R. (1997). Prescription for theory-driven social marketing research: A response to Goldberg's alarms. *Journal of Consumer Psychology*, 6(2), pp.189-196.
- Andreasen, R. (2002). Marketing social marketing in the social change marketplace. *Journal of public policy and marketing*, 21(1), pp.3-13.
- Andreasen, R. (2005). *Social marketing in the 21st century*. California: Thousand Oaks.

Anker, B. T. and Kappel, K. (2011). Ethical challenges in commercial social marketing. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage.

Arnould, E. and Thompson, C. (2005). Consumer Culture Theory (CCT): Twenty Years of Research. *Journal of Consumer Research*, 31(4), pp.868-882.

Ashworth, P.D. (2003). An approach to phenomenological psychology: the contingencies of the lifeworld. *Journal of Phenomenological Psychology*, 34(2), pp.145-156.

Atwoli, L. (2012). *Such faith healing claims dangerous*. [online] Daily Nation. Available at: <http://www.nation.co.ke/oped/Opinion/Such-faith-healing-claims-dangerous/-/440808/1696120/-/5t4f47z/-/index.html>. [Accessed 20 Apr. 2015].

Atwoli, L. (2013). *Nothing new in religious healing claims*. [online] Daily Nation. Available at: <http://www.nation.co.ke/oped/Opinion/Nothing-new-in-religious-healing-claims/-/440808/1967140/-/r2wtaxz/-/index.html> [Accessed 15 Jan. 2014].

Ayado, H. (2008). *Wary of ARVs' side effects, slum patients go herbal*. [online] Standard Digital News. Available at: [https://www.standardmedia.co.ke/?articleID=1144000527&story\\_title=wary-of-arvs-side-effects-slum-patients-go-herbal&pageNo=3](https://www.standardmedia.co.ke/?articleID=1144000527&story_title=wary-of-arvs-side-effects-slum-patients-go-herbal&pageNo=3) [Accessed 25 Jun. 2014].

Ayikukwei, R., Ngare, D., Sidle, J., Ayuku, D., Baliddawa, J. and Greene, J. (2007). Social and Cultural Significance of the Sexual Cleansing Ritual and its Impact on HIV Prevention Strategies in Western Kenya. *Sex Cult*, 11(3), pp.32-50.

## **B**

Bailey, R., Muga, R., Poulussen, R. and Abicht, H. (2002). The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya. *AIDS Care*, 14(1), pp.27-40.

Ball, K., Bauman, A., Leslie, E., and Owen, N. (2001). Perceived environmental aesthetics and convenience and company are associated with walking for exercise among Australian adults. *Preventive Medicine*, 33, pp.434-440.

Ball-Rokeach, J., Rokeach, M. and Grube, J. (1984). *The great American values test: influencing behavior and belief through television*. New York: Free Press.

Bandawe, C. (2005). Psychology Brewed in an African Pot: Indigenous Philosophies and the Quest for Relevance. *Higher Education Policy*, 18(3), pp.289-300.

Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, N.J.: Prentice-Hall.



- Bannerman, R., Burton, J. and Chien, W. (1983). *Traditional medicine and health care coverage*. Geneva: World Health Organization.
- Basch, F. (1990). *International health*. New York: Oxford University Press.
- Bascom, W. (1981). *Contributions to folkloristics*. Meerut, India: Folklore Institute.
- Basker, G. (2013). A review on hazards of khat chewing. *International Journal of Pharmacy and Pharmaceutical Science*, 5(supplement 3), pp.74-77.
- Bauman, E., Sallis, F., Dzewaltowski, A. and Owen, N. (2002). Toward a better understanding of the influences on physical activity: The role of determinants, correlates, causal variables, mediators, moderators and confounders. *American Journal of Preventive Medicine*, 23, pp.5-14.
- BBC News. (2010). *Deadly home-brewed liquor kills 17 in Kenya - BBC News*. [online] Available at: <http://www.bbc.co.uk/news/world-africa-10770370> [Accessed 23 Jan. 2014].
- Becker, G. (1993). *Human capital*. Chicago: The University of Chicago Press.
- Beckerleg, S. (2004). How 'cool' is heroin injection at the Kenya Coast. *Drugs: Education, Prevention and Policy*, 11(1), pp.66-77.
- Beckerleg, S., Telfer, M. and Hundt, G. (2005). The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal*, [online] 2(12). Available at: <http://doi.org/10.1186/1477-7517-2-12> [Accessed 15 Mar. 2015].
- Berelson, B. (1952). *Content analysis in communication research*, New York: The Free Press.
- Berg, B. (2001). *Qualitative research methods for the social sciences*. Boston: Allyn and Bacon.
- Berg-Schlosser, D. (1982). *Tradition and change in Kenya*. Paderborn: Schoeningh.
- Berg-Schlosser, D. (1984). African Political Systems: Typology and Performance. *Comparative Political Studies*, 17(1), pp.121-151.
- Berkley, F., Widy, R., Okware, S., Downing, R., Linnan, M., White, K. and Sempala, S. (1989). Risk factors associated with HIV infection in Uganda. *Journal of Infectious Diseases*, 160, pp. 22-30.
- Berry, J. (1979). A cultural ecology of social behaviour. In: L. Berkowitz (ed), ed., *Advances in experimental social psychology*, 1st ed. Boston: Allyn & Bacon.
- Black, J. (1989). *Child health in a multicultural society*. London: BMJ Publications.

- Blaikie, N. (1993). *Approaches to social enquiry*. Cambridge: Polity Press.
- Blanc, A. (2000). *The relationship between sexual behavior and level of education in developing countries*. Geneva: UNAIDS.
- Blaxter, L., Hughes, C. and Tight, M. (2001). *How to research*. Buckingham: Open University Press.
- Bloom, N., Novelli, D. (1981). Problems and challenges in social marketing. *Journal of Marketing*, 45 (2), pp.79-88.
- Blount, G.B. (1973). The Luo of South Nyanza, Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed., Nairobi: East African Publishers.
- Blum, H. (1974). *Planning for Health: Developmental Application of Social Change Theory*. New York: Human Sciences Press.
- Blum, L. (1983). *Expanding health care horizons: from a general systems concept of health to a national health police*. 2nd ed. Oakland, CA: Third Party.
- Boateng, F. (1983). African traditional education; a method of disseminating cultural values. *Journal of Black Studies*, 13(3), pp.321-336.
- Bond, H. (1991). Chinese values and health: a cross cultural examination. *Psychology Health*, 5, pp.137-152.
- Bookman, M. and Bookman, K. (2007). *Medical tourism in developing countries*. New York: Palgrave.
- Booth, K. (2004). *Local women, global science*. Bloomington, Ind.: Indiana University Press.
- Bourdieu, P. (1985). Forms of capital. In: J. Richardson, *Handbook of theory and research for the sociology of education*. Westport, Conn.: Greenwood Press.
- Boyatzis, R. (1998). *Transforming qualitative information*. Thousand Oaks, CA: Sage Publications.
- Brady, M. (1999). Female genital mutilation: complications and risk of HIV transmission. *AIDS patients care and STDs*, 13(12), pp.709-716.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp.77-101.
- Breidlid, A. (2005). HIV/AIDS, cultural constraints and education. *UWC papers in education*, 6(3), pp.50-57.

Breidlid, A. (2009). HIV/AIDS, cultural constraints and educational interventions strategies. In: J. Baxen and A. Breidlid, ed., *HIV/AIDS in Sub-Saharan Africa*, 1st ed. Tokyo, New York and Paris: United Nations University Press.

Brenkert, G (2002). Ethical challenges of social marketing. *Journal of Public Policy and Marketing*, 21, pp.14-25.

Brewer, D., Potterat, J. and Brody, S. (2007). Male circumcision in HIV prevention. *The Lancet*, 369(9573), p.1597.

Brislin, R. (2000). *Understanding culture's influence on behavior*. Fort Worth: Harcourt College Publishers.

Bryant, K. (2006). Expanding research on the role of alcohol consumption and related risks in the prevention and treatment of HIV/AIDS. *Substance Use Misuse*, 4, pp.1465–1507.

Bryman, A. (2008). *Social Research Methods*. 3<sup>rd</sup> edition. Oxford: Oxford University Press.

Bryman, A., Stephen, M. and Campo, C. (1996). The Importance of Context: Qualitative Research and the Study of Leadership. *Leadership Quarterly*, 7(3), pp.353-370

Buchanan, D. R., Reddy, S., and Hossain, Z. (1994). Social marketing: a critical appraisal. *Health Promotion International*, 9(1), pp. 49-57.

Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse Education Today*, 11, pp.461-466.

Buss, M. (1989). Sex differences in human mate preferences: evolutionary hypotheses testing in 37 cultures. *Behavioral and brain sciences*, 12, pp.1-49.

Buzzle. (2014). *General Overview of the Biopsychosocial Model*. [online] Available at: <http://www.buzzle.com/articles/general-overview-of-the-biopsychosocial-model.html> [Accessed 24 Aug. 2014].

## C

Cairns, G., Mackay, B. and MacDonald, L. (2011). Social marketing and international development. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.330-342.

Caldwell, C., Caldwell, P. and Quiggin, P. (1989). The social context of AIDS in sub-Saharan Africa. *Population and Development Review*, 15(2), pp. 185-233.

Caldwell, J. (1999). Reasons for limited sexual behavioral change in the sub Saharan African AIDS epidemic and possible future intervention strategies. In: J. Caldwell, ed., *Resistance to behavioral change to reduce HIV/AIDS infection in predominantly*

*heterosexual epidemics in third world countries*, 1st ed. Canberra: Health Transition Centre, pp.214-256.

Caldwell, L., (2005). Leisure and health: why is leisure therapeutic? *British Journal of Guidance and Counseling*, 33(1), pp. 7-26.

Campbell, M. and Gregory, F. (2004). *Mapping social relations*. Walnut Creek, CA: AltaMira Press.

Campinha-Bacote, J. (1992). Voodoo illness. *Perspectives in Psychiatric Care*, 28(1), pp.11-17.

Carlos, A. and Dialo, A. (1986). *Male involvement in family planning - a focus on Africa*. Africa Link: International Planned Parenthood Federation.

Carmody, D. and Carmody, J. (1993). *Native American religions*. New York: Paulist Press.

Carr, C. (2002). *Social Psychology*. Chinchester: Wiley.

Carringer, P. (1994). Not just a worthy cause: cause-related marketing delivers the goods and the good. *American Advertising*, 10(1), pp.16–19

Castelli, F., Pietra, V., Diallo, I., Schumacher, R. and Simpoire, J. (2010). Antiretroviral (ARV) Therapy in Resource Poor Countries: What do we Need in Real Life?. *The Open AIDS Journal*, 4(2), pp.28-32.

Castro, F., Manuel, B., and Martinez, C. (2004). The cultural adaptation of prevention interventions: resolving tensions between fidelity and fit. *Prevention Science*, 5(1), pp.41-45.

Castrol, G. (1998). Cultural competence training in clinical psychology: Assessment, clinical intervention, and research. In A. Bellack and M. Hersen (eds.), *Comprehensive Clinical Psychology*. Amsterdam: Pergamon/Elvesier.

Cateora, P. and Graham, J. (2005). *International marketing*. Boston: McGraw-Hill/Irwin.

Cavanagh, S. (1997). Content Analysis: Concepts, methods and application. *Nurse Researcher*, 4, pp. 5-16.

Centers for Disease Control and Prevention and The Academy for Educational Development. (2004). *Syringe disinfection for injection drug users*. Atlanta, GA.

Centers for Disease Control and Prevention (CDC), (2009). HIV infection among injection-drug users—34 states, 2004–2007. *MMWR- Morbidity and Mortal Weekly Report*, 58, pp. 1291–1295

- Chambers, R. (1983). *Rural development; putting the last first*. New York; John Wiley.
- Champion, J. C. and Shain, R. (1998). Life histories of woman abuse: The context of sexually transmitted diseases. *Issues in mental health nursing*, 19, pp.463-480.
- Chelson, K. (2005). Nanny or steward, the role of government in public health. Kings Fund.
- Cherlin, A., Laumann, E., Gagnon, J., Michael, R. and Michaels, S. (1995). Social Organization and Sexual Choices. *Contemporary Sociology*, 24(4), p.293.
- Chesney, M. (2000). Factors Affecting Adherence to Antiretroviral Therapy. *Clinical Infectious Diseases*, 30(Supplement 2), pp. S171-S176.
- Chinweizu, O. and Madubuike, I. (1983). *Towards the decolonization of African literature: Volume 1. African fiction and poetry and their critics*. Washington DC: Howard University Press.
- Chirumuuta, R. and Chirumuuta, R. (1989). *AIDS, Africa and Racism*. London: Free Association Books.
- Chisholm, D., Rehm, J., Van Ommeren, M. and Monteiro, M. (2004). Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies on Alcohol*, 65(6), pp.782-793.
- Chrisman, J. and Zimmer, A. (2000). Cultural competence in primary care. In P. Meredith and N. Horan, ed., *Adult Primary care*. Philadelphia: Saunders, pp.66-75.
- Cia.gov. (2011). Kenya- *The World Fact book — Central Intelligence Agency*. [online] Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html> [Accessed 20 Feb. 2013].
- Cline, R. and Haynes, K. (2001). Consumer health information seeking on the internet: the state of the art. *Health Education Resources*, 16(6), pp.21-26.
- Coast, E. (2001). Colonial preconceptions and contemporary demographic reality: Maasai of Kenya and Tanzania. In: *IUSSP (International Union for the scientific study of population*. Brazil.
- Cohen, D. and Atieno- Odhiambo, S. (1989). *Siaya. The Historical Anthropology of an African Landscape*. London: James Curry.
- Cohen, E. (1986). Lovelorn Farangs: The Correspondence between Foreign Men and Thai Girls. *Anthropological Quarterly*, 59(3), pp.115-127.
- Cole F.L. (1988). Content analysis: process and application. *Clinical Nurse Specialist*, 2(1), pp.53-57.

Coleman, J. (1990). *Foundations of Social Theory*. Cambridge, Mass: Harvard University Press.

Connell, W. (1987). *Gender and power: society, the person and sexual politics*. Cambridge: Polity Press.

Connor, P. and Becker, B. (1994). Personal Values and Management: What do we Know and Why don't we Know more?. *Journal of Management Inquiry*, 3(1), pp.67-73.

Cook, L. and Clark, B. (2005). Is there an association between alcohol consumption and sexually transmitted diseases? A systematic review. *Sexually Transmitted Diseases*, 32, pp.156-164.

Corbetta, P. (2003). *Social research*. London: Sage Publications.

Corbin, J. and Strauss, A. (2015). *Basics of qualitative research*. Los Angeles: Sage.

Crabtree, B. and Miller, W. (1992). A template approach to text analysis: developing and using codebooks, in B. Crabtree and W. Miller (eds). *Doing Qualitative research*. Newbury Park: Sage.

Crabtree, B. and Miller, W. (1999). *Doing qualitative research*. Thousand Oaks, Calif.: Sage Publications.

Creswell, J. (2003). *Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.

Crotty, M. (1998). *The foundations of social research*. 1<sup>st</sup> ed. London: Publishers.

Crotty, M. (2003). *The foundations of social research: meaning and perspectives in the research process*. 10th ed. London: Sage Publishers.

## D

Daily Nation, (2013). *Government urged to declare HIV national disaster*. [online] Mobile.nation.co.ke. Available at: <http://mobile.nation.co.ke/news/Government-urged-to-declare-HIV-national-disaster/1950946-1997660-format-xhtml-11kxnos/index.html> [Accessed 23 Mar. 2015].

Dalgic, T. and Heijblom, R. (1996). Marketing blunders revisited. *Journal of International Marketing*, 4(1), pp.81-91.

Dallabetta, A., Miotti, G. and Chipangwi, D. (1993). High socioeconomic status is a risk factor for human immunodeficiency virus type 1 (HIV-1) infection but not for sexually transmitted diseases in women in Malawi: Implications for HIV-1 control. *Journal of Infectious Diseases*, 167, pp. 36-42.

- Dann, S. (2010). Redefining social marketing with contemporary commercial marketing definitions. *Journal of Business Research*, 63, pp.147-153.
- Davis, D. and Whitten, R. (1987). The Cross-Cultural Study of Human Sexuality. *Annual Review in Anthropology*, 16(1), pp.69-98.
- Dawes, M. (1999). *Moi: AIDS a national disaster*. [online] Available at: <http://http://news.bbc.co.uk/2/hi/africa/538071> [Accessed 20 Oct. 2014].
- Denzin, N. (2006). *Sociological methods*. New Brunswick, N.J.: Aldine Transaction.
- Denzin, N. K. and Lincoln, Y. (1994). *Handbook of qualitative research*. Thousand Oaks: Sage.
- De Vincenzi, I. and Martens, T. (1994). Male circumcision. *AIDS*, 8(2), pp.153-160.
- Dey, I. (1993). Qualitative Data Analysis. *A user-friendly guide for social scientists*. London: Routledge.
- Diamond, J. (2002). *The religious success story*. Review Books: New York.
- Dibb, S. and Carrigan, M. (2013). Social marketing transformed. *European Journal of Marketing*, 47(9), pp.1376-1398.
- Dichter, M. and Gelles, R. (2012). Women's Perceptions of Safety and Risk Following Police Intervention for Intimate Partner Violence. *Violence Against Women*, 18(1), pp.44-63.
- Dirie, M. and Lindmark, G. (1991). A hospital study of the complications of female circumcision. *Tropical Doctor*, 21, pp.146-148.
- Dixon-Mueller, R. and Wasserheit, J. (1991). *The culture of silence*. New York: International Women's Health Coalition.
- Dolan, L. (2007). Handful of sites top search list for medical information. *American Medical News*, 50(11), pp.20-24.
- Donovan, R. (2011). Social Marketing's mythunderstandings. *Journal of Social Marketing*, 1(1), pp.8-16.
- Donovan, R. and Henley, N. (2003). *Social marketing*. Melbourne, Australia: IP Communications.
- Donovan, R. and Henley, N. (2010). *Principles and practice of social marketing*. Cambridge: Cambridge University Press.
- Downe-Wamboldt, B. (1992). Content analysis: method, applications, and issues. *Health Care for Women International*, 13, pp.313-321.

Durch, J., Bailey, L. and Stoto, M. (1997). *Improving the health in the community: A role for performance monitoring*. Washington, DC: National Academy Press.

Durkheim, É., Cosman, C. and Cladis, M. (2001). *The elementary forms of religious life*. Oxford: Oxford University Press.

Durkin, T. (1997). Using computers in strategic qualitative research. In: G. Miller, and R. Dingwall, *Context and method in qualitative research*, London: Sage Publications.

Dutta, M. (2007). Health information processing from television: the role of health orientation. *Health Communication*, 21(1), pp.1-9.

## E

Eagly, A. and Chaiken, S. (1993). *The psychology of attitudes*. Fort Worth, TX: Harcourt Brace Jovanovich College Publishers.

Edginton, C., Hudson, S. and Scholl Kathleen G., (2005). *Leadership for recreation, parks, and leisure services*. Champaign, Ill.: Sagamore.

Egger, G., Fitzgerald, W., Frape, G., Monaem, A., Rubinstein, P., Tyler, C. and McKay, B. (1983). Results of large scale media antismoking campaign in Australia: North Coast "Quit for Life" programme. *BMJ*, 287(6399), pp.1125-1128.

Egger, G., Spark, R. and Donovan, R. (2005). *Health promotion strategies and methods*. Sydney: McGraw-Hill.

Eggers, G. and Swinburn, B. (1997). An ecological approach to the obesity pandemic. *British Medical Journal*, 80, pp.315-477.

Eisenberg, L. (1977). Disease and illness: distinctions between professional and popular ideas of sickness. *Culture, medicine and psychiatry*, 1, pp.9-23.

Elchalal, U., Ben-Ami, B. and Brzezinski, A. (1999). Female circumcision: the peril remains. *British journal of urology international*, 83, pp.103-108.

Eliot, C. (1966). *The East Africa Protectorate*. New York: Barnes & Noble.

Elmis, S. (1983). The chewing of khat in Somalia. *Journal of Ethno pharmacology*, 8(2), pp. 163-176.

Elo, S. and Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62, pp.107-115.

Engel, G. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137(5), pp.535-544.

Erickson, J. (1995). The importance of authenticity for self and society. *Symbolic Interaction*, 18, pp.121-144.



Erulkar, A. (2004). The Experience of Sexual Coercion Among Young People in Kenya. *International Family Planning Perspectives*, 30, pp.182-189.

Evans, G. and Stoddart, L. (1994). *Producing health, consuming health care*. Why are some people healthy and others not?. In: Evans, G., Barer, L. and Maror, R. (eds.). *The determinants of health populations*. New York: Aldine De Gruyter.

## F

Fazio, H. (1995). Attitudes as object-evaluation associations: determinants, consequences and correlates of attitude accessibility. In: R. Petty and J. Krosnick, ed., *Attitude strength: Antecedents and consequences*, 1st ed. New Jersey: Erlbaum.

Feather, T. (1995). Values, valences and choices: The influence of values on the perceived attractiveness and choice of alternatives. *Journal of personality and social psychology*, 68, pp.1135-1151.

Fenton, L. (2004). Preventing HIV/AIDS through poverty reduction: the only sustainable solution? *Lancet*, 364, pp.1186-1187.

Ferrel, C. and Gresham, L. (1985). A contingency framework for understanding ethical decision making in marketing. *Journal of Marketing*, 49, pp.87-96.

Ferrell, O. and Hartline, M. (2011). *Marketing management strategies*. Australia: South-Western, Cengage Learning.

Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, Ill.: Row, Peterson.

Fielding, N. (2000). The Shared Fate of Two Innovations in Qualitative Methodology: The Relationship of Qualitative Software and Secondary Analysis of Archived Qualitative Data. *Forum Qualitative Sozialforschung /Forum: Qualitative Social Research*, [online] 1(3). Available at: <http://www.qualitative-research.net/fqs/fqs-eng.htm>. [Accessed 20 Apr. 2014].

Fine, H. (1981). *The marketing of ideas and social issues*. A. Fiszbein, N. Schady and F. Ferreira (2009). *Conditional cash transfers*. Washington D.C.: World Bank.

Flick, U. (1989). *An introduction to qualitative research*. London: Sage.

Foucault, M. and Miskowiec, J. (1986). Of Other Spaces. *Diacritics*, 16(1), p.22-27.

Foucault, M., Rabinow, P. and Faubion, J. (1997). *The essential works of Michel Foucault, 1954-1984*. New York: New Press.

Freeman, E. (1984). *Strategic Management: A stakeholder approach*. Boston, MA: Pitman Publishing.

Freire, P. (1973). *Education for critical consciousness*. New York: Continuum.

French, H. (1996). *Migrant Workers Take AIDS Risk Home to Niger*. [online] Nyti.ms. Available at: <http://nyti.ms/2cNLI0H> [Accessed 13 Mar. 2015].

French, J. (2011). Business as usual: the contribution of social marketing to government policy making and strategy development. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.359-374.

French, J. and Blair-Stevens, C. (2005). *Social Marketing Pocket Guide*. London: Social Marketing Centre.

French, J., Blair-stevens, C. (2006). From snake oil salesmen to trusted policy advisors: the development of a strategic approach to the application of social marketing in England. *Social Marketing Quarterly*, 12(3), pp.29-40.

Freud, S. (1989). *The future of an illusion*. New York: Norton.

Foeken, D. and Mwangi, A. (2000). Increasing food security through urban farming in Nairobi. In N. Bakker, M. Dubbeling, S. Gundel, U. Sabel-Koschella and H. Zeeuw (Eds.), *Growing cities, growing food: urban agriculture on the policy agenda*. Feldafing, Germany: Food and Agriculture Development Centre.

Fortson, G. (2008). The Gradient in Sub-Saharan Africa: Socioeconomic Status and HIV/AIDS. *Demography*, 45(2), pp.303–322.

Fournier, S. (1998). Consumers and their brands: developing relationship theory in consumer research. *Journal of consumer research*, 24(March), pp.343-373.

Fox, K. (1980). Time as a component of price in social marketing. 1980 Educators Conference Proceedings. Chicago: American Marketing Association.

Fox, K. and Kotler, P. (1980). The Marketing of Social Causes: The First 10 Years. *Journal of Marketing*, 44(4), p.24.

## G

Gable, L., Gostin, L., Hodge, J. (2008). HIV/AIDS, reproductive and sexual health, and the law. *American Journal of Public Health*. Volume 98, Issue 10, pp. 1779-1786.

Gagnon, H. and Simon, W. (2005). *Sexual conduct: The social sources of human sexuality*, 2<sup>nd</sup> ed. Brunswick and London: Aldine Transaction.

Gallant, M. and Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African youth. *Social Science and Medicine*, 58(7), pp.1337-1351.

Gannon, M. (1994). *Understanding global cultures*. California: Thousand Oaks.

Garcia-Moreno, C. (2005). Public health: violence against women. *Science*, 310(5752), pp.1282-1283.

Gathura, G. (2011). *HIV drugs 'that cause premature aging' named*. [online] Daily Nation. Available at: <http://www.nation.co.ke/news/HIV-drugs-that-cause-premature-aging-named/-/1056/1191144/-/14hilas/-/index.html>. [Accessed 20 Jan. 2015].

Gaudet, C. L., Wong, M.P., Brady, A., Kent, R. (1997). How are we managing? The transition from environmental quality to ecosystem health. *Ecosystem Health*, 3, pp. 3-10.

Geertz, C. (1973). Thick description: Towards an interpretive theory of culture, in C. Geertz, *The interpretation of cultures*. New York: Basic Books.

Geertz, C. (1983). *Local knowledge: further essays in interpretive anthropology*. New York: Basic Books.

Geibel, S., King'ola, N., Temmerman, M. and Luchters, S. (2012). The impact of peer outreach on HIV knowledge and prevention behaviours of male sex workers in Mombasa, Kenya. *Sexually Transmitted Infections*, 88(5), pp.357-362.

Gemson, S. (2013). *Herbal medicine industry in dire need of regulation*. [online] Daily Nation. Available at: <http://www.nation.co.ke/lifestyle/DN2/Herbal-medicine-industry-in-dire-need-of-regulation/-/957860/1697644/-/w1fvj5/-/index.html> [Accessed 15 Dec. 2014].

Georgas, J. (1989). Changing Family Values in Greece: From Collectivist to Individualist. *Journal of Cross-Cultural Psychology*, 20(1), pp.80-91.

George, K., Ellison, G. and Larson, B. (2002). Explaining the relationship between religious involvement and health. *Psychological Inquiry*, 13, pp.190-200.

Gherardi, S. and Truner, B. A. (1987). Real men don't collect soft data. *Quaderno*, 13, Dipartimento di politica Sociale, Universita di Trento.

Giddens, A. (1999). *Runaway world: how globalization is reshaping our lives*. London: Profile Books.

Giger, J. and Davidhizar, R. (1991). *Transcultural nursing*. St. Louis: Mosby.

Glaser, B. G. and Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine.

Goffman, E. (2014). *Stigma*. Johannesburg: MTM.

Goldberg, M. (1995). Social marketing: are we fiddling while Rome burns?. *Journal of Consumer Psychology*, 4(4), pp.347-370.

- Gorn, G. and Goldberg, E. (1982). Behavioral evidence of the effects of televised food messages on children. *Journal of consumer Research*, 9(2), pp.200-205.
- Gostin, L. (2008). *Public health law*. Berkeley: University of California Press.
- Gould, S. J. (1994). Sexuality and Ethics in advertising: A research agenda and policy guideline perspective. *Journal of advertising*, 23, pp.73-80.
- Gould, S. J. (1995). Sexualized aspects of consumer behaviour: An empirical investigation of consumer love maps. *Psychology and Marketing*, 12(August), pp. 395-413.
- Gould, W. (1988). Urban-Rural Return Migration in Western Province Kenya. In: *African Population Conference 1988, Vol 2*. Liege: IUSSP.
- Gray, P. B. (2003). HIV and Islam: is HIV prevalence lower among Muslims? *Social Science and Medicine*, 58(9), pp.1751-1756.
- Granehiem, U. and Lundman, B. (2004). Qualitative content analysis in Nursing Research: concept, procedures, and measures to achieve trustworthiness. *Nurse Education Today*, 24, pp.105-112.
- Graves, K., L., and Leigh, B. C. (1995). The relationship of substance use to sexual activity among young adults in the United States. *Family Planning Perspectives*, 27, pp.18-22.
- Graziani, M., Milella, M. and Nencini, P. (2008). Khat Chewing from the Pharmacological Point of View: An Update. *Substance Use and Misuse*, 43(6), pp.762-783.
- Gregson, S., Terceira, N., Mushati, P., Nyamukapa, C., and Campbell, C. (2004). Community group participation: Can it help young women to avoid HIV? An explanatory study of social capital and school education in rural Zimbabwe. *Social Science and Medicine*. 58, pp.2119-2132.
- Gregson, S., Waddell, H. and Chandiwana, S. (2001) School education and HIV control in sub-Saharan Africa: from discord to harmony? *Journal of International Development*, 13, pp.467-485.
- Gubrium, J. and Holstein, J. (1997). *The new language of qualitative method*. New York: Oxford University Press.
- Gubrium, J. and Holstein, J. (2002). *Handbook of interview research: context and methods*. Thousand Oaks: Sage.
- Gurdon, B. (1912). *A colony in the making, or, sport and profit in British East Africa. With map and illustrations*. London.

## H

- Hall, E. (1959). *The silent language*. Garden City, N.Y.: Doubleday.
- Hall, E. (1976). *Beyond culture*. Garden City, N.Y.: Anchor Press.
- Hall, E. (1982). *The hidden dimension*. Yarmouth, Me.: Interculturel Press.
- Hammersley, M. (1992). *What's wrong with ethnography?* London: Routledge.
- Hancock, J., Nalo, D., Aoko, M., Clark, H. and Forsythe, S. (1996). The Macroeconomic impact of HIV/AIDS. *AIDS in Kenya: Socio-economic impact and policy implications*, Family Health International/AIDS CAP.
- Hancock, T. and Perkins, F. (1985). The Mandala of health: a conceptual model and teaching tool. *Health Promotion*, 24, pp.8-10.
- Hardy, D. (1987). Cultural Practices contributing to the transmission of human immunodeficiency virus in Africa. *Reviews of Infectious Diseases*, 9(6), pp.109-119.
- Hargreaves, J. and Glynn, J. (2000). Educational attainment and HIV infection in developing countries; a systematic review. In: *XIIIth International AIDS Conference*, Durban.
- Harris, M. (1980). *Cultural Materialism. The struggle for a science of culture..* New York: Vintage Books.
- Harris, M. (1988). *Culture, people and nature: An introduction to general anthropology*. 5th ed. New York: Harper and Row.
- Harrison, D. (1982). Aesthetic aspect in African ritual setting. In: Johnson, A.(ed.). *Towards defining the African aesthetics*. Washington, DC: Three Continents.
- Harrison, J., Bosse, D. and Phillips, R. (2010). Managing for stakeholder, stakeholder utility function and competitive advantage. *Strategic Management Journal*, 31, pp. 58-74.
- Harwood, T. and Garry T. (2003). An overview of content analysis. *The Marketing Review*, 3, pp.479–498.
- Hatcher, A., Romito, P., Odero, M., Bukusi, E., Onono, M. and Turan, J. (2013). Social context and drivers of intimate partner violence in rural Kenya: implications for the health of pregnant women. *Culture, Health and Sexuality*, 15(4), pp.404-419.
- Hausbeck, K. and Brents, B. (2000). Inside Nevada's brothel industry. In: R. Waiter, ed., *Sex for sale*, 1st ed. New York: Routledge, pp.217-238.
- Heidenheimer, A., Michael, J. and Victor, T. (1989). Terms, Concepts, and Definitions: An Introduction. In: A. Heidenheimer, M. Johnston, and V. Le Vine, *Political corruption*, New Brunswick, U.S.A.: Transaction Publishers.

- Helble, M. (2011). The movement of patients across borders: challenges and opportunities for public health. *Bulletin of the World Health Organisation*, 89, pp.68-72.
- Helman, C. (2007). *Culture, health, and illness*. London: Hodder Arnold.
- Henry, P. (2001). An examination of the pathway through which social class impacts health outcomes. *Academy of marketing science review*, [online] 2001(3). Available at: <http://www.amsreview.org/articles/henry03-2001.pdf> [Accessed 10 Sep. 2014].
- Herold, E., and Van Kerkwijk, C. (1992). AIDS and sex tourism. *AIDS and Society*, 4(1), pp.1-8.
- Hershey, M. (2009). Kenya's delayed response to HIV/AIDS: A case study. In: *The annual meeting of the Midwest Political Science Association 67th Annual National Conference*. Chicago, Illinois.
- Herskovits, M. (1955). Peoples and Cultures of Sub-Saharan Africa. *The ANNALS of the American Academy of Political and Social Science*, 298(1), pp.11-20.
- Hewson, C. (2007). Gathering data on the internet: qualitative approaches and possibilities for mixed methods research. In: A. Jonson, ed., *The oxford handbook of internet psychology*, 1st ed. Oxford: Oxford University press.
- Hill, P. (2011). Impoverished consumers and social marketing. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California.
- Hirschman, E. and Holbrook, M. (1982). Hedonic Consumption: Emerging Concepts, Methods and Propositions. *Journal of Marketing*, 46(3), p.92.
- Hitlin, S. (2003). Values as the Core of Personal Identity: Drawing Links between Two Theories of Self. *Social Psychology Quarterly*, 66(2), p.118.
- Hitlin, S. and Piliavin, J. (2004). Values: Reviving a Dormant Concept. *Annual Review of Sociology*, 30(1), pp.359-393.
- Hoek, J., and Gendall, P. (2006). Advertising and obesity: a behavioral perspective. *Journal of Health Communication*, 11(4), pp.409-423.
- Hofstede, G. (1980). *Culture's consequences*. Beverly Hills, California: Sage Publications.
- Hofstede, G. (1983). National Cultures Revisited. *Cross-Cultural Research*, 18(4), pp.285-305.
- Hofstede, G. (1991). *Cultures and organizations*. London: McGraw-Hill.

- Hofstede, G. (1992). Turning Organizational Culture from Fad into Management Tool. *Creativity and Innovation Management*, 1(1), pp.41-45.
- Hofstede, G. (1994). *Uncommon Sense about Organizations: Cases, Studies and field Observations*. Thousand Oak CA: Sage Publications.
- Hofstede, G. (1995). Multilevel research of human systems: flowers, bouquets and gardens. *Human System Management*, 14(3), pp.207-218.
- Holliday, A. (2002). *Doing and Writing Qualitative Research*. London: Sage.
- Holmberg, S. (1996). The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *American Journal of Public Health*, 86(5), pp.642–654.
- Holsti, O. R. (1968). Content Analysis. In: G. Lindzey and E. Aronson, ed., *Handbook of Social Psychology*, 2nd ed. New Delhi: Amerind, pp.596-692.
- Hornik, R. (1995). Public health education and communication as policy instrument for bringing about changes in behavior. In: *The Society for Consumer Psychology Conference: The Role of Advertising in Social Marketing*. Atlanta.
- Hoskins, C. and Mariano, C. (2004). *Research in nursing and health*. New York: Springer Pub. Co.
- Howard-Grabman, L., and Snetro, G. (2003). *How to mobilize communities for health and social change*. Baltimore, MD: Health Communication Partnership.
- Huberman, A. and Miles, M. (2002). *The qualitative researcher's companion*. Thousand Oaks, CA: Sage Publications.
- Humphrey, A. (1960). Swot analysis for management consulting. In: SRI Alumni Association Newsletter, *SRI Alumni association newsletter December*, [online] California: SRI International, pp.7-8. Available at: <https://www.sri.com/sites/default/files/brochures/dec-05.pdf> [Accessed 15 Aug. 2015]. [Accessed 15 Aug. 2015].
- Hunt, D. (2007). Economic growth: should policy focus on investment or dynamic competition? *European Business Review*, 19(4), pp.274-291.
- Huntingford, B. (1973). The Nandi of Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.
- Huttlinger, K. and Tanner, D. (1994). The Peyote Way: Implications for Culture Care Theory. *Journal of Transcultural Nursing*, 5(2), pp.5-11.

## I

Iloa, M. (1990). Culture and health. In: R. Breslin, ed., *Applied Cross Cultural Psychology*. Newbury Park, CA: Sage.

International Institute for Legislative Affairs, (2014). *Alcoholic Drinks Control Act (2010)*. [online] International Institute for Legislative Affairs. Available at: <http://ilakenya.org/alcoholic-drinks-control-act-2010/> [Accessed 25 Mar. 2015].

IRIN, (2014). *HIV funding worries in Kenya*. [online] IRIN. Available at: <http://www.irinnews.org/report/100419/hiv-funding-worries-kenya> [Accessed 20 Apr. 2015].

Iwelunmor, J., Newsome, V. and Airhihenbuwa, C. (2013). Framing the impact of culture on health: a systematic review of the PEN-3 cultural model and its application in public health research and interventions. *Ethnicity and Health*, 19(1), pp.20-46.

## J

Jacob, H. (1973). The Pastoral Maasai of Kenya and Tanzania. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

Jaeger, E. and Rosnow, R. (1988). Contextualism and its implications for psychological inquiry. *British Journal of Psychology*, 30(1), pp.101-13.

Jain, C. (2001). *International Marketing*. 6th ed. London: Thomson Learning.

James, O. (2008). *The Selfish Capitalist*. London: Vermillion.

Jayasuriya, D. (1995). *HIV law, ethics and human rights*. New Delhi: UNDP Regional Project on HIV and Development.

Jensen, H. (2010). The logic of qualitative survey research and its position in the field of social research methods. *Qualitative Social Research*, [online] 11(2). Available at: <http://www.qualitative-research.net/index.php/fqs/article/view/1450/2946>. [Accessed 20 Mar. 2015].

Johansen, R. (2002). Pain as a counterpoint to culture: towards an analysis of pain associated with infibulation among Somali immigrants in Norway. *Medical Anthropology Quarterly*, 16, pp.312-340.

Johansen, R. (2006). Care for infibulated women giving birth in Norway- An anthropological analysis of health workers management of a medically and culturally unfamiliar issue. *Medical anthropology Quarterly*, 20, pp.516-544.

Johnson, A. (1982). *Towards defining the African aesthetics*. Washington, D.C: Three Continents Press.



Johnson, W., Diaz, R., Flanders, W., Goodman, M., Hill, A., Holtgrave, D., Malow, R. and McClellan, W. (2008). Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men. *Cochrane Database of Systematic Reviews*, 16(3), article no CD001230.

Jones, M and Wick, C. (1999). Convergent stakeholder theory. *Academy of Management Review*, 24, pp.206-221.

## K

Kahle, R. (1996). Social values and consumer behavior: research from the list of values. In: C. Seligman, J. Olson and M. Zanna, ed., *The psychology of values: the Ontario Symposium*, Erlbaum: New Jersey.

Kako, P. and Dubrosky, R. (2013). “You Comfort Yourself and Believe in Yourself”: Exploring Lived Experiences of Stigma in HIV-Positive Kenyan Women. *Issues in Mental Health Nursing*, 34(3), pp.150-157.

Kalichman, S. (2010). Social and Structural HIV Prevention in Alcohol-Serving Establishments. *Alcohol Research and Health*, 33(3), pp.184-194.

Kamaara, E. (2005). *Gender, youth sexuality, and HIV/AIDS*. Eldoret, Kenya: AMECEA Gaba Publications.

Kapiga, S. Shao, J., Lwhihula, G. and Hunter. D. (1994). Risk factors for HIV infection among women in Dar es salaam, Tanzania. *Journal of Acquired Immune Deficiency Syndrome*, 7(3), pp.301-309.

Kaplan, A. (1998). *The conduct of inquiry*. New Brunswick, N.J.: Transaction Publishers.

Karuki, J. (2013). *Kenya warned on HIV donor funding*. [online] Mobile.nation.co.ke. Available at: <http://mobile.nation.co.ke/news/Kenya-warned-on-HIV-donor-funding/1950946-1994386-format-xhtml-1wwt64z/index.html> [Accessed 26 Apr. 2015].

Kawachi, I., Kennedy, B. and Glass, R. (1999). Social capital and self-rated health: a contextual analysis. *American Journal of Public Health*, 89(8), pp.1187-1193.

Kayongo-Male, D. and Onyango, P. (1984). *The sociology of the African family*. London: Longman.

Keenan, J., Fuller, J., Cahil, L. and Kelly, K. (2004). *Catholic ethicists on HIV/AIDS prevention*. New York and London.

Kelly, A., Murphy, A., and Sikkema, J. (1997). Randomized, controlled, community-level HIV prevention intervention for sexual-risk behavior among homosexual men in US cities. *Lancet*, 350, pp.1500-1505.

- Kelly, R. (1982). *Leisure*. Englewood Cliffs, N.J.: Prentice-Hall.
- Kelly, R. (1996). *Leisure*. 3rd ed. Boston: Allen and Bacon.
- Kenya AIDS Indicator Survey (KAIS), (2007). Final report- 2007. Nairobi: Ministry of Health.
- Kenya AIDS Indicator Survey (KAIS), (2012). *Final report-2012*. Nairobi: Ministry of Health.
- Kenya Human Rights Commission (2011). *The outlawed amongst us*. [online] Available at: [http://www.khrc.or.ke/resources/publications/doc\\_download/14-the-outlawed-amongst-us.html](http://www.khrc.or.ke/resources/publications/doc_download/14-the-outlawed-amongst-us.html) [Accessed 10 Feb. 2015].
- Kenya National Bureau of Statistics (KNBS), (2010). *Kenya Demographic and Health Survey 2008-2009*. Nairobi: KNBS.
- Kenya National Bureau of Statistics (2011). *Counties population based on 2009 census*. [online] Available at: <http://www.knbs.or.ke/counties.php> [Accessed 9 Jan. 2014].
- Kenya, P., Mulindi, S., Osongo, J. and Gatei, M. (1998). *HIV/AIDS in Kenya: situation analysis for NASCOP*. Ministry of Health /NAAC Office of the President.
- Kenyatta, J. and Malinowski, B. (1965). *Facing Mount Kenya*. New York: Vintage Books.
- Kershaw, G. (1972). The Kikuyu of central Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 2*, 1st ed. Nairobi: East African Publishers.
- Kettel, W.D. and Bonnie, L. (1973). The Tuken of Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.
- Kiama, W. (1999). Where are Kenya's homosexuals? *AIDS Anal Africa*, 9(5), pp. 9–10.
- Kiberenge, K. (2009). *Are these healers or lords of deception?*. [online] Standard Digital News. Available at: <http://www.standardmedia.co.ke/business/article/1144026074/are-these-healers-or-lords-of-deception?pageNo=4> [Accessed 15 Feb. 2014].
- Kibet, L. (2013). *Donors likely to cut down on HIV and Aids funds*. [online] Standard Digital News. Available at: <http://www.standardmedia.co.ke/lifestyle/article/2000080794/donors-likely-to-cut-down-on-hiv-and-aids-funds> [Accessed 19 May 2014].

- Kibicho, W. (2005). Tourism and the Sex Trade in Kenya's Coastal Region. *Journal of Sustainable Tourism*, 13(3), pp.256-280.
- Kickbusch, I, Silberschmidt, G. and Buss, P. (2007). Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization*, 85(3), pp.230-232.
- Kigotho, A. (1997). Moi scuppers sex-education plans in Kenya. *The Lancet*, 350(9085), p.1152.
- Kiiti, N. (2005). Indigenous knowledge: an effective communication and education resource for addressing HIV/AIDS among young people in Eastern Kenya. *Journal of Development Communication*, 16(1), pp.40-50.
- Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeier, M., Theobald, S. and Tolhurst, R. (2009). Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive Health Matters*, 17(34), pp.10-19.
- King, N. and Horrocks, C. (2010). *Interviews in qualitative research*. Los Angeles: SAGE.
- Kiragu, K. and Zabin, L. (1993). Contraceptive use among high school students in Kenya. *International Family Planning Perspectives*, 21, pp.108-113.
- Kirby, D. (2000). School-based interventions to prevent unprotected sex and HIV among adolescents. In J. Peterson, and R. DiClemente (Eds.), *Handbook of HIV prevention*, New York: Plenum, (pp. 83–101).
- Kirby, D., Obasi, A., and Laris, B. (2006). The effectiveness of sex education and HIV education interventions in schools in developing countries. *Technical Report Series-World Health Organization*, 938, pp.106-120.
- Kissling, E., Allison, E., Seeley, J., Russell, S., Bachmann, M., Musgrave, S. and Heck, S. (2005). Fisher folk are among groups most at risk of HIV: cross-country analysis of prevalence and numbers infected. *AIDS*, 19(17), pp.1939-1946.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California Press.
- Kluckhohn, C. (1951). Values and value orientations in the theory of action. In: T. Parsons and E. Shils, ed., *Toward a general theory of action*, 1st ed. New York: Harper.
- Kluckhohn, C. (1954). Southwestern Studies of Culture and Personality. *American Anthropologist*, 56(4), pp.685-697.

Knodel, J. and Pramualratana, A. (1996). Prospects for Increased Condom Use Within Marriage in Thailand. *International Family Planning Perspectives*, 22(3), pp.97-102

Knowles, N. and Collett, P. (1989). Nature as myth, symbol and action: notes towards a historical understanding of development and conservation in Kenya. *Africa*, 59(4), pp.433-460.

Konings, E., Blattner, W., Levin, A., Brubaker, G., Siso, Z., Shao, J., Goedert, J. and Anderson, R. (1994). Sexual behaviour survey in a rural area of northwest Tanzania. *AIDS*, 8(7), pp.987-994.

Konty, A. and Dunham, C. (1977). Differences in value and attitude change over the life course. *Sociological Spectrum*, 17, pp.177-197.

Korir, L. and Njoroge, K. (2011). *Doctors alarmed as patients seek Loliondo 'wonder drug'*. [online] Standard Digital News. Available at: <http://www.standardmedia.co.ke/business/article/2000036949/doctors-alarmed-as-patients-seek-loliondo-wonder-drug>. [Accessed 17 Jun. 2014].

Kotabe, M. and Helsen, K. (2009). *The SAGE handbook of international marketing*. Los Angeles: SAGE.

Kotler, P. (1980). *Marketing management*. Englewood Cliffs, N.J.: Prentice-Hall.

Kotler, P. (1980). *Marketing Management, Analysis planning and control*. Englewood Cliffs, NJ: Prentice-Hall.

Kotler, P. (1998). *Marketing*. Sydney: Prentice Hall.

Kotler, P. (2001). *Kotler on marketing*. [New York]: Free Press.

Kotler, P. (2005). *According to Kotler*. New York: AMACOM

Kotler, P. and Lee, N. (2008). *Social marketing*. Los Angeles: Sage Publications.

Kotler, P. and Levy, S. (1969). Broadening the Concept of Marketing. *Journal of Marketing*, 33(1), p.10.

Kotler, P. and Levy, S. (1971). Demarketing, Yes, Demarketing. *Harvard Business Review*, 49(6), pp.74-80.

Kotler, P. and Roberto, N. (1989). *Social marketing*. New York: Free Press.

Kotler, P. and Zaltman, G. (1971). Social Marketing: An Approach to Planned Social Change. *Journal of Marketing*, 35(3), p.3.

Krapf, J. and Ravenstein, E. (1968). *Travels, researches, and missionary labours during an eighteen years' residence in Eastern Africa*. London: Cass.

Krippendorff, K. (1980). *Content Analysis: An Introduction to its Methodology*. Newbury Park: Sage Publications.

Kristiansen, C. and Zanna, M. (1991). Value Relevance and the Value-Attitude Relation: Value Expressiveness Versus Halo Effects. *Basic and Applied Social Psychology*, 12(4), pp.471-483.

Kroeber, A. and Kluckhohn, C. (1952). *Culture: A critical review of concepts and definitions*. New York: Random House.

Krueger, R. and Cassey, M. (2000). *Focus groups: a practical guide for applied research*. Thousand Oaks: Sage.

Kun, F. (1997). Female genital mutilation: the potential for increased risk of HIV infection. *International Journal of Gynecology and Obstetrics*, 59, pp.153-155.

Kumpfer, L., Alvarado, R., Smith, P., and Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, 3, pp 241-246.

Kugel, A. (1992). Sampling in qualitative inquiry. In: B. Crabtree and W. Miller, ed., *Doing Qualitative Research*, 1st ed. Newbury Park, CA: Sage, pp.31-44.

Kwena, A. (2004). Politics, etiquette and the fight against HIV/AIDS in Kenya: negotiating for a common front. *African Development*, 29(4), pp.113-131.

Kwena, Z., Cohen, C., Sang, N., Ngayo, M., Ochieng, J. and Bukusi, E. (2010). Fishermen as a suitable population for HIV intervention trial. *AIDS Research and Treatment*, 865903.

Kwendo, J. and Mukunga, M. (2009). *Rude, thieving staff in hospitals*. [online] Daily Nation. Available at: <http://www.nation.co.ke/oped/Letters/-/440806/686928/-/iys9r0/-/index.html>. Accessed 9/01/14. [Accessed 25 Feb. 2015].

Kyngas, H., and Vanhanen, L. (1999). Content analysis as a research method. *Hoitotiede*, 11, pp.3-12.

## L

LaBrie, J., Earleywine, M., Schiffman, J., Pedersen, E., Marriot, C. (2005). Effects of Alcohol, Expectancies, and Partner Type on Condom Use in College Males: Event-Level Analyses. *Journal of Sex Research*, 42, pp.259–266.

Laczniak, G. and Michie, D. (1979). The social disorder of the broadened concept of marketing. *Journal of the Academy of Marketing Science*, 7(3), pp.214-232.

Lambo, A. (1974). Psychotherapy in Africa. *Psychotherapy and Psychosomatics*, 24(4-6), pp.311-326.

- Landman, A., Ling, P. and Glantz, S. (2002). Tobacco Industry Youth Smoking Prevention Programmes: Protecting the Industry and Hurting Tobacco Control. *American Journal of Public Health*, 92(6), pp.917-930.
- Langdridge, D. (2004). *Introduction to research methods and data analysis in psychology*. Harlow: Pearson/Prentice Hall.
- Laumann, E. and Gagnon, J. (1995). A sociological perspective on sexual action. In: R. Parker and J. Gagnon, ed., *Conceiving sexuality: approaches to sex research in a post modern world*, 1st ed. New York: Routledge.
- Lawn and Kyngas (2005). L. (1999). Content Analysis (Finnish). Hoitotiede. Volume 11, pp. 3-12.
- LeClerc-Madlala, S. (2002a). Youth, HIV/AIDS and the importance of sexual culture and context- Social Dynamics. *Special Issue: AIDS and Society*, 28(1), pp. 20-41.
- LeCompte, M. and Goetz, J. (1982). Problems of Reliability and Validity in Ethnographic Research. *Review of Educational Research*, 52(1), p.31.
- Lee, A. (1966). Cultural Analysis in Overseas Operations. *Harvard Business Review*. pp.106-114.
- Leeming, D. (1990). *The world of myth*. New York: Oxford University Press.
- Lefebvre, R. (2007). The new technology: the consumer as participant rather than target audience. *Social Marketing Quarterly*, 13, pp.31-42.
- Lefebvre, R. (2011). Social models for social marketing: social diffusion, social networks, social capital, social determinants and social franchising. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.32-43.
- Le Grand, J. (2007). The politics of choice and competition in public services. *Political Quarterly*, 78(2), pp.207-213.
- Lehman, A., Postrado, L. Roth, D., McNary, S. and Goldman, H. (1994). Continuity of care and client outcomes in the Robert Wood Johnson Foundation Programme on Chronic Mental Illness. *Milbank Quarterly*, 72(1), pp.105-122.
- Levine, R. (1962). Witchcraft and Co-Wife Proximity in Southwestern Kenya. *Ethnology*, 1(1), p.39.
- LeVine, R. and LeVine, B. (1966). *Nyansonga, A Gusii community in Kenya*. New York: John Wiley.
- Levine, S. (1979). *Mothers and wives. Gusii women of East Africa*. Chicago: University of Chicago Press.

Lewis, I. M. (1973). The Somali and North Eastern Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

Lightfoot-Klein, H. (1989). *Prisoners of ritual: an odyssey into female genital circumcision in Africa*. New York: Haworth Press.

Lin, K., Inui, T., Kleinman, A. and Womack, W. (1982). Sociocultural Determinants of the Help-seeking Behavior of Patients with Mental Illness. *The Journal of Nervous and Mental Disease*, 170(2), pp.78-85.

Lincoln, Y. and Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, Calif.: Sage Publications.

Lincoln, Y. and Guba, E. (1990). Judging the quality of case study reports. *International Journal of Qualitative Studies in Education*, 3(1), pp.53-59.

Lomas, J. (1998). Social capital and health: implications for public health and epidemiology. *Social sciences and medicine*, 47(9), pp.1181-1188.

Lottenberg, D., Schechter, C. and Strand, J. (2011). Segmentation and targeting. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage handbook of social marketing*, 1st ed. London: Sage Publications, pp.125-135.

Luck, D. (1969). Broadening the Concept of Marketing. Too Far. *Journal of Marketing*, 33(3), p.53.

Lugard, F. (1960). *The rise of our East African empire*. Edinburgh: William Blackwood and Sons.

Lukalo, S. (1973). The Maragoli of Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, Nairobi: East African Publishers.

Lunt, P. K. and Livingstone, S. M. (1992). *Mass consumption and personal identity*. Buckingham: Open University Press.

## **M**

MacFadyen, L., Stead, M. and Hastings, B. (2003). Social marketing. In: M. Baker. *The marketing book*. Oxford: Butterworth-Heinemann.

MacLachlan, M. (2006). *Culture and health*. Chichester, England: John Wiley and Sons.

Madill, A., Jordan, A. and Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, pp 1-20.

- Markus, H. and Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98(2), pp.224-253.
- Marmot, M. (2000). Social determinants of health: from observation to policy. *The Medical Journal of Australia*, 172(8), pp.379-382.
- Marshall, C. and Rossman, G. (2006). *Designing qualitative research*. Thousand Oaks, Calif.: Sage Publications.
- Mason, J. (1996). *Qualitative researching*. Thousand Oaks: Sage.
- Mathews, J. and Cramer, E. (2008). Using technology to enhance qualitative research with hidden populations. *The qualitative Report*, 13(2), pp. 301-315.
- Mayer, I. (1973). The Gusii of Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.
- Mays, N. and Pope, C. (1996). Rigor in qualitative research. In N. Mays and C. Pope, *Qualitative research in health care*. London: BMJ Books.
- Mazrui, A. (1986). *The Africans: A triple heritage*. Boston: Little, Brown.
- Mbiti, J. (1973). The Kamba of Central Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.
- Mbiti, S. (1969). *African religions and philosophy*. London: Heinemann.
- McCaffrey, M. (1995). Female genital mutilation: consequences for reproductive and sexual health. *Sexual and marital therapy*, 10, pp.189-200.
- McCracken, G. (1986). Culture and consumption: A theoretical account of the structure and movement of the cultural meaning of consumer goods. *Journal of consumer research*, 13(June), pp.71-84.
- McCracken, G. (1988). *The long interview*. Newbury Park: Sage.
- McDermott, J. R., McCormack, B. and Thackeray, R. (2011). Social marketing and the health educator. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.405-418.
- McDermott, L., Stead, M. and Hastings, G. (2005). What is and what is not social marketing: the challenge of reviewing the evidence. *Journal of Marketing Management*, 21, pp.545-553.
- Merriam-webster dictionary, (2016). *Definition of BARRIER*. [online] Merriam-webster.com. Available at: <http://www.merriam-webster.com/dictionary/barrier> [Accessed 17 Jun. 2016].



Merriam-webster dictionary, (2016). *Definition of ENABLE*. [online] Merriam-webster.com. Available at: <http://www.merriam-webster.com/dictionary/enable> [Accessed 1 Jul. 2016].

Michelo, C., Sandoy, F. and Fylkesnes, K. (2006) Marked HIV prevalence declines in higher educated young people: evidence from population-based surveys (1995–2003) in Zambia. *Aids*, 20, pp.1031–1038.

Miles, M. B. and Huberman, A. (1984). *Qualitative data analysis: a sourcebook of new methods*. Beverly Hills: Sage.

Miles, M. and Huberman, A. (1994). *Qualitative data analysis*. Thousand Oaks: Sage Publications.

Miller, J. (2003). An Arresting Experiment: Domestic Violence Victim Experiences and Perceptions. *Journal of Interpersonal Violence*, 18(7), pp.695-716.

Ministry of Health Kenya, (2005a). *AIDS in Kenya: trends, interventions and impact*. Nairobi: National AIDS and STI Control Programme.

Minujin, A., Vandemoortele, J. and Delamonica, E. (2002). Economic growth, poverty and children. *Environment and Urbanization*, 14(2), pp.23-43.

Molnar, A. (2005). *School commercialism: from democratic ideal to market commodity*. New York: Taylor and Francis.

Morisky, D. (2006). *Overcoming AIDS*. Greenwich: IAP-Information Age Pub.

Morley, D. (1991). Kenya: Maasai warriors and their sexual partners. *The Lancet*, 337(8742), pp.667-668.

Morojele, K., Kachieng'a, A. and Makoko, E. (2006). Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine*, 62, pp.217-227.

Morse, J. (1991). *Qualitative nursing research*. Newbury Park, Calif.: Sage Publications.

Moses, S., Bradley, J., Nagelkerke, N., Ronald, A., Ndinya-Achola, J. and Plummer, F. (1990). Geographical Patterns of Male Circumcision Practices in Africa: Association with HIV Seroprevalence. *International Journal of Epidemiology*, 19(3), pp.693-697.

Mossie, A., Mekonnen, Z. (2002). Khat (*Catha edulis* Forsk) chewing, socio demographic description and its effect on academic performance. *Ethiopia Medical Journal*, 42(2), pp.125-36.

Muiruri, J. (2013). *Senators demand sacking of Kemsas bosses*. [online] Daily Nation. Available at: <http://www.nation.co.ke/news/politics/Senators-demand-sacking-of-Kemsas-bosses/-/1064/1958934/-/ulv3jn/-/index.html>. [Accessed 16 Mar. 2015].

Murdock, G. (2016). The common denominator of culture. In: L. Ralph, ed., *The science of man in the world crisis*, 1st ed. New York: Columbia University Press.

Murdock, P. (1980). *Theories of illness: A world survey*. Pittsburgh: University of Pittsburgh Press.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., Watson, P. (1998). Qualitative research methods in health technology assessment: a review of the literature. *Health Technology Assessment*, 2(16), pp.3-9.

Muturi, N. (2005). Communication for HIV/AIDS Prevention in Kenya: Social–Cultural Considerations. *Journal of Health Communication*, 10(1), pp.77-98.

Mwakera, M. (2009). *Why Kenyans turn to herbalists*. [online] Daily Nation. Available at: <http://www.nation.co.ke/news/-/1056/666522/-/4downnz/-/index.html>. [Accessed 10 Jan. 2015].

Mwambia, P. K. S. (1973). The Meru of Central Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

Mwangi, T. (2013). Dying to live: the search for universal health care. *The Daily Nation Kenya*. [online] Available at: <http://www.nation.co.ke/lifestyle/DN/The-case-for-universal-healthcare> [Accessed 9 Jan. 2014].

Mwaura, N. (2010). *Catholic church where people of all faiths seek divine power*. [online] Daily Nation. Available at: <http://www.nation.co.ke/lifestyle/lifestyle/1214-932398-e2dyv0/index.html> [Accessed 15 Sep. 2015].

Mwaura, P. (2008). Stigmatization and Discrimination of HIV/AIDS Women in Kenya: A Violation of Human Rights and its Theological Implications. *Exchange*, 37(1), pp.35-51.

## N

Nacc.or.ke. (2015). *Kenya-HIV-County-Profiles-2016.pdf*. [online] Available at: <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf> [Accessed 3 Nov. 2016].

Nandwa, J. and Bukenya, A. (1983). *African oral literature for schools*. Nairobi: Longman.

Nardone, A., Frankis, S., Dodds, P. (2001). A comparison of high risk sexual behaviour and HIV testing amongst a bar-going sample of homosexual men in London and Edinburgh. *European Journal of Public Health*, 11, pp.185-189.

Nasirumbi, H. (2000). Gender sensitivity and development in health policies: A case study of HIV/AIDS policies in Kenya. In: Kwesi Kwaa Prah and Abdel Ghaffar Mohammed eds., *Africa in transformation: political and economic transformation and social economic development responses in Africa*. Addis Ababa: OSSREA-Addis Ababa, pp.299-307.

National AIDS/STD Control Programme, (2003). *HIV and AIDS in Kenya 2003: Lessons from epidemiology and implications for programmes*. Nairobi: NASCOP.

National AIDS Control Council (NACC), (2006). *Country report: Kenya: UNGASS 2006: United Nations General Assembly Special Session on HIV/AIDS*. Nairobi: Office of the President.

National AIDS Control Council (NACC), (2007b). *Report of consultative process and results from the most at risk populations*. Nairobi: NACC.

National AIDS Control Council (NACC), (2014). *Kenya AIDS Response Progress Report*. Nairobi: NACC.

National AIDS and STI Control Programme (NASCOP), (2009). *Kenya AIDS Indicator Survey 2012: final report*. Nairobi: Ministry of Health-Kenya.

National AIDS and STI Control Programme (NASCOP)- Ministry of Health- Kenya, (2012). *Kenya AIDS Indicator Survey: 2012*. Nairobi: NASCOP.

National AIDS and STI Control Programme (NASCOP)- Ministry of Health- Kenya, (2013). *Kenya AIDS Indicator Survey 2013*. Nairobi: NASCOP.

Ndeti, K. (1973). The Kamba of Central Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

Ndungu, N. (2012). *Yes, we must lock quacks out of herbal medicine industry*. [online] Standard Digital News. Available at: [http://www.standardmedia.co.ke/?articleID=1144030185&story\\_title=yes-we-must-lock-quacks-out-of-herbal-medicine-industry&pageNo=3](http://www.standardmedia.co.ke/?articleID=1144030185&story_title=yes-we-must-lock-quacks-out-of-herbal-medicine-industry&pageNo=3) [Accessed 20 Aug. 2014].

Ndungu, M. (2010). *Catholic church where people of all faiths seek divine power*. [online] Daily Nation. Available at: <http://www.nation.co.ke/lifestyle/lifestyle/-/1214/932398/-/98yer2/-/index.html>. [Accessed 17 Jan. 2014].

Neulinger, J. (1981). *The psychology of leisure*. Springfield, Ill.: C.C. Thomas.

Neundorff, K. (2002). *The Content Analysis Guidebook*. Thousand Oak, CA: Sage Publications.

Ngugi wa Thiong'o. (1993). *Moving the center: The struggle for cultural freedom*. London: Curry.

Nigg, C., Allegrante, J. and Ory, M. (2002). Theory comparison and multiple behaviour research: common themes advancing health behavior research. *Health Education research*, 17, pp.670-679.

Njoroge, B., Gallo, M., Sharma, A., Bukusi, E., Nguti, R., Bell, A., Jamieson, D., Williams, D. and Eschenbach, D. (2010). Diaphragm for STI and HIV Prevention: Is It a Safe Method for Women at High Risk?. *Sexually Transmitted Diseases*, 37(6), pp.382-385.

Njue, C., Nzioka, C., Ahlberg, M., Perted, M. and Voeten, C. (2009). If you do not abstain, you will die of AIDS: AIDS education in Kenya public schools. *AIDS Education and Prevention*, 21(2), pp.169-179.

Nyawira, J. (2014). *Death toll of killer brew rises to 94*. [online] Standard Digital News. Available at: <http://www.standardmedia.co.ke/article/2000119687/death-toll-of-killer-brew-rises-to-94> [Accessed 23 Aug. 2014].

Nzioka, C. (2001). Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya. *Reproductive Health Matters*, 9(17), pp.108-117.

## O

Oakley, A. (1999). People's way of knowing: gender and methodology. In: S. Hood, B. Mayall and S. Oliver, ed., *Critical issues in social research: power and prejudice*, 1st ed. Philadelphia: Open University Press, pp.154-170.

Obonyo, O. (2013). *Shock of farmers using Anti-Retroviral (ARV) drugs, to 'fatten' chicken*. [online] Standard Digital News. Available at: [http://www.standardmedia.co.ke/mobile/?articleID=2000096749&story\\_title=shock-of-farmers-using-anti-retroviral-arv-drugs-to-fatten-chicken&pageNo=2](http://www.standardmedia.co.ke/mobile/?articleID=2000096749&story_title=shock-of-farmers-using-anti-retroviral-arv-drugs-to-fatten-chicken&pageNo=2). [Accessed 15 Aug. 2014].

Ochieng, L. (2013). *Faith healer or prophet of doom?* [online] Daily Nation. Available at: <http://www.nation.co.ke/lifestyle/DN2/Faith-healer-or-prophet-of-doom/957860-1690928-32etdmz/index.html> [Accessed 20 May 2015].

Ocholla-Ayayo, A. and Schwarz, R. (1991). *Report on sex practices and the spread of STDs and AIDS in Kenya*. Nairobi: University of Nairobi.

Ociti, P. (1973). *African Indigenous Education*. Nairobi, Kenya: East African Literature.

O'Connor, W. and Lubin, B. (1984). *Ecological approaches to clinical and community psychology*. New York: Wiley.

Okal, J., Luchters, S., Geibel, S., Chersich, M., Lango, D. and Temmerman, M. (2009). Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya. *Culture, Health and Sexuality*, 11(8), pp.811-826.

Okwembo, A. (2010). *Kenyan herbal drugs 'highly' contaminated*. [online] Daily Nation. Available at: <http://www.nation.co.ke/news/-/1056/857318/-/3b5c6xz/-/index.html>. [Accessed 20 Mar. 2015].

Olson, A. and Kendrick, V. (2008). Origins of attitudes. In: W. Crano and R. Prislin, ed., *Attitudes and persuasion*, 1st ed. New York: Psychological Press.

Omondi-Odhiambo. (1997). Men's participation in family planning decisions in Kenya. *Population Studies*, 51(1), pp.29-40.

Onyango-Omuodo, D. (1984). Promoting male responsibility in family planning in the Africa region. In: International planned parenthood federation (IPPF), *male involvement in family planning: programme initiatives*, London, England, pp. 9-12.

Onyewuenyi, C. (1999). Traditional African Aesthetics: A philosophical perspective. In K. Christensen (ed.). *Philosophy and Choice*. London: Mayfield Publishing Company.

Ornstein, R. and Sobel, D. (1987). *The healing brain*. New York: Simon and Schuster.

Ortner, S. (1996). *Making gender*. Boston: Beacon Press.

Oti, S., Mutua, M., Mgomella, G., Egondi, T., Ezech, A., and Kyobutungi, C. (2013). HIV mortality in urban slums of Nairobi, Kenya 2003-2010: a period effect analysis. *BMC Public Health*, [online] 13(588). Available at: <http://bmcpublikealth.biomedcentral.com/articles/10.1186/1471-2458-13-588> [Accessed 21 Feb. 2015].

Othieno, C., Obondo, A, and Mathai, M. (2012). Improving adherence to antiretroviral treatment for people with harmful alcohol use in Kariobangi, Kenya through participatory research and action. *BMC Public Health*, 12(1), pp.677.

Oyebola, O. (1986). National medical policies in Nigeria. In: M. Last, and G. Chavunduka, *The Professionalisation of African medicine*. Manchester [England]: Manchester University Press in association with the International African Institute.

## P

Packard, R. and Epstein, P. (1992). Medical Research on AIDS in Africa: A Historical Perspective. In: E. Fee and D. Fox, ed., *AIDS: The making of a chronic disease*. Berkeley: University of California Press.

Padian, N., Buvé, A., Balkus, J., Serwadda, D. and Cates, W. (2008). Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward. *The Lancet*, 372(9638), pp.585-599.

Palmer, A. and Hartley, B. (2002). *The Business Environment*, 4th ed., Maidenhead: McGraw-Hill.

Papas, R., Sidle, J., Gakinya, B., Baliddawa, J., Martino, S., Mwaniki, M., Songole, R., Omolo, O., Kamanda, A., Ayuku, D., Ojwang, C., Owino-Ong'or, W., Harrington, M., Bryant, K., Carroll, K., Justice, A., Hogan, J. and Maisto, S. (2011). Treatment outcomes of a stage 1 cognitive-behavioral trial to reduce alcohol use among human immunodeficiency virus-infected out-patients in western Kenya. *Addiction*, 106(12), pp.2156-2166.

Pargament, K. (2002). The bitter and the sweet: an evaluation of the costs and benefits of religiousness. *Psychological Inquiry*, 13, pp.168-181.

Park, J., Chung, H., Hoo, S. (2009). Is the internet a primary source for consumer information research? Group comparison for channel choices. *Journal of Retailing and Consumer services*, 17(5), pp.92-99.

Pantelis, C., Hindler, C. and Taylor, J. (1989). Use and abuse of khat (*Catha edulis*): a review of the distribution, pharmacology, side effects and a description of psychosis attributed to khat chewing. *Psychological Medicine*, 19(03), p.657-668.

Parker, D., Harford, T., Rosenstock, I. (1994). Alcohol, other drugs, and sexual risk-taking among young adults. *Journal of Substance Abuse*, 6, pp.87-93.

Parker, R. and Gagnon, J. (1995). *Conceiving sexuality*. New York: Routledge.

Parkhurst, J. (2010). Wealth and poverty: the link with HIV in Africa. *Bulletin of the World Health Organisation*, 88, pp.519-526.

Parking, D. (1973). The Luo of Kampala, Nairobi and Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

Parking, D. and Monica, A. (1973). The Giriama of the Kenya Coast. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

- Pasquale, A. (1984). The evil eye phenomenon. *Home Healthcare Nurse*, 2(3), pp.32-35.
- Patterson, B., Landay, A., Siegel, J., Flener, Z., Pessis, D., Chaviano, A. and Bailey, R. (2002). Susceptibility to Human Immunodeficiency Virus-1 Infection of Human Foreskin and Cervical Tissue Grown in Explant Culture. *The American Journal of Pathology*, 161(3), pp.867-873.
- Patton, M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, Calif.: Sage Publications.
- Peattie, K. and Peattie, S. (2011). Social marketing for a sustainable environment. In: H. Gerald, A. Kathryn and B. Carol, ed., *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.152-166.
- Peñaloza, L. (1994). Crossing boundaries/drawing lines: A look at the nature of gender boundaries and their impact on marketing research. *International Journal of Research in Marketing*, 11(4), pp.359-379.
- Philips, P., Ruth, E. and Wagner, M. (1993). Psychology and survival. *Lancet*, 342, pp.1142-1145.
- Polit, D. and Beck, C. (2004). *Nursing research. Principles and methods*. Philadelphia, PA; Lippincott Williams and Wilkins.
- Pope, C. and Mays, N. (2000). *Qualitative research in health care*. London: BMJ Books.
- Pope, C., Ziebland, S. and May, N. (2000). Qualitative research in healthcare: analysing qualitative data. *British Medical Journal*, 320, pp. 114-16.
- Porter, M. (1985). *Competitive advantage*. New York: Free Press.
- Posner, B. and Schmidt, W. (1996). The Values of Business and Federal Government Executives: More Different Than Alike. *Public Personnel Management*, 25(3), pp.277-289.
- Prostitution.procon.org. (2013). *Prostitution Laws of Nevada - Legal Prostitution - ProCon.org*. [online] Available at: <http://prostitution.procon.org/view.background-resource.php?resourceID=000749> [Accessed 21 Sep. 2013].
- Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, 6, pp.65-78.
- Pyne-Mercier, L., John-Stewart, G., Richardson, B., Kagondou, N., Thiga, J., Noshay, H., Kist, N. and Chung, M. (2011). The consequences of post election violence on antiretroviral HIV therapy in Kenya. *AIDS Care*. 23(5), pp.562-568.

## Q

Quigley, M., Munguti, K. and Grosskurth, H. (1997). Sexual behaviour patterns and other risk factors for HIV infection in rural Tanzania: A case-control study. *AIDS*, 11, pp.237-248.

Quigley, R., Watts, C. (2005). Challenging beliefs about the marketing of food. *New Zealand Medical Journal*, 118, pp.1218. Available at: <http://www.nzma.org.nz/journal/118-1218/1554>.

Quinn, G., Ellery, J., Thomas, K., and Marshall, R. (2010). Developing a common language for using social marketing: an analysis of public health literature. *Health Marketing Quarterly*, 27(4), pp. 334-353.

Quinn, N. (2005). *Finding culture in talk*. New York: Palgrave Macmillan.

## R

Ragin, C. (1999). Using Qualitative Comparative Analysis to Study Causal Complexity. *Health Services Research*, 34(5), pp.1225–39.

Ragin, C. (2013). *The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies*. University of California Press.

Ragin, C. and Becker, H. (1989). How the microcomputer is changing our analytic habits. In: G. Blank et al. (eds), *New Technology in Sociology: Practical Applications in Research and Work*. New Brunswick, NJ: Transaction Publishers.

Raikes, P. (1994). Monogamists sit by the Doorway: Notes on the construction of gender, ethnicity and rank in Kisii, Western Kenya. *The European Journal of Development Research*, 6(2), pp.63-81.

Ramirez de Arellano, B. (2007). Patients without borders: the emergence of medical tourism. *International Journal of Health Services*, 37, pp.193-198.

Raval, D. and Subramanian, B. (2004). Cultural Values Driven Segmentation in Social Marketing. *Journal of Nonprofit & Public Sector Marketing*, 12(2), pp.73-85.

Read, M. (1966). *Culture, health and disease: Social and cultural influences on health programmes in developing countries*. London: Tavistock Publications.

Reid, S. (2009). Injection drug use, unsafe medical injections, and HIV in Africa: a systematic review. *Harm Reduction Journal*, 6(1), p.24.

Republic of Kenya, (2006). *The Sexual Offences Act No.3 of 2006*. [online] Available at: <http://www.thesexualoffencesact.com> [Accessed 16 Apr. 2014].



Resnikow, K., Soler, R., Braithwait, L., Ahluwalia, S. and Butler, J. (2000). Cultural sensitivity in substance abuse prevention. *Journal of Community Psychology*. 28, pp. 271–290.

Rice, E. (2006). Influences, usage and outcomes of internet health information searching: multivariate results from the pew surveys. *International Journal of Medical informatics*, 25(1), pp.20-25.

Robson, C. (1993). *Real world research. A resource for social scientists and practitioner-researchers*. Oxford: Blackwell Publishers.

Rokeach, M. (1968). *Beliefs, attitudes, and values*. San Francisco: Jossey-Bass.

Ross, C. and Mirowsky, J. (2001). Neighborhood Disadvantage, Disorder, and Health. *Journal of Health and Social Behavior*, 42(3), p.258.

Rossman, G. and Wilson, B. (1994). Numbers and words revisited: Being shamelessly eclectic?, *Quality and Quantity*, 28(3), pp.315-327.

Rossman, J. and Schlatter, B. (2000). *Recreation programming*. Champaign, Ill.: Sagamore.

Rothman, A. (2000). Toward a theory-based analysis of behavioral maintenance. *Health Psychology*, 19(1S), pp.64-69.

Rothschild, M. (1999). Carrots, sticks and promises: a conceptual framework for the management of public health and social issue behavior. *Journal of marketing*, 63(4), pp.24-37.

Royne, B., and Levy, M. (2008). Does marketing undermine public health? *Journal of Consumer Marketing*, 7, pp.473-475.

Rudman, L. (2004). Sources of Implicit Attitudes. *Current Directions in Psychological Science*, 13(2), pp.79-82.

Rye, S. (2002). *Circumcision in urban Ethiopia, practices, discourses and contexts*. Oslo: Center for development and environment.

## S

Santelli, J., Ott, M., Lyon, M., Rogers, J., Summers, D. and Schleifer, R. (2006). Abstinence and abstinence-only education: A review of U.S. policies and programmes. *Journal of Adolescent Health*, 38(1), pp.72-81.

Scanlon, D. (1964). *Traditions of African education*. New York: Bureau of Publications, Teachers College, Columbia University.

Schein, E. (2004). *Organizational culture and leadership*. San Francisco: Jossey-Bass.

- Schutz, A. and Natanson, M. (1982). *Collected papers*. Hague: M. Nijhoff.
- Schwartz, D. (1985). Caribbean folk beliefs and western psychiatry. *Journal of psychosocial nursing*, 12(11), pp.26-30.
- Schwartz, H. (1994). Are there universal aspect in the structure and content of human values?. *Journal of social issues*, 50, pp.19-45.
- Schwartz, S. and Bilsky, W. (1987). Toward a universal psychological structure of human values. *Journal of Personality and Social Psychology*, 53(3), pp.550-562.
- Seale, C. (1999). *The quality of qualitative research*. London: Sage.
- Seijas, H. (1975). An approach to the study of medical aspects of culture. *Current Anthropology*, 14, pp.344-345.
- Seth, A. (1990). Sources of value creation in acquisitions: An empirical examination. *Strategic Management Journal*, 11, pp.431-446.
- Sharma, A., Bukusi, E., Gorbach, P., Cohen, C., Muga, C., Kwen, Z. and Holmes, K. (2008). Sexual Identity and Risk of HIV/STI Among Men Who Have Sex With Men in Nairobi. *Sexually Transmitted Diseases*, 35(4), pp.352-354.
- Silverman, D. (2005). *Doing qualitative research*. London: Sage Publications.
- Silverman, D. (2014). *Interpreting qualitative data*. Los Angeles, Calif.: Sage.
- Sindiga, I. (1999). *Tourism and African development*. Aldershot, Hampshire, England: Ashgate.
- Singelis, T., Triandis, H., Bhawuk, D. and Gelfand, M. (1995). Horizontal and Vertical Dimensions of Individualism and Collectivism: A Theoretical and Measurement Refinement. *Cross-Cultural Research*, 29(3), pp.240-275.
- Skinner, B. (1968). *The technology of teaching*. New York: Appleton-Century-Crofts.
- Singh, H. and Montgomery, C. (1987). Cooperate acquisition strategies and economic performance. *Strategic management journal*, 8, pp.377-386.
- Sirower, M. (1997). *The synergy trap: How companies lose the acquisition game*. New York: Free Press.
- Sivakumaran, S. (2007). Sexual Violence Against Men in Armed Conflict. *European Journal of International Law*, 18(2), pp.253-276.
- Skaff, M., Chesla, A., Myc, D., and Fisher, L. (2002). Lessons in cultural competence: Adapting research methodology for Latino participants. *Journal of Community Psychology*. 30, pp.305-323.
- Skinner, B. (1981). Selection by consequences. *Science*, 213(4507), pp.501-504.

- Skocpol, T. (2003). Double engaged social science: the promise of comparative historical analysis. In: J. Mahoney and D. Rueschemeyer, *Comparative historical analysis in the social sciences*. Cambridge, U.K.: Cambridge University Press.
- Slack, J. (2005). Hope for the Future: Cultural Studies in the Enclave. *The Communication Review*, 8(4), pp.393-404.
- Smith, J., Nalagoda, F., Wawer, M., Serwadda, D., Sewankambo, N., Konde-Lule, J., Lutalo, T., Li, C. and Gray, R. (1999). Education attainment as a predictor of HIV risk in rural Uganda: results from a population-based study. *International Journal of STD and AIDS*, 10(7), pp.452-459.
- Smith, W. (2011). Social marketing: a future rooted in the past. In: H. Gerald, A. Kathryn and B. Carol, *The Sage Handbook of social marketing*. Thousand Oaks, California: Sage, pp.419-424.
- Sobo, E. (1995). *Choosing unsafe sex*. Philadelphia: University of Pennsylvania Press.
- Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research*, 34(5), pp.1101-18.
- Soola, O. (1991). Communication and education as vaccine against the spread of acquired immune deficiency syndrome (AIDS) in Africa. *Africa Media Review*, 5(3), pp.33-40.
- Souad (2004). *Burned alive: The shocking, true story of one woman's escape from an 'honour' killing*. London: Banton.
- Southall, A. W. (1973). The Luo of South Nyanza, Western Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.
- Spotswood, F. and Tapp, A. (2013). Beyond persuasion: a cultural perspective of behaviour. *Journal of Social Marketing*, 3(3), pp.275-294.
- Spradley, J. (1980). Participant Observation. New York: Holt, Rinehart and Winston.
- Stackman, W., Pinder, C. and Connor, E. (2000). Values lost: redirecting research on values in the workplace. In: N. Ashkanasy, C. Wilderom and M. Peterson, ed., *Handbook of organisational culture and climate*, 1st ed. CA: Sage: Thousand Oaks.
- Stall, R., McKusick, L., Wiley, J., Coates, T., Ostrow, D. (1986). Alcohol and drug use during sexual activity and compliance with safe sex guidelines for AIDS: the AIDS Behavioral Research Project. *Health Education Quarterly*, 13, pp.359-71.
- Stanko, A. and Hobdell, K. (1993). Assault on men: masculinity and male victimization. *British Journal of Criminology*, 33(3), pp. 400-415.

Stead, M., Hastings, G. and McDermott, L. (2007). The meaning, effectiveness and future of social marketing. *Obesity Reviews*, 8(s1), pp.189-193.

Steinfeld, L., Newmann, J., Onono, M., Cohen, R., Bukusi, A. and Grossman, D. (2013). Overcoming barriers to family planning through integration: Perspectives of HIV-positive men in Nyanza province, Kenya. *AIDS Research and Treatment*, 2013, pp. 1–8.

Stiglitz, J. (2011). [online] Available at:  
<http://http://www.vanityfair.com/society/feature/2011/05/top-one-percent-201105>  
[Accessed 5 Aug. 2015].

Strauss, A. and Corbin, J. (1998). *Basics of qualitative research*. Thousand Oaks: Sage Publications.

Sumartojo, E. (2000). Structural factors in HIV prevention: concepts, examples, and implications for research. *AIDS*, 14, pp. S3-S10.

## T

Talle, A. (1987). Women as heads of houses: The organization of production and the role of women among pastoral Maasai in Kenya. *Ethnos*, 52, pp.50-80.

Talle, A. (1988). *Women at a loss*. Stockholm: Dept. of Social Anthropology, University of Stockholm.

Talle, A. (1993). Transforming women into pure agnates: aspects of female infibulation in Somalia. In: V. Broch-Due, I. Rudie and T. Bleie, ed., *Carved flesh, cast selves: gender symbols and social practices*, 1st ed. Oxford: Berg, pp.83-106.

Talle, A. (1995). Bar workers at the border. In: K. Klepp, P. Biswalo and A. Talle, ed., *Young people at risk: fighting AIDS in Northern Tanzania*, 1st ed. Oslo: Scandivanian University Press, pp.18-30.

Talle, A. (2007). ‘Serious Games’: Licenses and Prohibitions in Maasai Sexual Life. *Africa*, 77(03), pp.351-370.

Tapsoba, P., Moreau, A., Niang, Y. and Niang, C. (2004). What kept away African professionals from studying MSM and addressing their needs in Africa? Challenges and obstacles. In: *15th International AIDS Conference*. Bangkok.

Tayeb, M. (1994). Organizations and National Culture: Methodology Considered. *Organization Studies*, 15(3), pp.429-445.

Taylor, A. (2001). In: C. Jain. *International Marketing*, 6th ed. London: Thompson Learning.

Taylor, E. (2007). *Primitive culture*. New York: Putnam's Sons.

Taylor, S. and Bogdan, R. (1984). *Introduction to qualitative research methods*. New York: Wiley.

Tegang, S., Emukule, G. and Kitungulu, B. (2008). *APHIA II Baseline Behavioral Monitoring survey; Coast and Rift Valley: Kenya*. [online] <http://www.fhi.org>.

Available at:

[http://www.fhi.org/en/HIVAIDS/pub/survreports/res\\_KenyaBMSReport.htm](http://www.fhi.org/en/HIVAIDS/pub/survreports/res_KenyaBMSReport.htm)

[Accessed 20 Aug. 2014].

Terpstra, V. and David, K. (1991). *The cultural environment of international business*. Cincinnati, OH: South-Western Pub. Co.

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. Bristol, PA: Falmer.

Tesser, A. (1993). The importance of heritability in psychological research: The case of attitudes. *Psychological Review*, 100(1), pp.129-142.

The Daily Nation Kenya, (1999). Moi rules out government sanction on use of condoms to fight AIDS. November, 26<sup>th</sup>.

Thekaekera, M. (2005a). Combating caste: the stink of untouchability and how those most affected are trying to remove it. *New Internationalist*. 380, pp.9-12.

Thompson, J. (1968). *Through Maasai land: a journey of exploration among the snow clad volcanic mountains and strange tribes of ester equatorial Africa*. 3rd ed. London: Frank Cass.

Thuy, N., Nhung, V., Thuc, N., Lien, T. and Khiem, H. (1998). HIV infection and risk factors among female sex workers in southern Vietnam. *AIDS*, 12(4), pp.425-432.

Tinga, K. (2004). The Presentation and Interpretation of Ritual Sites: the Mijikenda Kaya case. *Museum International*, 56(3), pp.8-14.

Tjøtta, E., Hungnes, O. and Grinde, B. (1990). An assay for quantifying infectious HIV particles. *Journal of Virological Methods*, 27(2), pp.169-174.

Transparency International, (2013). *Our Organisation - overview*. [online]

Transparency.org. Available at:

[http://www.transparency.org/whoweare/organisation/faqs\\_on\\_corruption](http://www.transparency.org/whoweare/organisation/faqs_on_corruption). Accessed 12/12/2013. [Accessed 20 Apr. 2015].

Travis, A. (2013). *Theresa May ignores experts and bans use of qat*. [online] the Guardian. Available at: [https://www.theguardian.com/politics/2013/jul/03/theresa-may-bans-qat?CMP=share\\_btn\\_link](https://www.theguardian.com/politics/2013/jul/03/theresa-may-bans-qat?CMP=share_btn_link) [Accessed 12 Feb. 2014].

Travis, P. and Cassels, A. (2006). Safe in their hands? Engaging private providers in the quest for public health goals. *Bulletin of the World Health Organization*, 84(6), pp.427-427.

Triandis, H. (1972). *The analysis of subjective culture*. New York: Wiley-Interscience.

Triandis, H. (1994). *Culture and social behavior*. New York: McGraw-Hill.

Triandis, H. (1995). *Individualism & collectivism*. Boulder: Westview Press.

Triandis, H., Bontempo, R., Villareal, M., Asai, M. and et al, (1988). Individualism and collectivism: Cross-cultural perspectives on self-group relationships. *Journal of Personality and Social Psychology*, 54(2), pp.323-338.

Trompenaars, A. and Hampden-Turner, C. (1998). *Riding the waves of culture*. New York: McGraw Hill.

Turan, J., Bukusi, E., Onono, M., Holzemer, W., Miller, S. and Cohen, C. (2010). HIV/AIDS Stigma and Refusal of HIV Testing Among Pregnant Women in Rural Kenya: Results from the MAMAS Study. *AIDS and Behaviour*, 15(6), pp.1111-1120.

Turan, J., Miller, S., Bukusi, E., Sande, J. and Cohen, C. (2008). HIV/AIDS and maternity care in Kenya: how fears of stigma and discrimination affect uptake and provision of labor and delivery services. *AIDS Care*, 20(8), pp.938-945.

Tylee, A., Haller, D., Graham, T., Churchill, R. and Sanci, L. A. (2007). Youth-friendly primary care services: how are we doing and what more needs to be done?. *Lancet*, 369(9572), pp.1565–1573.

## U

Uba, L. (1992). Cultural barriers to health care for southeast Asian refugees. *Public Health Reports*, 107, pp.544-548.

Ueda, H. (1973). The Kamba of Central Kenya. In: A. Molnos, ed., *Cultural source material for population planning in East Africa Vol 3*, 1st ed. Nairobi: East African Publishers.

UNAIDS. (1999). *Health and family planning indicators: Measuring sustainability* (Vol. II). Geneva, Switzerland: UNAIDS.

UNAIDS, (2001). *The global strategy framework on HIV/AIDS*. Geneva.

UNAIDS, (2006). *AIDS Epidemic update*. [online] Available at: [http://data.unaids.org/pub/EpiReport/2006/2006\\_EpiUpdate\\_en.pdf](http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf) [Accessed 10 Mar. 2015].

UNAIDS (2012). *Q&A with Ambrose Rachier-Chair of the HIV Equity tribunal Kenya*. [online] Available at: <http://http://www.UNAIDS.org/en/resources/presscentre/featuresstories>. [Accessed 16 Dec. 2013].

UNDP, (2010). *Real wealth of nation: pathway to human development*. New York: UNDP.

UNDP, (2012). *Sex work and the law in Asia and the Pacific*. Bangkok, Thailand: UNDP Asia-Pacific Regional Centre.

UNESCO (2001). *A cultural approach to HIV/AIDS prevention and care*. Paris: UNESCO.

UN-HABITAT (2003). *Slums of the World: The face of urban poverty in the new millennium?* Nairobi, Kenya: United Nations Human Settlements Program.

United States Department of State, (2011). *Partnering to Achieve Epidemic Control in Kenya*. [online] Pefar.gov. Available at: <http://www.pepfar.gov/countries/kenya/index.htm> [Accessed 15 Jun. 2011].

## V

Valenzuela, F. (1997). Alcohol and neurotransmitter interactions. *Alcohol health and Research World*, 21(2), pp. 144-148.

Van Donk, M. (2002). *The Missing Element: HIV/AIDS in Urban Development Planning. Reviewing the South African Response to the HIV/AIDS Epidemic*. Working Paper No 118, University College London, London: The Development Planning Unit.

Vangen, S. (2004). Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway. *European Journal of Obstetrics and Gynecology*, 112, pp.29-35.

VanLeeuwen, J., Waltner-Toews, D., Abernathy, T. and Smit, B. (1999). *Evolving Models of Human Health Toward an Ecosystem Context*. [online] ResearchGate. Available at: [http://www.researchgate.net/publication/227664188\\_Evolving\\_Models\\_of\\_Human\\_Health\\_Toward\\_an\\_Ecosystem\\_Context](http://www.researchgate.net/publication/227664188_Evolving_Models_of_Human_Health_Toward_an_Ecosystem_Context) [Accessed 29 Oct. 2015].

Van Manen, M. (1990). *Researching lived experience*. [Albany, N.Y.]: State University of New York Press.

Varadarajan, P. R., and Menon, A. (1988). Cause related marketing: a co-alignment of marketing strategy and corporate philanthropy. *Journal of Marketing*, 52(3), pp.58-74.

Verheij, R. (1996). Explaining urban-rural variation in health: a review of interactions between individual and environment. *Social Science and Medicine*, 42, pp:923-935.

Vincent, C. and Furnham, A. (1996). Why do patients turn to complementary medicine? An empirical study. *British Journal of Clinical Psychology*, 35, pp.37- 48

Vitell, J., Rallapalli, K. and Singhapakdi, A. (1993). Marketing norms: The influences of personal moral philosophies and organizational ethical cultures. *Journal of the Academy of Marketing Science*, 21, pp.331-337.

## W

Wagura, A. (2008). Living positively: *The not-so-pleasant side-effects of ARVs*. [online] Daily Nation. Available at: <http://www.nation.co.ke/lifestyle/Living/-/1218/502972/-/2fpyli/-/index.html>. [Accessed 12 Mar. 2015].

Wallack, L., Dortman, L., Jernigan, D. and Themba, M. (1993). *Media advocacy and public health*. California: Sage.

Wallendorf, M. and Arnould, E. (1991). "We Gather Together": Consumption Rituals of Thanksgiving Day. *Journal of Consumer Research*, 18(1), p.13.

Walley, C. (1997). Searching for "voices": Feminism, anthropology and the global debate over female genital operations. *Cultural anthropology*, 12(3), pp.405-438.

Walsh, D., Rudd, R., Moeykens, B. and Moloney, T. (1993). Social marketing for public health. *Health Affairs*, 12(2), pp.104-19.

Warner-Smith, P. and Brown, P. (2002). The town dictates what I do. The leisure, health and well being of women in a small Australian country town. *Leisure studies*, 21(1), pp.39-56.

Wassef, N. and Manşūr, A. (1999). *Investigating masculinities and female genital mutilation in Egypt*. [Cairo]: National NGO Center for Population and Development.

Weinreich, N. (1995). Building social marketing into your program. *Social Marketing Quarterly*, 2(2), pp.18-20.

Weinreich, N. (2010). *Hands-on social marketing: A step-by-step guide to designing change for good*. CA: Sage Publications.

Weiss, H., Quigley, M. and Hayes, R. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS*, 14(15), pp.2361-2370.

Wesangula, D. (2010). *Insured patients turned into a cash cow*. [online] Daily Nation. Available at: <http://www.nation.co.ke/news/-/1056/865842/-/3ak2x7z/-/index.html>. [Accessed 16 Feb. 2015].



WHO, (1978). Declaration of Alma-Ata. In: *International Conference on primary health care*. [online] Alma-Ata: WHO. Available at: <http://www.who.int> [Accessed 4 Mar. 2013].

WHO, (2003). *World Health Organization definition of health*. [online] Available at: <http://www.who.int/about/definition> [Accessed 24 Feb. 2013].

WHO, (2008). *Kenya: Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections*. [online] Available at: [http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_KE.pdf](http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_KE.pdf). [Accessed 20 Mar. 2014].

Wiebe, D. (1952). Merchandising commodities and citizenship on television. *Public Opinion Quarterly*, 15, pp.679-691.

Wilkinson, R. and Marmot, M. (1998). *Social determinants of health: The solid facts*. Copenhagen: WHO.

Williams, M. (2000). Interpretivism and generalisation. *Sociology*, 34, pp.209-24.

Williams, M., McCurdy, S., Atkinson, J., Kilonzo, G., Leshabari, M. and Ross, M. (2007). Differences in HIV risk behaviors by gender in a sample of Tanzanian injection drug users. *AIDS Behavior*, 11, pp.137-144.

Williams, R., Lavisso-Mourey, R. and Warren, C. (1994). The concept of race and health status in America. *Public Health Reports*, 109, pp.28-41.

Willig, C. (1999). *Applied discourse analysis*. Buckingham: Open University Press.

Willis, J. (2002). *Potent brews*. London: British Institute in Eastern Africa in association with James Currey.

Wing, D. and Thompson, T. (1995). Causes of Alcoholism: A Qualitative Study of Traditional Muscogee (Creek) Indians. *Public Health Nursing*, 12(6), pp.417-423.

Wing, M. (1998). A comparison of traditional folk healing concepts with contemporary healing concepts. *Journal of community Health Nursing*, 15(3), pp. 143-154.

Wingood, G., DiClemente, R. and Raj, A. (2000). Identifying the Prevalence and Correlates of STDs Among Women Residing in Rural Domestic Violence Shelters. *Women and Health*, 30(4), pp.15-26.

Winkelman, M. (1998). Cross-cultural assessments of the ecological hypothesis. *Ethnology*, 37(3), pp.285-287.

Winkelman, M. (2009). *Culture and health*. San Francisco: Jossey-Bass.

Winnet, R. (1995). A framework for health promotion and disease prevention programmes. *American Psychologists*, 50, pp.341-350.

Wright, R. (2006). *Consumer Behavior*. London: Thomson Learning.

Wyatt, S., Henwood, F., Hart, A. and Smith, J. (2005). The digital divide, health information and everyday life. *New Media and Society*, 7(2), pp.199-281.

Wymer, W. (2010). Rethinking the boundaries of social marketing: Activism or advertising?. *Journal of Business Research*, 63, pp.99-103.

Wymer, W., Knowles, P., and Gomes, R. (2006). *Non profit marketing: marketing management for charitable and nongovernmental organizations*. Thousand Oaks, CA: Sage Publications.

## Y

Yin, R. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publishing.

Youri, P. (1994). *Female Adolescent Health and Sexuality in Kenyan Secondary Schools: A Survey Report*. Nairobi, Kenya: African Medical Research Foundation (AMREF).

## Z

Zainuddin, N., Previte, J. and Russell-Bennett, R. (2011). A social marketing approach to value creation in a well-women's health service. *Journal of Marketing Management*, 27(3-4), pp.361-385.

Zanna, P. and Rempel, K. (1988). Attitudes: a new look at an old concept. In: D. Bar-Tal and A. Kruglanski, ed., *The psychology of knowledge*, 1st ed. New York: University Press.

Ziraba, A. K., Madise, N. J., Matilu, M., Zulu, E., Kebaso, J., Khamadi, S., Okoth, V. and Ezech, A. C. (2010). The effect of participant non response on HIV prevalence estimates in a population-based survey in two informal settlements in Nairobi city. *Population Health Metrics*, 8(22), pp.1-10.

Zukewich N., Norris D. (2005), *National Experiences and International Harmonization in Social Capital Measurement: A Beginning*, Statistics Canada.

Zulu, E., Dodoo F., Ezech, C. (2003). Urbanization, poverty and sex: roots of risky sexual behaviors in slum settlements in Nairobi, Kenya. In: E. Kalipeni, J. Oppong, S. Craddock, J. Ghosh, *HIV/AIDS in Africa: Mapping the Issues*. Malden, MA: Blackwell Publishing, pp.167–174.

## Appendices- Two Qualitative Open Ended Questionnaires

**Data collection standardized open ended question guide A**

**(Kindly type your responses in the spaces provided)**

**Administrative questions**

1. In what province of Kenya is your organisation based?
2. What is your position in the organisation?
3. How long have you been in that position?
4. How long have you been working in your organisation?
5. What is your gender?
6. What age group do you fall under?  
20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80 and above
7. What is your highest educational attainment level?
8. What aspect/s of HIV/AIDS does your programme focus on?

9. Which Kenyan tribal group/s are in your target audience? Rate them from majority to minority based on approximate representative numbers of audiences in each tribal group.
10. Describe your programme target group demographically e.g. (age, gender, religion, education, earnings among others)

**Cultural aspects**

11. What are the main economic activities (jobs done for livelihood) engaged in by your target audiences' groups e.g. cash crop farming, carving, fishing among others?
12. What challenges do the above economic activities present to your programme?
13. How do you deal with the challenges posed by economic activities of your target groups?

14. Explain any consumption patterns among your target audiences that pose challenges to your programme work (e.g. alcohol, prostitutions among others)
15. How do you deal with these consumption patterns related challenges?
16. Explain the challenges posed to your program work by the language/s used by your target audiences.
17. How do you deal with these language related challenges?
18. What challenges does your programme encounter in relation to what your target audiences regard as beautiful and sexually desirable e.g. attractive bodies, attractive men or women among others?

19. How do you deal with this concept of beautiful and sexually attractive individuals or bodies related challenge?
20. What challenges does your programme encounter in relation to child hood (0-12 years/minors) related sexual practices?
21. How does your programme deal with these challenges?
22. What challenges are posed to your programme by pre-marital sexual (from 13 years onwards but before marriage) practices amongst your target audiences?
23. How does your programme deal with these challenges?

24. What challenges does your programme encounter in relation to extra marital (after marriage) sexual relationships amongst your target audiences?
25. How does your programme deal with these challenges?
26. What challenges in relation to educational aspects does your programme encounter? E.g. literacy levels, educational attainments, among others)
27. How do you deal with these educational related challenges?
28. What are the challenges posed to your program work by your target audiences cultural views regarding the girl child (0-12 years old) e.g childhood marriages, female circumcision among others?

29. How do you deal with these girl child (0-12 years old) related views challenges?
30. What challenges are posed to your program work by your target audiences views regarding women (after Menarche- onset of monthly period on wards around 13 years onwards)?
31. How do you deal with these women related views challenges?
32. What challenges are posed to your program work by your target audiences' cultural views regarding boys (ages 0-12 years)?
33. How do you deal with these boy child views related challenges?



34. What challenges are posed to your program work by your target audiences views regarding men (puberty ages 13 onwards)?
35. How do you deal with these male related views challenges?
36. What challenges to your programme work do you encounter in relations to your target audiences views regarding the family? E.g. monogamous, polygamous preferences among others
37. How do you deal with these family related challenges?
38. What are the religions practiced by your target audiences from the majority to minority followers?

39. What challenges to your programme work do you encounter in relation to the religious beliefs held by your target audiences?
40. How do you deal with religious beliefs related challenges?
41. What challenges does your programme encounter in relation to the cultural related views held by your target audiences towards how individuals get infected with the HIV/AIDS virus?
42. How do you deal with these cultural related views regarding how individuals acquire the HIV/AIDS virus?
43. What challenges does your programme encounter in relation to your target audiences views regarding how to treat (curing using any form of medication) individuals infected by the HIV/AIDS virus?

44. How do you deal with these challenges regarding cultural views regarding treatment (curing using any form of medication) for HIV/AIDS?
45. What challenges does your program experience in relation to cultural views on how to socially treat or relate to individuals living with HIV/AIDS virus?
46. How do you deal with the challenges of culturally held views of how to socially treat or relate to individuals living with HIV/AIDS?
47. What challenges does your programme work encounter in relation to your target audiences' cultural views regarding HIV related deaths?
48. How do you deal with these HIV/AIDS related death views challenges?

49. What cultural practices performed by your target audiences pose challenges to your programme work e.g. tattoos, female circumcision, lack of male circumcision among others?
50. How do you deal with these cultural related practices challenges?
51. What cultural related beliefs (convictions held regarding HIV/AIDS) by your target audiences pose a challenge to your programme work e.g. AIDS is cause by witchcraft, bad eyed people among others?
52. How do you deal with the challenge of beliefs held by your target groups?
53. What cultural attitudes (evaluations of positives and negatives in relation to HIV/AIDS) held by your target audiences pose challenges to your programme work e.g stigmatising infected people among others?

54. How do you deal with the challenge of attitudes held by your target audiences?
55. What cultural values (judgment of what is important in life in relation to HIV/AIDS) held by your target audiences pose a challenge to your programme work? E.g. wife inheritance, having many children, polygamy among others
56. How do you deal with the challenge of values held by your target audiences?
57. How do the taboos (social prohibitions or bans based on moral judgments in relation to HIV/AIDS) held by your target audiences pose challenges to your program work? E.g. homosexuality, rape, incest, bisexuality among others
58. How do you deal with cultural taboos related challenges?

59. Do the myths (traditional stories that explain social phenomena like HIV/AIDS) held by your target audiences pose any challenges to your program work? E.g. HIV is a punishment from ancestors or God for immorality among others
60. How do you deal with the challenge of myths held by your target audiences?
61. Explain any cultural symbols (can be a: symbol, logo, picture, name, face, person, building or other images that are readily recognized and generally represents an object or concept with great cultural significance to a wide cultural group) pose any challenges to your program work? Eg many wives, many children, among others
62. How do you deal with the challenge of cultural symbols?
63. What programme related challenges are posed by the norms (standard expected behaviour in relation to HIV/AIDS) of your target groups? E.g. pressure to marry, have children among others

64. How do you deal with the challenge of cultural related norms?
65. What challenges do recreational or leisure activities of your target group pose to your programme work?
66. How do you deal with these recreational or leisure activities related challenges?
67. What cultural aspects of your target audiences have acted as enablers/ helpers or have positively facilitated your programme work?
68. What cultural changes in relation to your target audiences would be necessary to enhance the success of your current and future HIV/AIDS programmes?

69. How can these cultural changes in your opinion be achieved?
70. Who can facilitate these changes and why?
71. Generally how can cultural barriers be dealt with in your geographical region to maximize HIV/AIDS programmes success
72. What cultural changes would be necessary among other tribal groups (apart from the ones in your target audiences) to enhance the success of HIV/AIDS programmes?
73. Kindly share other relevant information regarding culture and how it affects your programme work or how it should be dealt with to enhance your programme work.

Thank you very much for taking the time to answer these interesting questions on your programme work. All the findings from the analysis will be shared with yourselves as promised. Kindly email me your filled in questionnaires at: [jackykendi@yahoo.com](mailto:jackykendi@yahoo.com).



## **Data collection standardized open ended question guide B**

**(Kindly type your responses in the spaces provided, you may wish to delete the lines and answer below the questions neatly)**

### **Administrative questions**

1. In what province of Kenya is your organisation based?
2. What is your position in the organisation?
3. How long have you been in that position?
4. How long have you been working in your organisation?
5. What is your gender?
6. What age group do you fall under?  
20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80 and above
7. What is your highest educational attainment level?
8. Does the physical natural environment of your target audience pose any challenges to your programme work? e.g. rivers, mountains, forests, weather among others?
9. How do you deal with the challenge of the natural environment?

10. Does the physical man-made environment of your target audiences pose threats to your programme work (e.g. proximity/ presence or absence of hospitals, schools, parks, pubs or bars among others?)
11. How do you deal with the above physical man made environment related challenges?
12. What structures would enhance your programme activities if they were to be made available to your target audiences and why?
13. Explain any relevant cultural training your staff undergo in order to understand your target audiences?
14. How do you deal with cultural incompetence or lack of cultural knowledge of your staff members in relation to your target audiences?

15. Explain any cultural related challenges encountered in relation to working with other organisations in relation to your program?
16. What competition do you encounter in working with your target audiences in as far as your program work is concerned? (e.g., commercial marketing of alcohol, local alcohol brews, booming prostitution in the area, poverty, illiteracy among others)
17. How do you deal with the competition challenges?
18. What ethical (what is considered right or wrong by the target audiences) challenges do you encounter in your programme work?
19. How do you deal with these ethical challenges?
20. Explain any national issues that pose challenges to your programme work? (E.g. elections, famine among others)

21. How do you deal with the above cited national challenges?
22. Explain any international issues that pose challenges to your programme work (e.g. funding, terrorism among others)
23. How do you deal with these international related challenges?
24. Explain briefly the challenges posed to your program work by the stakeholders (parties with interest in your program work e.g. government, media, families, churches among others)
25. How do you deal with these stakeholder related challenges?

26. What challenges do you encounter in relation to the legal environment (relating to laws of Kenya) in your programme work?
27. How do you deal with these legal related challenges?
28. How does the technological environment pose challenges to your programme work? E.g. use of computers, internet, mobile phone among others)
29. How do you deal with these technological related challenges?
30. Explain how the economic environment (wealth creation, poverty, unemployment among others) poses any challenges to your programme work?

31. How do you deal with the economic related challenges?
32. What challenges does the political environment power structures (e.g. local leaders like chiefs, sub-chiefs, member of parliaments among others) of your target group, pose to your programme work?
33. How do you deal with the political environment related challenges?
34. What challenges do you encounter in relation to the folk or traditional medicine (faith healers, witchdoctors, fortune tellers, herbalists among others) health care systems of your target audiences?
35. How do you deal with folk or traditional related health care systems challenges?

36. What challenges do you encounter in relation to the popular (families, friends, colleagues providing care) health care systems of your target audiences in relation to HIV/AIDS?
37. How do you deal with the above challenges?
38. What challenges do you encounter in relation to professional health care systems (modern medicine practiced by doctors and nurses) of the target audiences?
39. How do you deal with these challenges posed by professional health care systems of the target audiences in relation to HIV/AIDS?
40. What political aspects related to your target audiences' environment have acted as enablers/ helpers or have positively facilitated your programme work?

41. What technological aspects related to you target audiences' environment have acted as enablers/ helpers or have positively facilitated your programme work?
42. What economical aspects related to you target audiences' environment have acted as enablers/ helpers or have positively facilitated your programme work?
43. What legal aspects related to you target audiences' environment have acted as enablers/ helpers or have positively facilitated your programme work?
44. What social facilities in relation to your target audiences' environment would be necessary to enhance the success of your current and future HIV/AIDS programmes?
45. In your opinion, who can implement the above cited: political, technological, economic, legal and environmental changes?



46. Kindly share any other relevant information regarding the political, environmental, technological, economical and legal environment and how it affects your programme work or how it should be dealt with to enhance your programme work.

Thank you very much for taking the time to answer these interesting questions on your programme work. All the findings from the analysis will be shared with yourselves as promised. Kindly email me your completed interview guide at: [jackykendi@yahoo.com](mailto:jackykendi@yahoo.com).