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“If she was a man, none of this could have happened to her”: Social representations of gendered vulnerability to HIV in narratives written by female and male Kenyan youth

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Abstract

"If she was a man, none of this could have happened to her": Social representations of gendered vulnerability to HIV in narratives written by female and male Kenyan youth

By Kristina Countryman

Background: Young Kenyan women aged 15-24 years are more than twice as likely to have HIV than young men of the same age. HIV prevention efforts have yet to eliminate this gender disparity, as they have largely focused on individual-level strategies that fail to adequately address the underlying structural and cultural vulnerabilities that put young women at increased risk.

Objective: This research sought to better understand the contextual factors and cultural meanings that inform gendered vulnerability to HIV in Kenya by analyzing youth-written narratives from the 2014 Global Dialogues contest. Global Dialogues is an international script-writing contest that invites youth to write scripts for short films to educate their communities about HIV/AIDS.

Methods: A random sample of 110 narratives, stratified by age, place of residence, and sex of author, was analyzed. Descriptive statistics of quantifiable narrative elements (e.g. sex of character contracting HIV) were generated, and narratives from the 15-19 year-old strata (n=40) were analyzed qualitatively to better understand representations of female and male characters, gendered risk factors, and blame for HIV infection. Texts by male and female authors were compared.

Results: Representations of female protagonists were overwhelmingly negative, falling into one of three categories: a good girl gone 'bad', a scheming or unfaithful woman, or a victim of gendered socio-cultural norms and structural constraints. All contracted HIV and, with little exception, were blamed for their infections, and experienced tragic outcomes. Representations of male protagonists were less easily categorized and mitigating circumstances were often presented for their HIV infections. Tragic outcomes occurred less for male protagonists, and they were more likely to access ARVs. Peer pressure was an important risk factor for male and female characters. Female characters were additionally subject to: partner pressure for sex, poverty, and economic dependence on men. Finally, male authors blamed female protagonists for their HIV infections more than female authors.

Conclusion: The lack of agency and stigmatizing representations of female characters points to larger socio-cultural norms and structural barriers that are placing young women at increased risk for HIV. It is recommended that youth prevention efforts adopt a gender-transformative approach. Use of combined microfinance-mentorship programs for young women should be also explored.

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This thesis is dedicated to my mother and my dear friend Mabel. The former taught me about the lingering gender inequalities in the U.S. from an early age, and the latter taught me about the incredible hardships that a Black South African woman faces—and is the reason that I am in public health. Thank you both for the incredible love and lessons of courage that you have given to me.

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Definition of Terms

AIDS- acquired immune deficiency syndrome

ART- antiretroviral therapy

ARVs- antiretrovirals

DHS- Demographic and Health Surveys

HIV- human immunodeficiency virus

NACC- National AIDS Control Council, Kenya

NASCOP- National AIDS and STI Control Programme, Kenya

PEP- post-exposure prophylaxis

PEPFAR- President's Emergency Plan for AIDS Relief

PrEP- pre-exposure prophylaxis

SSA- sub-Saharan Africa

UNAIDS- Joint United Nations Programme on HIV/AIDS

USAID- United States Agency for International Development

WHO- World Health Organization

I. Introduction

Sub-Saharan Africa carries the highest burden of HIV/AIDS in the world. Of an estimated 36.9 million people living with HIV/AIDS worldwide in 2014, 25.8 million (69.9%) were living in sub-Saharan Africa (SSA) (WHO, 2015). Young people aged 15-24 represent approximately 2.9 million of those living with HIV in SSA (UNAIDS, 2014). Young women are at increased risk in SSA, with more than 4 in 10 of all new infections occurring in women aged 15-24 (UNAIDS, 2014). Furthermore, young women aged 15-24 in SSA are twice as likely as young men to be living with HIV, and women in SSA become infected with HIV 5-7 years earlier than men (UNAIDS, 2014). There is a clear and urgent need for effective HIV prevention interventions for young women living in sub-Saharan Africa.

Kenya is home to the fourth largest HIV epidemic in the world, with 1.4 million people living with HIV in 2014 (AVERT, 2015; UNAIDS, 2015). That same year, Kenya also accounted for 7% of new HIV infections in sub-Saharan Africa, an estimated 100,000 (Carter, 2014; NACC, 2014a; UNAIDS, 2014). Kenya's HIV prevalence is currently at 6.04%, but this varies dramatically across its counties and provinces (AVERT, 2015; UNAIDS, 2015). Kenya's Nyanza province in the southwest has the highest HIV prevalence of any province, at 15.1% (NASCOP, 2014). Furthermore, Homa Bay County in Nyanza has the highest prevalence in the country at 27.1%, while Wajir County in northeastern Kenya has the lowest HIV prevalence, at less than 0.2% (NACC, 2014a). Kenya is considered to have a generalized HIV epidemic, with heterosexual transmission being the dominant mode of transmission (NASCOP, 2014). However, HIV disproportionately affects women, particularly young women. In 2014, women had an HIV prevalence of 7.6%, vs. 5.6% for men (NACC, 2014b). Both women and youth are considered

key populations in Kenya (NACC & NASCOP, 2012). Youth aged 10-24 years account for 29% of new HIV infections in Kenya, and AIDS is the leading cause of death and morbidity for this age group (NACC, 2015). The HIV burden is not equally felt by all youth however; similar to statistics for SSA, young Kenyan women between the ages of 15-24 are more than twice as likely to have HIV than young Kenyan men of the same age (NACC, 2014a). Young women aged 15-24 account for 21% of new adult infections are each year in Kenya, the largest percentage in the new adult infections category after heterosexual sex within unions (NACC, 2014b). Furthermore, the 2014 Kenya Demographic and Health Survey (DHS) shows that young men have a more comprehensive knowledge[*] of HIV prevention than young women, at 63.7% and 54.2%, respectively (USAID, 2014). Young women clearly represent a population of significant importance for programmatic and policy response in Kenya's HIV epidemic.

Problem Statement

Young women aged 15-24 in Kenya are disproportionately affected by HIV, with a prevalence of 3.0%, while young men of the same age group have a prevalence of 1.3% (NACC, 2014a). While this represents a significant drop since a 2003 high of 5.9%, HIV prevalence among young women remains unacceptably high (NACC, 2014a). HIV prevention efforts have yet to eliminate this gender disparity, as they have largely focused on individual-level prevention strategies that fail to address the underlying structural and cultural vulnerabilities that put young women at increased risk (Ahlberg, Jylkäs, & Krantz, 2001; Conn, 2013; Harper et al., 2014; McClure, McFarland, & Legins, 2014). Research among youth in Nyanza, Kenya, has shown that HIV

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[*] "Comprehensive knowledge" of HIV prevention in the Kenya DHS is defined as knowing that a healthy-looking person can have HIV, knowing that consistent condom use during sexual intercourse and having one uninfected faithful partner can reduce the risk of contracting HIV, and dismissing the myths that AIDS can be transmitted by mosquito bites, and that HIV cannot be contracted through sharing food with a person who has AIDS (KDHS, 2014).

knowledge alone was not enough to change the perceptions of risk for young women, suggesting that their lack of control over sexual risk situations may be preventing knowledge from translating into risk perception, and thus behavior change (Tenkorang & Maticka-Tyndale, 2014). Therefore, understanding gender as a social driver of HIV infection is key to combatting the HIV epidemic among young women in Kenya. In order to address these gendered vulnerabilities, there is a need to understand what aspects of gender are putting young women at risk from the perspectives of the youth themselves. Currently, there is little information on how young Kenyans are making sense of gender norms or gendered vulnerabilities to HIV infection. This is problematic given the need for HIV prevention interventions that target young people and address youth social norms and gender as social drivers of HIV infection.

Purpose Statement

The purpose of this research is to better understand the contextual factors and cultural meanings that inform gendered vulnerability to HIV in Kenya from the perspective of Kenyan youth.

Research Questions

In order to fulfill the purpose of this research, I analyzed 110 Kenyan youth-written narratives about HIV submitted to the 2014 Global Dialogues scriptwriting contest. The following research questions guided the analysis:

1. How are male and female characters being represented in the narratives written by male and female authors? How do they compare?
2. Are female characters more likely to be blamed for their infection than males?
    a. What structural vulnerabilities inform females' risk of infection?
    b. How is female vs. male sexuality represented?

c. How is the moral of the story being constructed and how does it relate to gender?

3. Is it more likely that a female character will become HIV-infected?
4. Are stories with female protagonists less hopeful?
5. How is female agency represented?

Significance Statement

This research analyzes a unique dataset of youth-written narratives that allows us to examine the ways in which they are making sense of HIV and gender (Winskell, Brown, Patterson, Burkot, & Mbakwem, 2013). This research draws on The Theory of Social Representations, which contends that our perceptions and opinions of objects, people, and events are based on the collective representations shared within our societies (Moscovici, 1984). These social representations communicate the collective norms and values of a society in symbolic form (Winskell, Hill, & Obyerodhyambo, 2011). Therefore, social representations allow us to see how a society makes sense of and gives meaning to different social phenomena. Social representations are generally subconscious, rendering them potentially less subject to informant bias in social science research than attitudes, which often reflect conscious judgments (Winskell, Hill, et al., 2011). Narratives are sources from which these social representations and symbolic meanings can be drawn, and have been identified as valuable and underused sources of data in the study of social representations (Winskell et al., 2013). Through the investigation of representations of gender and HIV in the Global Dialogues narratives, this research aims to describe Kenyan gender norms and social and cultural context and thereby inform the development of culturally appropriate HIV education and communication interventions for Kenyan youth. Particularly valuable will be the representations of gender that employ positive

deviance, or characters whose traits and behavior in the narratives differ from the norm in positive, desirable ways (Murphy, 2005). Positive deviant narratives will help provide models from which to build behavior change campaigns that are culturally appropriate and feasible.

II. Literature Review

This literature review provides the contextual background to this study. It summarizes the current literature on the relation of gender inequity to HIV risk, the factors shaping young women's vulnerability to HIV in Kenya, and the social ecological risk factors for Kenyan youth. Compounding women's higher biological susceptibility to HIV through penile-vaginal sex, the literature points to inequitable gender norms as fundamental drivers of HIV/AIDS in women and girls in SSA, and describes the need for large scale social structural HIV interventions that focus on gender. The literature also highlights a gap in understanding of the context-specific aspects of gender that are putting women at increased HIV risk in SSA, and a need to better understand how structural factors (social, economic, political, environmental) shape sexual behaviors in different contexts (Auerbach, Parkhurst, & Caceres, 2011; Wamoyi et al., 2014). Greater understanding of both these themes is necessary for the creation of gender-focused, social structural HIV interventions. There is relatively limited literature available on these localized gender norms and structural factors that increase HIV risk among Kenyan youth.

HIV/AIDS and Gender Inequity

In 2014, there were approximately 16 million women globally living with HIV, comprising nearly half of all people living with HIV. However, 80% of these women lived in sub-Saharan Africa (UNAIDS, 2014). Speaking to the continued challenges of the HIV/AIDS epidemic, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Michel Sidibé, said in 2010, "This epidemic unfortunately remains an epidemic of women" (UN, 2010). The reasons for this are both biological and social in nature. Women have a greater biological susceptibility to HIV infection through penile-vaginal sex, and this is even more pronounced in

young women during adolescence, as they are more prone to cervical ectopy, which has been linked to increased acquisition of STIs (Harrison, Colvin, Kuo, Swartz, & Lurie, 2015; Lee, Tobin, & Foley, 2006). Furthermore, the presence of other STIs eases the transmission of HIV in women (Harrison et al., 2015). However, biology is only one aspect of women's greater vulnerability to HIV/AIDS. Researchers have stated that understanding the gender roles and relations that are shaping women's risk are crucial to understanding and addressing the HIV epidemic (Greig, Peacock, Jewkes, & Msimang, 2008). The World Health Organization (WHO) defines 'gender' as, "the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men" (WHO, 2016). The WHO states that gender roles, norms, and relationships can impact people's vulnerability to different diseases, health conditions, mental and physical wellbeing, and access to health services. Yet, they make clear that the social construction of gender can be changed (WHO, 2016). Broadly speaking, the factors putting women at increased risk for HIV infection include harmful gender norms, limited access to education, limited legal rights, economic inequalities, and gender-based violence (Greig et al., 2008; Gupta, Ogden, & Warner, 2011; Hardee, Gay, Croce-Galis, & Peltz, 2014; MacPherson, Richards, Namakhoma, & Theobald, 2014; Small, Nikolova, & Narendorf, 2013). For younger women in SSA, age-disparate sexual relationships are also an important factor of their increased vulnerability to HIV/AIDS (Harrison et al., 2015).

Harmful Gender Norms

Arguably the most important factors contributing to women's increased HIV risk are harmful gender norms. This is because harmful gender norms are at the heart of women's limited access to education, limited legal rights, economic inequalities, and gender-based violence. Gender

norms are a set of socially constructed behaviors and roles deemed appropriate for males and females in a particular culture (Gupta et al., 2011). Most societies around the world are patriarchal, meaning that the gender norms benefit men over women, thus creating environments of gender-based discrimination that pervades many aspects of society (Hardee et al., 2014). Gender norms also inform beliefs about sexual behaviors and relationships. Gendered sexual norms that increase women's HIV risk in systems of patriarchy include: acceptance of multiple concurrent sexual partners for men, acceptance of the sexual coercion of women, sexual ignorance and submissiveness for women, tolerance of physical and sexual violence against women, male control of condom use, and acceptance of the sexual partnering of younger females with older males (Conn, 2013; Gupta et al., 2011; Hardee et al., 2014; MacPherson et al., 2014; Gina M. Wingood, Camp, Dunkle, Cooper, & DiClemente, 2009). These norms are the products of harmful definitions of masculine 'power' and feminine submission, which shape women's vulnerability to HIV.

Limited Access to Education

Despite significant increases in primary school enrollment since the Millennium Development Goals called for universal primary education for all, girls still face several gender-based barriers to staying in school (Hardee et al., 2014; Jewitt & Ryley, 2014; UN, 2015). These barriers include: pressures from parents to leave school early to marry; sexual coercion and transactional sex leading to pregnancy; a lack of finances for uniforms, school fees and supplies; a lack of school sanitary facilities for girls; and expectations to stay home to complete household chores (Conn, 2013; Hardee et al., 2014; Jewitt & Ryley, 2014). Underlying all of these barriers are issues of poverty, unequal power, and harmful gender norms. Studies have consistently shown

that the more years of schooling a girl has, the more it reduces her risk for HIV. Female education has been shown to reduce engagement in risky sexual behaviors, increase HIV knowledge and the ability to talk about HIV with partners, delay onset of sexual activity and marriage, reduce teenage pregnancy, negotiate sex and condom use, leave abusive relationships, and enhance economic opportunities (Alsan & Cutler, 2013; Behrman, 2015; Greig et al., 2008). As was so powerfully put by Greig et al. (2008), "..education is a cornerstone of gender equity and empowerment of women. Education provides a basis for economic empowerment, access to political power, access to information about HIV, and knowledge and ideas that can be used to change attitudes and make independent life decisions" (p. 7).

Limited Legal Rights and Economic Inequalities

In many countries, inequitable gender norms are codified into policies and laws. Broadly, these include women's inability to own or inherit property and other economic assets (e.g. houses), to seek a divorce, to sue or testify in court, to enter into legal contracts, to have access to credit, to work without consent from a husband, to consent to medical treatments, and to open bank accounts (Greig et al., 2008; Hardee et al., 2014; Klugman, 2015). These laws create a situation where women are economically dependent on men, rendering them less likely to leave abusive relationships or to negotiate condom use, and more likely to have an early sexual debut, engage in transactional sex or commercial sex work, and to accept a male partner who has other partners. All of these behaviors put women at increased risk for HIV infection (Greig et al., 2008; Gupta et al., 2011; Hardee et al., 2014). Even in countries where women's participation in the labor force is relatively high, as in Tanzania and Rwanda, large pay gaps between men and women exist (Klugman, 2015).

Gender-Based Violence

Worldwide, more than one-third of women experience physical or sexual violence, and this number varies significantly by region (Hardee et al., 2014). "Violence is a consequence of gender power inequities, at both a societal and relationship level, and also serves to reproduce power inequities" (R. K. Jewkes, Dunkle, Nduna, & Shai, 2010 p. 41). Gender-based violence and gender inequitable relationships have been consistently associated with women's increased HIV risk (R. K. Jewkes et al., 2010). As with women with limited economic and legal rights, women in violent relationships are less likely to have the ability to negotiate condom use, and have a partner who has multiple sexual partners (Hardee et al., 2014). From a biological perspective, women in violent relationships tend to have an increased frequency of both forced and non-forced sex, which creates trauma to the vaginal wall, making HIV transmission more likely (Gupta et al., 2011).

Age-disparate sexual relationships

Across SSA, the practice of younger women in sexual relationships with older men (men more likely to be HIV-infected) is common. This practice is an important driver of young women's higher rate of HIV than young men in their same age group. These age-disparate sexual relationships are largely driven by the economic need of young women as older male partners can provide anything from small gifts to school uniforms; the so-called "sugar daddy phenomenon" (Harrison et al., 2015 p.208). Another key HIV risk factor is young women's lack of power within these age-disparate relationships, where they have little ability to negotiate safer sex, and are at risk of violence if they insist on condom use. Age-disparate relationships are

further products of the unequal gender norms and relations that exist across sub-Saharan Africa (Harrison et al., 2015).

Theory of Gender and Power

These gendered risk factors exist due to systems of patriarchy, in which women experience a lack of power and privilege relative to men (Greig et al., 2008). The theory of gender and power asserts that there are three interrelated and inseparable social constructs that serve to hold male dominance and put women at risk: the sexual division of power, the sexual division of labor, and the structure of cathexis, or the social norms enforcing patriarchy. These social constructs exist at two levels, the societal and the institutional (Gina M. Wingood et al., 2009). Indeed, Wingood et al. (2009) found that the theory of gender and power was a useful framework for understanding the specific factors that put African American women at risk for HIV infection. Through the application of this theory, the researchers were able to create several HIV prevention interventions that showed increased consistent condom use, increased partner support for safer sex, greater sexual assertiveness and self-control, and increased HIV/AIDS knowledge (Gina M. Wingood et al., 2009).

One of these interventions, SiSTA, was adapted for use in South Africa in a randomized control trial with women between the ages of 18 and 35. SISTA South Africa was also based in the Theory of Gender and Power, and utilized trained local health educators (women) to conduct the intervention. Results at the 6-month follow-up revealed a significant reduction in the mean number of unprotected vaginal intercourse acts among participants. There were also increases in HIV knowledge, more accepting attitudes towards HIV stigma, and reports of greater

relationship control (G. M. Wingood et al., 2013). Given the effectiveness of the SiSTA intervention in South Africa, further adaptions to other SSA countries is warranted.

Need for Social Structural HIV/AIDS Interventions Focusing on Gender

Since the early 1990's there has been an understanding of the significant role that gender plays in HIV infection and international calls to address gender norms in HIV programs and policies in the parts of the world where women are affected most (Greig et al., 2008). To date however, "no country has yet achieved impact on gender-related HIV vulnerability at sufficient scale to change the course of the AIDS epidemics they face; there is a persistent and critical gap between policy action and grassroots impact globally" (Gupta et al., 2011 p. S370). Several successful gender-based HIV interventions have been tried in sub-Saharan Africa, especially South Africa, but these interventions have never been implemented at the national level (Gibbs, Willan, Misselhorn, & Mangoma, 2012; Small et al., 2013). There has been a lack of political will by donor and recipient governments to make the issues of gender inequities, harmful sexual norms, and social influences on behavior the focal point of their HIV intervention strategies (Greig et al., 2008; Marston & King, 2006). Instead, issues of gender equity are marginalized as additional concerns (Greig et al., 2008). A further reason the influence of gender on HIV risk has not been adequately addressed in the HIV/AIDS response is due to the focus on individualistic prevention strategies such as abstaining, using a condom, or being faithful. These prevention strategies have failed to recognize the social contexts in which women live, where their agency to apply these strategies is lacking due to inequitable gender norms. There is a need for HIV prevention strategies to move beyond individual approaches and consider the larger social drivers of the epidemic (Auerbach et al., 2011; Hardee et al., 2014; Tenkorang & Maticka-Tyndale, 2014).

'Gender' as a social driver of HIV/AIDS

Gender norms and power relations vary across cultures and societies. This fact is essential to understanding and responding to gender inequities as a social driver of HIV. Rather than referring to gender inequity generally as a social driver of HIV, we "…must identify the specific ways in which gender (and sexuality) dynamics operate in conjunction with other social and cultural dynamics in particular social contexts to produce vulnerability, or not, and target HIV prevention efforts accordingly" (Auerbach et al., 2011 p. S295). Indeed, it has been stated that HIV/AIDS program designers and implementers have had inadequate understandings of sexuality in different social and cultural contexts, and how that sexuality interacts with gender (Gupta et al., 2011). In a systematic review of gender based HIV interventions in SSA, Small and Nikolova (2013) found only eight studies that specifically focused on the intersection of gender and HIV, over half of which were conducted in South Africa. They conclude with a call for more research into the interactions between sexual risk and gender across the continent, stating that the social and cultural diversity of SSA means that interventions will have to be tailored to the specific context (Small et al., 2013).

HIV/AIDS and Gender Inequity in Kenya

In studies on the sexual health of Kenyan youth, findings have pointed to three main factors placing young women at increased risk for HIV: gendered sexual scripts, traditional practices, and economic disempowerment (Harper et al., 2014; Maticka-Tyndale et al., 2005; Carolyne Njue, Voeten, & Remes, 2011; Secor-Turner, Randall, & Mudzongo, 2014). Underlying all of these factors are highly gendered norms that create a fundamental lack of power and agency for women over their sexual health and their lives.

Sexual script theory, first introduced by Gagnon and Simon (1973), states that sexual behaviors are informed by a set of socially constructed definitions and actions, or scripts, that guide the steps leading to sex. Rather than being dictated solely by biology, sexual encounters are dictated by a cultural script of verbal and non-verbal cues that are learned over time and shared among the members of society (Gagnon, 2005). Maticka-Tyndale et al. (2005) studied the sexual scripts of young Kenyans in order to understand both how youth experience sexuality and the larger socio-cultural contexts in which that sexuality is rooted. Results from the study revealed that the sexual activity of young Kenyans follows a predetermined script combining traditional cultural norms and expectations with Western ideals of romantic. The traditional beliefs imbued in these sexual scripts included: the belief that once puberty is reached sexual activity must take place; material goods are exchanged for women; and that women must acquiesce to the sexual demands of men (Maticka-Tyndale et al., 2005).

The sexual scripts were a sequence of events usually initiated by the boy, starting with gift giving or love letter writing to show interest to a girl, and ending with a sexual interaction between the two. The act of gift giving meant that the girl was obligated to repay through sex, and while initial refusal of the gift(s) was expected, cultural norms did not permit a total refusal from the girl. Importantly, participants in this research never described a situation where a girl said 'no' and the boy accepted. If the girl continued to refuse sex, it was carried out with force (Maticka-Tyndale et al., 2005). In this way, girls had limited control over when and how they would have sex, and they even described sex as their "obligation to boys and men" (p. 36). Likewise, boys described sex as their "duty, an expectation of their friends, kin, and society"

(Maticka-Tyndale et al., 2005 p.36). While both boys and girls feel obliged by culture and tradition to follow these sexual scripts, boys have significantly more power in the sexual relationship.

Maticka-Tyndale et al. (2005) contends that the results show the complex nature of sexual interactions among Kenyan youth, and supports the position that HIV prevention interventions need to be aware of the "cultural forces, social norms and patterns, situational factors, gender roles, and the perception that sexual encounters are impulsive and physiologically driven" (p. 38). What is needed, the researchers argue, are strategies for young people to deconstruct these scripts, with examples of youth who have utilized other, more healthy scripts, showing them that as social constructs, sexual interactions can be changed. Importantly, the researchers found that the young participants were open to deconstructing these scripts, as several participants expressed doubts about the cultural beliefs surrounding the necessity for sex once puberty is reached. Furthermore, several participants noted strategies of avoiding scripted situations, such as participating in adult-supervised activities like sports, drama, and debate clubs (Maticka-Tyndale et al., 2005).

The significant role of gendered sexual scripts on youth sexual behavior was also described in a study by Harper et al. (2013), where youth pointed out how disempowering these scripts were for young women, and how this limited their sexual decision-making and left them vulnerable to sexual violence and rape. Furthermore, the lack of power young women had in sexual relationships made them less able to negotiate condom use. At the same time, young men felt pressure to adhere to the cultural ideas of masculinity that encouraged having sex and having

multiple sexual partners (Harper et al., 2014). A study of youth HIV risk situations in Kisumu, western Kenya, also found that boys and men are expected to conform to cultural norms of masculinity that include having multiple concurrent sexual partnerships (Carolyne Njue et al., 2011). These norms of masculinity also encourage the sexual relationships between older men and younger women, and serve to "increase the acceptance and justification of violence against women" (Carolyne Njue et al., 2011 p.5). Cultural norms did not permit multiple sexual partnerships for women, and women's subordinate position created highly unequal power dynamics in sexual relationships that favored men. The researchers concluded that these gender-related power differences are putting young women at risk for HIV (Carolyne Njue et al., 2011).

Gendered cultural norms that disempower women are also intertwined with traditional practices. Traditional practices noted by youth in focus groups included: forced marriage of young girls to older men, wife inheritance, polygamy, and initiation of sex after circumcision (male and female). Young participants in this study noted the particular vulnerability of young women to HIV/AIDS in the face of these practices (Harper et al., 2014).

The economic disempowerment of women was also found to place young women in Kenya at increased risk of HIV. Because of women's lack of control over resources and finances, they are forced to rely on men for their basic needs (Carolyne Njue et al., 2011). Transactional sex has been a widespread practice of young women, for both survival and social status (Harper et al., 2014; Maticka-Tyndale et al., 2005). Meeting their basic survival needs such as food, clothes, and shelter were noted as the dominant reasons that young women engage in transactional sex, and this led to he desirability of older men, who were more likely to have an income than young

men (Harper et al., 2014; Maticka-Tyndale et al., 2005; Carolyne Njue et al., 2011). Reports of young women engaging in transactional sex to help provide for the basic needs of their family were also documented (Maticka-Tyndale et al., 2005; Carolyne Njue et al., 2011). This was noted with young women who had lost one or both parents, and needed to take care of siblings or help a single parent bring resources to the family (Carolyne Njue et al., 2011).

Risk Factors for HIV/AIDS for Youth in Kenya

A helpful theoretical framework for understanding the social and cultural dynamics of youth HIV risk in different contexts is Bronfenbrenner's (1993) ecological systems theory (Bronfenbrenner, 1993). This theory situates the individual within their social contexts, delineating five separate social systems that influence the individual, and with which the individual interacts. These systems are the microsystem, mesosystem, exosystem, macrosystem, and the chronosystem. The microsystem includes family, peers, neighborhood, school, religious affiliations, health services, and the workplace. The mesosystem consists of the interactions and relationships between the elements of the microsystem. The exosystem is the larger social context of the individual, and includes the health context, government/political system, economic system, and education system. The macrosystem is the cultural beliefs and values that shape the other systems. Finally, the chronosystem is the time period in which all systems are situated (Bronfenbrenner, 1993). It is within this multi-layered social system that the individual exists, interacting with social forces they can and can't control, and through which HIV risk or resilience factors are exerted.

Ecological Systems Theory in the Kenyan Context

Harper et al. (2013) used Bronfenbrenner's ecological systems theory to better understand the social factors that influence HIV risk and resilience behaviors of rural Kenyan youth. The research highlighted risk factors experienced by both young men and young women, and also the specific risk factors of young women. Through focus groups with rural youth ages 14-24 years, they found that HIV risk factors exist on the intrapersonal (individual), interpersonal (microsystem), institutional/community (exosystem), and sociocultural/policy (macrosystem) levels (Harper et al., 2014).

Intrapersonal risk factors included a lack of knowledge about HIV/AIDS, inaccurate information about HIV prevention, and alcohol and/or drug use. On the interpersonal level, risk factors included peer pressure to engage in sexual intercourse, sexual violence, and lack of parent-child communication about sex and HIV/AIDS. Importantly, it was noted that peers could also have a positive influence on sexual behaviors, given that they have accurate information about HIV/AIDS and promote healthy behaviors. Institutional/community risk factors included: a lack of social and recreational activities; a lack of employment opportunities; financial and peer pressures for females to engage in transactional sex, particularly with older men; a lack of adult role models; and a social taboo about talking to parents or adults about sexual matters (Harper et al., 2014).

The sociocultural/policy risk factors included: traditional practices; cultural myths stating that if a man has sex with a virgin, he will be cured of HIV/AIDS; Western influences of individualism, materialism, and perceived sexual promiscuity; the discouragement and myth perpetuation about

condoms and condom use by the Catholic Church; a lack of HIV testing or care seeking behaviors for fear of stigma or breach of confidentiality; prevalence of violence against women and rape; gender inequality in marriage; and gendered norms surrounding sexuality where women lack the ability to say when she will have sex, with whom, and whether or not a condom will be used (Harper et al., 2014).

When asked what interventions would be successful among youth in the context of these issues, the youth suggested activities such as HIV prevention groups that included condom use skills building, condom distribution, sports and social clubs, and community HIV anti-stigma campaigns. Importantly, the participants also stated that the creation of HIV prevention activities should involve the youth (Harper et al., 2014). The researchers further point out the importance of this suggestion:

> "Involvement of young people would not only increase the relevance and effectiveness of these activities but also leverage the positive aspects of peer influence on HIV risk and protective behaviors" (Harper et al., 2014 p. 11).

Situations of sexual risk-taking among youth

In two qualitative studies of HIV risk situations among youth in Kisumu, Kenya, found that local brew dens, porn video halls, and 'disco funerals' were places where substantial sexual risk behaviors took place for young people (Carolyne Njue et al., 2011; C. Njue, Voeten, & Remes, 2009). The local brew dens in Kisumu were places that sold inexpensive and illegal local liquors and beers, but also tobacco and drugs such as marijuana and khat. Youth were easily able to access these alcohols and drugs, and they reported that this led to sex with multiple partners, and sex without a condom. Porn video halls were rooms that played porn movies at night, and were

popular leisure spots among youth, especially young men. Again, these halls were cheap and easily accessed by the youth, and some youth as young as twelve attended. It was observed in these halls that adolescents would find places of darkness and engage in sex (Carolyne Njue et al., 2011). In both local brew dens and porn video halls, the participants noted that sexual violence and use of force by males was common. This was especially true for the first acts of sex experienced by girls. Reports of condom use at first sex were also low, and reports of multiple sexual partners were high (Carolyne Njue et al., 2011).

Disco funerals are events mixing modern and traditional (Luo) culture in Kisumu. Funerals traditionally last for several days to over a week, and members of the community and extended family gather at the family of the deceased house. During this time period, music (mostly with strong sexual messages) is played and dancing occurs throughout the night once parents have left. Alcohol and drug use was also mentioned as common among the youth during these funerals. Accounts of forced sex and gang rape of young women were alarmingly high. Transactional sex, and 'bidding' on girls with the help of the DJ were also reported as common. Participants stated that most boys did not use condoms, and that this was due to the hurriedness of the act, discomfort in using them, and simply not having any. Finally, the researchers suggest that since Luo culture often encourages adolescent sexual experimentation, and because funerals traditionally include sexual acts through widow inheritance and widow sexual cleansing, parents may see funerals as an culturally acceptable place for adolescents to begin their sexual careers (C. Njue et al., 2009).

In light of these contexts of substantial HIV risk for youth, the researchers suggested some interventions: engaging young men HIV behavior change interventions that focus on attitudinal changes related to power dynamics in sexual relationships; empowering young women in how to negotiate safe sex; income generating and loan programs that address the poverty experienced by young women; positive parenting interventions; the promotion of condoms and safe sexual practices at disco funerals through peer educators and DJs (Carolyne Njue et al., 2011; C. Njue et al., 2009).

Summary

The literature points to inequitable gender norms as causing a fundamental lack of power for women. This lack of power is seen in sexual relationships, in decision-making about their own livelihoods, in their ability to access education, and in their lessened ability or complete inability to participate in economic activities. In this way, inequitable gender norms have been shown to be key drivers of HIV risk and infection. However, there is a gap in the literature in understanding the context-specific aspects of gender that are putting women at increased HIV risk in SSA, and a gap in the understanding of how structural factors shape sexual behaviors in different contexts. There is also limited information about these gendered aspects and structural factors in relation to HIV risk on Kenyan youth, and studies have been limited to Western Kenya. Furthermore, little data exists on how young Kenyans make sense of gender disparities in the context of HIV/AIDS. Understanding the symbolic representations of gender and HIV/AIDS can give insights into cultural blame and stigma, which is key to understanding how to deconstruct harmful social norms and gendered sexual scripts. The goal of this research is to help fill this gap in the literature.

III. Methodology

Introduction

Global Dialogues is a multi-country project that mobilizes youth up to age 24 to write short stories or film scripts about pressing health and social issues, particularly HIV/AIDS, in an effort to educate their communities and make their voices heard (Global Dialogues, 2015). This project, known as “Scenarios from Africa” until 2012, has been present in Africa since 1997. Mobilized through social media, local, national, and international media, non-governmental organizations and community-based organizations, youth are invited to participate in a scriptwriting competition that invites them to speak out and contribute to social change. Participants from all countries are given an identical leaflet, available in multiple languages, providing them instructions and potential topics for their narratives. Entries are first judged at the national level, with national winners moving on to the international level. Some of the final winning narratives are adapted into short films by prominent directors and then donated to local television stations and disseminated via the Global Dialogues YouTube channel and other websites. These films are often used for educational purposes in the community (Winskell, Hill, et al., 2011). By 2014, Global Dialogues had made 39 short films and had an archive of over 75,000 youth written narratives (Winskell et al., 2015). The narratives submitted to the contest provide a unique source of data for understanding how young people understand, engage with, and represent the health and social issues they face. The purpose of this study is to use these narratives by male and female Kenyan youth to analyze social representations of gendered vulnerability to HIV, in order to better understand the socio-contextual factors and cultural meanings that are putting young Kenyan women at risk. It is hoped that findings might help

inform the development of culturally appropriate HIV prevention communication and interventions.

Study population and sample

This project is part of a broader study of young Africans' social representations of HIV and uses the methodologies of that study. Data comes from narratives submitted to the Global Dialogues contest, held in Kenya from January 1 to March 31, 2014. Participants could choose from six suggested topics: (1) sex, drugs and alcohol; (2) violence against girls and women; (3) taking or avoiding sexual risks; (4) living with HIV/AIDS; (5) someone attracted to people of the same sex; or (6) a free choice topic related to HIV/AIDS, sexuality, violence against women, or alcohol, drugs and sex. A total of 2,741 narratives were submitted and became the overall sampling frame for this study. Texts were eligible for inclusion as long as they were individually authored (i.e. not submitted by a team of participants), written in English (narratives in Kiswahili were excluded), contained a narrative (i.e. texts incorporating a plot-driven story), and mentioned HIV/AIDS. In the event that multiple texts by the same author were sampled, only the first sampled text was included. This was done to ensure greater breadth of representation in the sample. For the purposes of this research, only narratives submitted in response to topics 3, 4, and 6 – deemed of most immediate relevance to the theme of HIV – were included. This yielded a total of 1,179 narratives. The narratives were then divided into twelve strata based on age (10-14, 15-19, and 20-24), sex (M/F), and place of residence (urban/rural). Place of residence was established by the author on their contest leaflet. Ten narratives from each of these twelve strata were then randomly selected for inclusion, for a goal of 120 narratives total. Preliminary studies have shown that this sample size is adequate for identification of social representations across

priority themes. After reviewing the sampled texts in light of the aforementioned inclusion criteria, some strata did not have ten eligible texts. This led to a total sample size of 110 texts, from which basic descriptive statistics were drawn. In-depth qualitative analysis was undertaken for the central age stratum, the 15-19 age group, which included males and females from both urban and rural areas, yielding a total sample of 40 narratives (Figure 1).

Data processing and analysis

Data analysis used both quantitative and qualitative methods. Quantifiable elements of the narrative (e.g. the sex of characters who become infected with HIV; HIV transmission route), was entered using the online survey platform Qualtrics, and exported for analysis in Microsoft Excel. Sampled eligible narratives were transcribed verbatim into Microsoft Word and then entered into MAXQDA11 qualitative data analysis software (VERBI Software, 1989-2015). Qualitative analysis methods were informed by grounded theory (Corbin, 2008) and thematic narrative analysis (Riessman, 2008), with the narrative as the constant point of reference throughout the analysis (Winskell et al., 2013).

The entire sample of 110 narratives was analyzed in two ways: (1) using descriptive statistics on the quantifiable elements of the narratives, and (2), using a narrative-based methodology where a one-paragraph summary highlighting the plot and key messages was written for each narrative, and coded with up to six (out of 44) thematic keywords. We used a codebook of thematic keywords developed for a previous analysis of African Global Dialogues narratives (Winskell, Hill, et al., 2011) and updated it for the 2014 dataset using an iterative process. This narrative-

based methodology allowed for a comparison of the major overlapping themes across gender strata.

In-depth, qualitative analysis was conducted on the 40 narratives from the 15-19 age groups of urban and rural females and males (see Figure 1). These narratives were analyzed by applying thematic, descriptive codes (Miles, 1994) to text segments, and by writing memos for emergent themes (Winskell, Hill, et al., 2011). A codebook of inductive and deductive themes developed for a previous analysis of African Global Dialogues narratives (Winskell, Hill, et al., 2011) was used and adjusted iteratively to capture emerging themes in the 2014 data, such as "growing up with HIV", and "PEP and PrEP", for a total of 74 thematic codes.

Utilizing the three analytical methods of descriptive statistics, narrative-based summaries and related keywords, and qualitative coding, allowed for data triangulation. The quantitative analysis yielded descriptive statistics and quantified the themes of the narratives, and the qualitative analysis provided an in-depth examination of how young authors engaged with those themes. The narrative-based analysis gave a holistic view of the data, which helped to offset any de-contextualization or fragmentation of the narratives that may have occurred with the other methods (Winskell et al., 2013).

Ethical Considerations

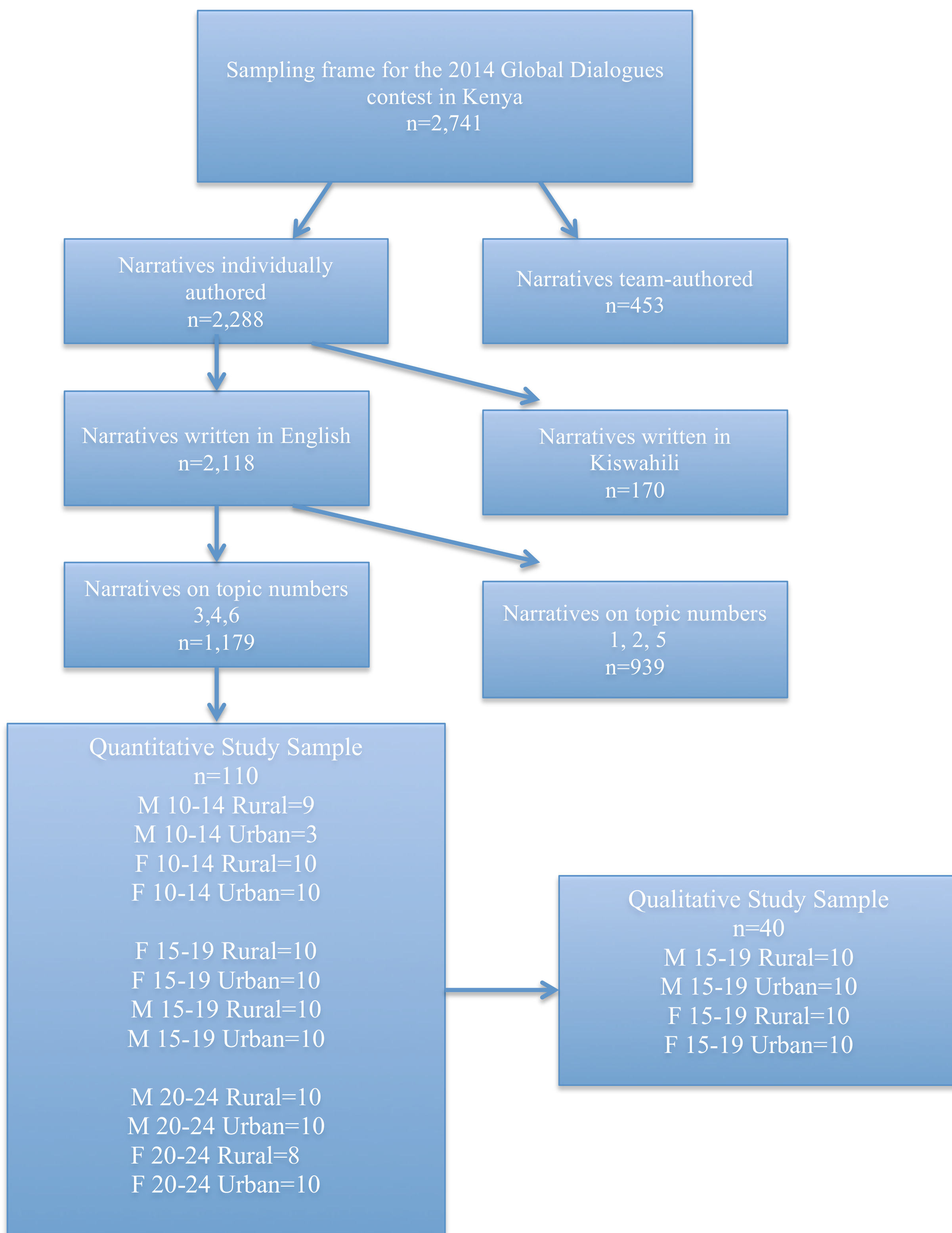
This research was exempt from IRB approval as it was a secondary analysis from an existing dataset that was de-identified prior to the start of analysis. Approval for the broader longitudinal study was granted to Dr. Winskell by Emory University's Institutional Review Board.

Limitations and Delimitations

While the data set is unique and offers great insight into youth understandings and social representations of HIV/AIDS, it does have limitations. As participants in the contest self-select, the sample is not constructed to reflect the composition of the Kenyan youth population. Participation in the Global Dialogues contest is limited to those who know of the contest and have the capability and interest to participate. Therefore, the data is likely to represent youth who are better educated, more knowledgeable about HIV, more motivated and engaged than the general youth population (Winskell, Obyerodhyambo, & Stephenson, 2011). However, while written by individuals, these narratives provide access to social representations from the larger social groups to which they belong (C. Campbell, Skovdal, Mupambireyi, & Gregson, 2010). And as the research seeks to understand a range of cultural meanings of HIV among the youth populations, the use of these narratives as a source of social representations of HIV is fitting (Winskell, Obyerodhyambo, et al., 2011).

The dataset was also delimited to only those narratives written in English, and by individuals. This may create potential to miss some cultural understandings and insights. However, as the vast majority of participants chose to write in English and individually, this is unlikely to seriously limit the findings.

Figure 1. Sampling Flowchart



IV. Results

Results of this study are presented in two sections. The first section presents results from the quantitative analysis of all 110 narratives by authors with ages ranging from 10-24 years, and the second section presents an in-depth qualitative analysis of the 40 narratives comprising the 15-19 year-old strata. The quantification of themes and outcomes highlights the patterns across the narratives, and the qualitative analysis provides an in-depth examination of how the young authors engaged with those themes to portray gendered representations and HIV risk factors.

Section I. Quantitative Results

The dataset includes 110 narratives written by youth with an age range of 10-24 years. The average age was 17.5 years. Basic demographic characteristics are provided in Table 1. Female authors were slightly more represented than male authors, as were authors from rural areas.

Table 1. Total number of narratives by sex and residence of author, n=110

Author Sex	Rural Residence (%)	Urban Residence (%)	Number of Narratives (%)
Female	28 (48.3)	30 (51.7)	58 (52.7)
Male	29 (55.8)	23 (44.2)	52 (47.3)
Total	57 (51.8)	53 (48.2)	110 (100)

Sex of the Protagonists

The narratives were categorized according to whether the primary protagonist(s) was/were female, male, both male and female, or of unknown or unspecified sex. Results are provided in Table 2. A greater number of narratives have a female (43.7%) than a male (32.7%) protagonist.

Female authors are more likely to write narratives with a female versus male protagonist, and vice versa.

Table 2. Sex of protagonist by sex of author, n=110

Protagonist Sex	Author Sex: Female	Author Sex: Male	Total (%)
Female	35	13	48 (43.7)
Male	10	26	36 (32.7)
Female & Male	5	7	12 (10.9)
No specific sex/sex unknown	8	6	14 (12.7)
Total	58	52	110 (100)

Narrative Subtopics

The narratives were classified into categories according to whether they focused on prevention, infection, post-infection or a combination of these (prevention/infection, infection/post-infection, prevention/post-infection, prevention/infection/post-infection, or other). More than three-quarters of the narratives were about HIV infection, post-infection, or a combination of both topics. The most frequent category was the combination infection and post-infection, accounting for 32.7% of narratives. Notably, narratives about HIV prevention comprised just 10% of the sample, and narratives combining prevention with infection or post-infection topics accounted for nearly the same proportion. Poems personifying HIV and narratives about the overall effects of HIV on the people of Kenya were classified as ‘other’, and comprise 3.6% of the dataset (See Table 3).

Table 3. Subtopic of narratives by sex of author, n=110

Subtopic of Narrative	**Author Sex: Female (%)**	**Author Sex: Male (%)**	**Total (%)**
Infection	15	14	29 (26.4)
Infection/post-infection	21	15	36 (32.7)
Post-infection	10	8	18 (16.4)
Prevention	5	6	11 (10.0)
Prevention/infection	1	3	4 (3.6)
Prevention/infection/post-infection	4	2	6 (5.5)
Prevention/post-infection	1	1	2 (1.8)
Other	1	3	4 (3.6)
Total	58	52	110

Who Becomes Infected with HIV?

To ascertain whether it is more likely that a female character will become infected with HIV, narratives in which an HIV infection occurs (n=66) were further analyzed by sex of the character that becomes infected. Results presented in Table 4 show that infection occurs in female characters over 2.5 times (54.5%) more often than in male characters (19.7%), indicating that young authors represent females as at considerably greater risk of HIV infection than males. However, this proportion depends upon the sex of the author. Table 5 shows that female authors are far more likely to depict a female (72.2%) than a male (5.6%) becoming infected. Interestingly, male authors depict infection of male and females characters with nearly the same frequency, at 36.7% and 33.3% respectively.

Table 4. Sex of character contracting HIV in infection-related narratives, n=66

Which character becomes infected?	Frequency	Percent
Female	36	54.5%
Male	13	19.7%
Female & Male	13	19.7%
Unclear/ sex unknown	4	6.1%
Total	66	100%

Table 5. Sex of character contracting HIV in infection-related narratives by sex of author, n=66

Which character becomes infected?	Female (%)	Male (%)	Female and Male (%)	Unclear/ sex unknown (%)	Total (%)
Female Author	26 (72.2)	2 (5.6)	7 (19.4)	1 (2.8)	36 (100)
Male Author	10 (33.3)	11 (36.7)	6 (20.0)	3 (10.0)	30 (100)
Total	36 (54.5)	13 (19.7)	13 (19.7)	4 (6.1)	66 (100)

Mode of HIV Transmission

Transmission of HIV in the infection narratives was overwhelmingly through heterosexual contact (74.3%). There were no narratives in which HIV was transmitted through homosexual contact, and in 13.6% of infection narratives, the mode of HIV transmission was unclear (See Table 6).

Table 6. Mode of HIV transmission in narratives containing HIV infection, n=66

Mode of HIV transmission	Frequency	Percent
Heterosexual contact	49	74.3%
Blood route	7	10.6%
MTCT	1	1.5%
Unclear	9	13.6%
Total	66	100%

Hopefulness Post-Positive HIV Diagnosis

Several of the narratives included a discussion of how characters deal with their positive HIV diagnosis. Some narratives were markedly more hopeful post-positive HIV diagnosis than others, and these narratives were quantified to assess how young authors imagine life with HIV/AIDS. Narratives were classified as unhopeful if they ended with the protagonist's diagnosis or death without envisaging a fulfilling life between diagnosis and death. The presence or absence of hope was stratified by both sex of the protagonist and sex of author, to answer the following questions: (1) Are narratives with female protagonists less hopeful? (2) Does the hopefulness at the end of the narrative differ based on the sex of author?

Of the total dataset (n=110), 88 narratives were eligible for inclusion in this analysis. The remaining 22 texts were not applicable as they were either exclusively about HIV prevention, or were poems about HIV. In 50 narratives (56.8%), there was an absence of hope post-positive diagnosis, while 37 (42.1%) narratives contained hope post-positive diagnosis (See Table 7).

Table 7. Total narratives with the presence or absence of hope post-positive HIV diagnosis by sex of the protagonist, n=88

Sex of protagonist	**No hope post-diagnosis**	**Yes, hope post-diagnosis**	**Hope post-diagnosis unclear**	**Total (%)**
Female protagonist	23 (53.5)	20 (46.5)	0 (0)	43 (100)
Male protagonist	15 (53.6)	13 (46.4)	0 (0)	28 (100)
Female and male protagonist	7 (77.8)	2 (22.2)	0 (0)	9 (100)
No specific sex/sex unknown	5 (62.5)	2 (25.0)	1 (12.5)	8 (100)
Total	50 (56.8)	37 (42.1)	1 (1.1)	88 (100)

The sex of the protagonist did not affect the hopefulness of the narrative. Narratives with female and male protagonists ended without hope in 53.5% and 53.6% of cases respectively. Stratifying by sex of author, however, shows that male authors have a slightly higher proportion of narratives containing hope post-positive HIV diagnosis than female authors, at 46.3% and 38.3%, respectively (See Tables 8 & 9). Male authors notably depicted more hopeful endings for male protagonists at 55%, than did female authors at 25%. This was not as pronounced for narratives with a female protagonist, where male authors depicted hopeful endings at 50%, and female authors depicted hopeful endings at 45.2%. Female authors were therefore more likely to depict unhopeful outcomes for male protagonists than female protagonists, whereas male authors depicted unhopeful endings at nearly the same frequency regardless of sex of the protagonist.

Table 8. Female-authored narratives with the presence or absence of hope post-positive HIV diagnosis by sex of the protagonist, n=47

Sex of protagonist	**No hope post-diagnosis**	**Yes, hope post-diagnosis**	**Hope post-diagnosis unclear**	**Total (%)**
Female protagonist	17 (54.8)	14 (45.2)	0 (0)	31 (100)
Male protagonist	6 (75.0)	2 (25.0)	0 (0)	8 (100)
Female and male protagonist	3 (75.0)	1 (25.0)	0 (0)	4 (100)
No specific sex/sex unknown	2 (50.0)	1 (25.0)	1 (25.0)	4 (100)
Total	28 (59.6)	18 (38.3)	1 (2.1)	47 (100)

Table 9. Male-authored narratives with the presence or absence of hope post-positive HIV diagnosis by sex of the protagonist, n=41

Sex of protagonist	**No hope post-diagnosis**	**Yes, hope post-diagnosis**	**Hope post-diagnosis unclear**	**Total (%)**
Female protagonist	6 (50.0)	6 (50.0)	0 (0)	12 (100)
Male protagonist	9 (45.0)	11 (55.0)	0 (0)	20 (100)
Female and male protagonist	4 (80.0)	1 (20.0)	0 (0)	5 (100)
No specific sex/sex unknown	3 (75.0)	1 (25.0)	0 (0)	4 (100)
Total	22 (53.7)	19 (46.3)	0 (0)	41 (100)

Blame for Actual or Potential HIV Infection

A protagonist's HIV infection, or their potential HIV infection, was often depicted as a result of some wrongdoing by the protagonist, thus resulting in explicit blame of the protagonist. A total of 90 narratives in the total dataset (n=110) were eligible to be analyzed for the existence of blame. Ineligible texts (n=21) included those exclusively about HIV prevention, or poems about HIV. A narrative was said to have blame when a clear link was drawn between HIV infection (or potential HIV infection) and wrongdoing by the protagonist. This included: direct statements that the protagonist's behavior was "bad", "immoral", "wrong", or "irresponsible"; statements that the protagonist learned a lesson or faced consequences for their actions (notion of punishment); and statements of condemnation or shame by other characters or the narrator for the protagonists' actions. In 33 narratives (36.7%), blame for HIV was present, while in 50 (55.5%) blame for HIV was not present (See Table 10). The presence or absence of blame for a female protagonist was almost equally divided in narratives: 45.4% do not contain blame, while 43.2% do. Blame of

a female protagonist is unclear in 11.4% of the narratives, which is notable as only narratives with a female protagonist have unclear blame. The absence of blame is far more prominent than the presence of blame in narratives with a male protagonist, at 67.9% and 32.1%, respectively. Overall, female protagonists are blamed more for their actual or potential HIV infection (43.2%), than are male protagonists (32.1%).

Table 10. Total narratives with the presence or absence of blame for actual or potential HIV infection, by sex of the protagonist, n=90

Sex of protagonist	No blame for HIV infection (%)	Yes, blame for HIV infection (%)	Blame for HIV infection unclear (%)	Total (%)
Female protagonist	20 (45.4)	19 (43.2)	5 (11.4)	44 (100)
Male protagonist	19 (67.9)	9 (32.1)	0 (0)	28 (100)
Female and male protagonist	6 (60.0)	2 (20.0)	2 (20.0)	10 (100)
No specific sex/sex unknown	5 (62.5)	3 (37.5)	0 (0)	8 (100)
Total	50 (55.5)	33 (36.7)	7 (7.8)	90 (100)

To better understand how the assignment of blame differs between female and male authors, Tables 11 and 12 present blame stratified by sex of the author and sex of the protagonist. Most notably, female authors are less likely to blame female protagonists (37.5%) than are male authors (58.3%), and male authors are less likely to blame male protagonists (25%) than are female authors (50%). This indicates that the young authors are more sympathetic to protagonists of their same sex, but that male authors are considerably less sympathetic to protagonists of their

opposite sex than are female authors. Nonetheless, female authors have a larger overall percentage of narratives with blame (41.7%) than do male authors (31%).

Table 11. Female-authored narratives with the presence or absence of blame for actual or potential HIV infection by sex of the protagonist, n=48

Sex of protagonist	**No blame for HIV infection (%)**	**Yes, blame for HIV infection (%)**	**Blame for HIV infection unclear (%)**	**Total (%)**
Female protagonist	17 (53.1)	12 (37.5)	3 (9.4)	32 (100)
Male protagonist	4 (50.0)	4 (50.0)	0 (0)	8 (100)
Female and male protagonist	2 (50.0)	2 (50.0)	0 (0)	4 (100)
No specific sex/sex unknown	2 (50.0)	2 (50.0)	0 (0)	4 (100)
Total	25 (52.0)	20 (41.7)	3 (6.3)	48 (100)

Table 12. Male-authored narratives with the presence or absence of blame for actual or potential HIV infection by sex of the protagonist, n=42

Sex of protagonist	**No blame for HIV infection (%)**	**Yes, blame for HIV infection (%)**	**Blame for HIV infection unclear (%)**	**Total (%)**
Female protagonist	3 (25.0)	7 (58.3)	2 (16.7)	12 (100)
Male protagonist	15 (75.0)	5 (25.0)	0 (0)	20 (100)
Female and male protagonist	4 (66.7)	0 (0)	2 (33.3)	6 (100)
No specific sex/sex unknown	3 (75.0)	1 (25.0)	0 (0)	4 (100)
Total	25 (59.5)	13 (31.0)	4 (9.5)	42 (100)

Section II. Qualitative Results

To examine and describe the themes presented above more in-depth, a qualitative analysis was conducted on the female and male authored narratives that comprise the 15-19 year-old age stratum from both urban and rural youth (n=40). As this is the central age stratum, it was deemed likely to best represent the sample. Qualitative results are presented in the following order: (1) representations of female and male characters, (2) HIV risk factors for females and males, (3) blame for HIV infection, and (4) representations of characters that display positive deviance, or behaviors that differ positively from the norm (Murphy, 2005).

Representations of Female Characters

Female protagonists were more numerous than male protagonists, and were presented in three ways: (1) a good, hardworking girl who engaged in behavior deemed inappropriate and met a tragic end, (2) an unfaithful, promiscuous or dishonest partner who brought HIV risk or infection to a male, or (3) a victim of gendered socio-cultural norms and structural constraints. Only three narratives feature female protagonists who do not contract HIV and were able to persevere through hardships or situations of peer pressure.

'Good girl gone bad'

The vast majority of female protagonists were represented as 'good' girls who go 'bad'. At first, these females were presented as intelligent and hardworking students. They were praised and admired by peers and community members for their discipline and high academic achievements. Soon these females began to act out of character, however, and engaged in behaviors deemed inappropriate and even immoral for young women. These behaviors included talking to boys,

going out to parties or disco's, drinking alcohol, and occasionally, doing drugs. All of the females in these narratives entered into a sexual relationship (committed or casual) with a male, and in one narrative, a college-aged female had both a boyfriend and a transactional relationship with an older man. All of these relationships led to HIV infection or presumed HIV infection, and in the end, all of these females were abandoned by their partners. The dominant narrative was that girl-boy relationships were bad for schoolgirls, and such relationships would shatter their future plans and dreams.

Unfaithful, scheming, and women with multiple partners

The second most common female protagonist depicted in the narratives was one that was scheming, unfaithful, or had multiple partners. These representations were more frequent among female authors than male authors. In cases of female infidelity, the cause was the woman's desire for wealth and material possessions. In one narrative, the female protagonist had an affair with her boyfriend's best friend because she was "so materialistic" and his friend was a "working man" who was a better prospect than her own "humble" boyfriend (M 18 R). In another narrative, a married woman left her husband for another man because she "couldn't stand living in a slum" anymore, and the other man could buy the "fancy clothes and shoes" she had always wished for (F 17 R). Again, these narratives ended with the female contracting HIV and being left alone. Only female characters were depicted as desiring wealth or material goods.

Female protagonists were sometimes depicted as having multiple concurrent sexual partners, although this behavior was more commonly associated with male protagonists. These females were also described as having immense beauty, which led to too much attention from males and

a great deal of pride. One female protagonist stated that the admiration she received for her beauty at a young age led her to become “proud” and sleep with “each and every man” that came her way (F 16 U). These women with multiple partners were also depicted as scheming and malicious. They failed to disclose their positive HIV status, or intentionally infected hundreds of men before they themselves died.

Victim of gendered socio-cultural norms and structural constraints

The final type of female protagonist was represented as a victim of gendered socio-cultural norms and structural constraints. These females suffered as a result of early marriage, forced marriage, polygamy, patriarchy, the undervaluing of girls’ education, poverty, and economic dependence on men. In two narratives, the young females were forced to drop out of school as it was time for their initiation into womanhood and/or circumcision (female genital cutting), and their fathers had arranged polygamous marriages with elderly men. In the instances where the girl’s mother disagreed with her husband’s decision to marry off their daughter, she was powerless to stop it, as her husband had all the power: they “decided to quiet and let their father did everything he wanted to do since he is the one who has all authority as well as the head of the family” (F 16 R). Another motivator for forced marriage to an elderly man was the prospect of financial gain for the parents; marriage of their daughter brought a bride price payment. In all cases of forced or polygamous marriage, the female characters ended up contracting HIV.

Female characters were also represented as victims of poverty with little power to change their situations. In a narrative written by 15-year-old rural female, a young girl who was a good student was forced to drop out of school because her mother could no longer afford the school

fees. Her mother sent her to be a live-in maid for a man who forced her to get circumcised. The man later drugged and raped her, infecting her with HIV. Without the financial support of men, female characters were also seen as disempowered and unable to go on. In one narrative, the female protagonist lost her husband to AIDS, and she was described as being unable to "manage" the family due to "stress and confusion" (M 16 R). Without the help of her husband, her children dropped out of school, became involved in drugs, and her daughter became a "famous prostitute" in the city (M 16 R). In the end, both mother and daughter died from AIDS.

Representation of Male Characters

On the whole, male protagonists were more difficult to categorize than female protagonists. Males were not in the protagonist role as often, and were not described in as much depth as female protagonists. The representations of their behaviors were also more nuanced, which will be further discussed in the section on blame for HIV. Male protagonists and characters were more fluid, containing a variety of characteristics, rather than strict definitions. Common characteristics included: being sex-driven, perpetrators of sexual coercion and violence, prone to deception and abandonment, or income sources for females. Conversely, they were also represented as victims of female infidelity and intentional infection (as illustrated in the previous section), and even female-perpetrated rape. Male protagonists were more likely to receive support when HIV infected than female characters, and they benefited from the two mentions of post-exposure prophylaxis (PEP) use in this age stratum[1].

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[1] There are a total of four narratives in the entire sample (n=110) that reference a character using PEP; all of these are male characters.

Sex-driven males

In both female and male-authored narratives, male protagonists were portrayed as beings driven by uncontrollable sexual desire. They usually had multiple concurrent partners, which were kept secret from their girlfriends or wives. These partners could be other girlfriends or wives, casual sex partners, sex workers, or housemaids. In one narrative, the sex-driven young man assumed the 'good gone bad' persona. The protagonist was described as a "very good and kind boy" who did so well in primary school that he earned a scholarship to his "dream" high school (F 16 U). Once there however, he got involved with a new group of friends and began sleeping with prostitutes, watching "pornographic movies", and was said to "change girls like his innerpants" (F 16 U). Even in an instance where a male character was in a committed relationship, he was described as "demanding sex" because he "could not stand his feelings anymore" (F 17 R). Another narrative described a young man who suddenly lost interest in his girlfriend after they had sex because he had "gotten what he wanted" (F 15 R). Unlike with female characters, where sex was represented more as driven by pursuit of wealth or as inappropriate and immoral behavior, male sex drive was described as a type of "moodiness" that was a part of their very being (M 16 R).

Sexual coercion and violence

At times, male sexual desire led to sexual coercion. In a poem titled, "I wish I knew", a young women was coerced into sex with a man who had been buying her gifts and showering her with "sweet words" before he "forced" her to "sneak" from her home to meet him and have sex (M 16 U). In the narratives, sexual violence also took the form of rape. When rape occurred, it was usually by an ancillary or unknown male character that was not held accountable for his actions.

In only one narrative did a male protagonist commit rape, and he was held accountable. Stories about rape usually involved the man drinking too much alcohol or doing drugs, and in one case, a man gave a young girl either an alcoholic drink or a drink spiked with drugs. In one narrative about rape, the genders are reversed; a wife raped her husband. In this case, the male protagonist received the support of his neighbor to go to the clinic, where he received PEP and counseling that it "was not his fault" (M 16 U). Such counseling and access to medication was notably absent from the narratives about male-perpetrated rape of females.

Male deception and abandonment

Closely linked to their depiction as sex-driven, male characters were also represented as deceptive and quick to abandon their female partners. In their pursuit of sexual relationships with females, male characters often convinced females that they were committed and in love, but left these females behind once they had sex, or when the female became pregnant or HIV positive. Other narratives described male deception in cases where the male protagonist had secret affairs or girlfriends, or in one case, a secret family.

Men as sources of wealth

Narratives that discuss a man's wealth were more often narratives with female protagonists. In these narratives, male characters were represented not only as the breadwinners of their families, but also as sources of wealth for women who were poor or desired material gain. Only three narratives with male protagonists made any mention of wealth. Two of these narratives followed the same formula as narratives with a female protagonist; in one, the man was rich and the breadwinner of the family, and in the other, the man spent a lot of money and bought expensive

gifts for his girlfriend. The third narrative involved a wealthy old man who married and paid the bride price for over two hundred women. The depiction of women as financially dependent upon men was important because it placed the female characters in situations of HIV risk, as they lacked the power to negotiate the terms of their sexual relationships with the male characters that provided for them.

Female and Male Risk for HIV

Female and male characters were subject to a number of factors that put them at risk for HIV infection. Shared female and male risk factors included: peer pressure and influence, partying, alcohol and drugs, male sex drive and multiple partners, female beauty, and traditional practices. However, female characters were subject to additional risk factors that male characters were not. Female characters experienced partner pressure for sex and sexual expectations through male gift giving. They also experienced risk due to poverty and economic dependence on men. Several of these risk factors for female and male characters mirrored their representations. For example, in the same way that females were characterized as victims of traditional practices and males were characterized as being sex-driven, it was those same characteristics that put them at risk for HIV.

Peer pressure and influence

Several narratives attribute a character's HIV risk to peer pressure. This was especially true of the 'good gone bad' narratives. Peer pressure was often depicted as getting into a 'bad' group of friends, where previously 'good' characters were led astray. Peer pressure always revolved around sex, drugs, and alcohol use. In two of the 'good girl gone bad' narratives, the female protagonists were "mocked" and "bullied" for their virginity, which led them both to have sex,

and they contracted HIV (F 19 U; M 16 R). It isn't until one male character "fell into a bad group of friends" that he began to do drugs, go to nightclubs and sleep with prostitutes, and have multiple partners (F 16 U). However, in the very same narrative, others were said to have attempted to warn him about his behavior. A few of the 'good girl gone bad' narratives also state that friends of the female protagonists warned them about the dangers of their behaviors. But such positive peer influence was never successful; it was the peer pressure to engage in risky behaviors that prevailed.

A type of pressure unique to females was partner pressure for sex. This pressure occurred most prominently through the act of male gift giving. Intertwined in two of the 'good girl gone bad' narratives was the expectation from male characters that once gifts or money was given to female characters, they had to reciprocate with sex. For one female protagonist peer and partner pressure intersected:

> *"…one day as she walking through the town near to her school, a boy who was smartly dressed approached her and requested her for a girlfriend. Due to the pressure she got from her schoolmates, it was so hard to resist the request, besides the boy was handsome. As time went on, the boy who was named John managed to persuade her to have sex with him. To add to that, the girl was given a lot of things and money any this made her to not ignore having sex."*-M 16 R

The expectation of sex after gift giving was also expressed in terms of force in the narratives. Two narratives described the female either being "forced" by the male to have sex after receiving gifts, or the male "taking" sex from the female (M 16 U; F 16 U). In two narratives, male pressure for sex occurred without gift giving, however. One narrative described this in a romantic relationship where "a time reached when the boyfriend demanded for sex", indicating that sex was an expectation in boyfriend-girlfriend relationships (F 17 R). In another narrative,

the pressure for sex comes from a male friend at school, who tried to persuade the female protagonist to join him in an empty classroom so that he could “show” her how much he “loved” her (M 17 R).

Alcohol, drugs, partying

Both female and male characters were put at risk for HIV through alcohol, drugs, and partying. Alcohol and drugs were mentioned with similar frequency in the narratives. Alcohol use was slightly more frequent for male characters, but drug use was equal for both male and female characters. Drug and alcohol use by male characters was often associated with physical and sexual violence perpetrated against female characters. The kinds of “drugs” were not often specified, however, and limited to a few mentions of weed and/or bhang (marijuana), cigarettes and shisha (tobacco), and one mention of cocaine. Injecting drug use was mentioned once, but again, the exact drug was not specified. Eventually, all instances of drug or alcohol use by protagonists led to their HIV infection. In general, it was the mind-altering effects of drugs and alcohol that led female and male characters to engage in risky sexual behaviors. Alcohol and drug use sometimes occurred with partying. “Partying” was a loosely used term in the narratives that was synonymous with going to nightclubs or disco’s, but was also occasionally applied to house parties. Partying did not differ in frequency between female or male characters. Partying, alcohol, and drug use was collectively referenced as “bad” behavior in the narratives.

Male sex drive and multiple partners

Males’ constant pursuit of female sex partners placed both male and female characters at risk for HIV infection. Male sex drive was usually linked with multiple concurrent partners. Men in the

narratives kept their additional partners secret, which put their main female partners at additional risk. One narrative described a man's inability to reach his "sexual pleasure to the climax" with his wife, so he started to go out to bars to meet other women to sleep with (M 16 R). This man soon contracted HIV/AIDS, infected his wife, and then passed away. A similar narrative played out for a young woman who, after deciding to sleep with her boyfriend, found him "naked with some girls" after making an unexpected visit (F 15 R). She then decided to get tested for HIV, and found out that she was positive. There were narratives depicting female protagonists as having multiple partners, but these differed from narratives with male protagonists as females with multiple partners were said to be doing it either for material gain or because they were under the influence of drugs or alcohol. The motivation behind having multiple partners did not change the risk for HIV infection however, and in the end these characters contracted HIV.

Female beauty

In the narratives, female beauty placed both female and male characters at risk for HIV infection. As discussed previously, female characters that were described as beautiful received significant levels of attention from male characters that placed them at risk. Once they received this attention, they engaged in 'bad', sexual behaviors that ended in HIV infection. This was most pronounced in a narrative involving a female with multiple partners, where the narrator directly attributed the protagonist's HIV infection, and ultimate AIDS death, to her beauty. The protagonist, whose figure was described as a "permanent HALLELYAH", told the narrator that, "beauty wins all" and that every man had wished to date her, and that almost every man had (F 19 U). The narrator stated that in the past she, like every other girl who knew her, had wished to

be just like her because she seemed to get everything she wanted. After the protagonist's death however, the narrator saw her beauty in a different light:

> *"I thank God for my face even though am not that beautiful, maybe not the centre of attraction, I thank God as no man ever looks at me. Not lyke Beryl who captivated the attention of every man. She is now gone."*- F 19 U

In another narrative, it was the beauty of the female protagonist that caught the attention of a wealthy male, which led the woman to leave her husband and ultimately contract HIV from this new partner. Male attraction to beauty was also mentioned as an initial factor that sparked the female protagonist's downfall in some 'good girl gone bad' narratives. Female beauty was not just a risk factor for female characters however. Male characters were sometimes unable to resist the temptation of a beautiful female, which put them at risk for HIV infection. In one example, a man from a small village made a visit to Nairobi, and was immediately impressed with the city and all the "girls wearing short clothes" that he decided to stay a while (F 17 U). He soon met the most beautiful girl that he had ever seen, and after a few months, he grew thinner and thinner, and ultimately died of AIDS. The moral, we were told, was that youth needed to "take care with their lives" and abstain, and whenever one saw a beautiful girl they should "think twice" because "HIV/AIDS is real" (F 17 U).

Traditional practices

Although traditional practices were mostly a risk for female characters, they put both female and male characters at risk. As discussed previously, traditional practices included early marriage, forced marriage, and polygamy. Underlying both of these practices was a system of patriarchy or male power, and a devaluation of girls' education. The only practice here that was also

represented as placing male characters at risk was polygamy. It was through one of his many new wives that one man contracts HIV. In all narratives that discussed polygamy or forced marriage, the female characters contracted HIV. The power of males in the narratives placed female characters at risk because it precluded their being able to choose when and whom they would marry, and eliminated their ability to negotiate when they would have sex, as was also discussed with male gift giving. Although not widespread in the narratives, there was mention of a culture of failing to value girls' education that ultimately forced some female characters to drop out of school, which put them in situations where they contracted HIV.

Poverty and economic dependence on men

Widespread poverty and economic dependence on men were factors that specifically put female characters at risk for HIV. One of the most distinct examples of poverty was commercial sex work. The majority of narratives that mention sex work attributed it to the female character's poverty. These characters were described as needing to earn money to provide food for themselves and/or their family members. In all instances of commercial sex work, the female character became infected with HIV. There were very few instances of formally employed female characters, and the jobs mentioned were low skilled and gendered: housemaid, tailor, and janitor. In these narratives, the female characters were said to work only because their husbands or parents could not adequately provide for them. The only exception to this was one narrative in which the female protagonist worked hard in school and became a teacher, but shortly into her career she learned that she had AIDS due to her past actions.

Economic dependence on men was also depicted in a narrative about transactional sex. This occurred in only one narrative, and the female protagonist was said to have a “sugar daddy” that gave her money, took her shopping, took her to restaurants, and brought her traveling – all with the expectation of sex in return. The end result of her transactional relationship was HIV infection. In this case, however, the driving force for the female protagonist was a desire for wealth and material gain, rather than absolute poverty, and she was blamed for her HIV infection. Still, male characters were depicted as the main source of income in the narratives, and female characters were depicted as dependent upon them. This was also seen in the few narratives where a wife lost her husband to AIDS, which left her poor and destitute before she also died of the disease. While examples of male employment was not delineated either, male characters were never depicted as financially dependent upon female characters, or as having to place themselves in sexual risk situations in order to survive.

Blame for HIV

As discussed in the quantitative analysis (n=110), blame for a character’s actual or potential HIV infection was often assigned in the narratives. While the numbers showed that female authors wrote both more narratives containing blame and more narratives featuring female protagonists, male authors blame female protagonists more than female authors (58.3% and 37.5%, respectively). The aim of this section is to better understand these differences, and describe how the young authors express blame for male and female protagonists, and in what circumstances.

Blame in the narratives was constructed in moral terms. These characters were said to have “bad”, “immoral”, “wrong”, or “irresponsible” behaviors that caused their infections, and this

often led to condemnation and shaming by other characters, or the narrator. Although religion itself was rarely discussed in the narratives, blame was also represented through the tragic outcome of the narrative, where a protagonist learned a lesson or faced consequences for their actions. In this way, HIV/AIDS was largely depicted as a disease that only bad, immoral people acquired. The analysis of this stratum (n=40) showed a clear and overwhelming blame of female protagonists for their actual or potential HIV infection, especially of female protagonists that were depicted as 'good girls gone bad' or as dishonest and unfaithful. HIV/AIDS served as a punishment for their 'immoral' behaviors, and these narratives ended without hope for living a fulfilling life with HIV. Even in instances where female characters were victims of cultural norms or structural constraints, they were not completely free from blame for the decisions they made in desperate situations. On the other hand, male protagonists were far less likely to be blamed for their HIV infection, and they rarely suffered consequences for the same behaviors that female characters did. Therefore, the following analysis of blame for actual or potential HIV infection is separated into two categories: blame of female characters, and blame of male characters. Blame in the narratives was communicated in three ways: through explicit commentary by the narrators, through negative story outcomes, and on occasion, through the reactions of other characters. These modes of communication were not mutually exclusive, and more than one was usually present in the narratives.

Blame of female characters for actual or potential HIV infection

Blaming of female characters for their actual or potential HIV infection was most prevalent in the 'good girl gone bad' narratives. These formerly hardworking and studious females engaged in behaviors described as "immoral", or socially "inappropriate" such as talking to boys, going

out to parties or disco's, drinking alcohol, or doing drugs. Very moralistic in tone, all of these narratives communicated blame through devastating consequences for the female's 'bad' actions. Most of them also contained explicit blame from the narrator, such as the following narrative:

> *"What shocked her most was that she knew that she had AIDS, and she was pregnant. Her life was hopeless now with no whereabouts nor anything to change it…She lay by her bedside thinking carefully what she will do next. Alas! She got an answer and with in no minute she took a rop and hang herself on the roof of her small thatched hut. What a wasted life! She had left a one month old baby with no mother nor father. The most thing that made herself to die was that she had HIV and nobody can marry a HIV positive person. What a silly lady!"*-M 16 U

None of these narratives envisioned a happy or fulfilling life for the female character after her positive HIV diagnosis. Two of the narratives ended with the female committing suicide: one by hanging herself (as quoted in the narrative above), and the other by overdosing on pills. Another two narratives depicted the females as full of despair and regret, and indicated that their futures were "doomed". The remaining narratives ended dramatically, with one female learning of her HIV status through a suitcase full of ARVs left in her room by her partner, and the other female learning of her status as her ex-boyfriend drunkenly spelt out the word A-I-D-S to her.

Less common was the communication of blame through the reactions of other characters. Unlike the other 'good girl gone bad' narratives, one narrative expressed blame for the female protagonist's actions through peer reactions and a foil female character. The "bad" female protagonist had both a boyfriend and a "sugar daddy", was called "the whore" and was looked at with "scornful eyes" by her peers when she became pregnant and missed her classes (F 16 U). Her best friend on the other hand, was a good, hardworking student, who always studied and

avoided boys. In the end, the "bad" girl was abandoned by both men, and was presumed to be HIV positive.

Blame of female characters was not limited to just these 'good girl gone bad' narratives, however. Narratives that depicted female protagonists as being unfaithful, scheming, or as having multiple partners, also communicated blame through negative outcomes and overt blame by the narrator. In instances where the narrator expressed blame, it was often communicated in terms of a character learning a lesson or facing consequences. In one narrative, the female protagonist left her husband for a wealthy man who lavished her with gifts, but who ultimately transmitted HIV to her. And although this man severely abused her physically and sexually, the narrator offered no consequence or lesson for him unlike for the female protagonist. In the end, she "looked miserable" and was "emaciated"; the narrator tells us,

"Indeed pride comes before a fall. She learnt it the hard way." –F 17 R

All of the protagonists in these narratives featuring unfaithful or scheming females experienced negative outcomes. Whether it was abandonment by their male partners, or death from AIDS, these narratives ended without hope for the female protagonist to live a fulfilling life post-positive HIV diagnosis. Even in the single case of an unfaithful female receiving ARVs, she was said to have "lost everything" and lived a life of regret while her ex-husband remarried and lived "happily" (F 17 R). In almost all cases, female protagonists were explicitly blamed for unfaithfulness, while male characters were not. For instance, one female protagonist had an affair with her boyfriend's friend because he had money to spend on her. She soon learned that she had contracted HIV from the affair, and disclosed to her boyfriend, who left her. In the end, the

narrator stated that she was left alone to face her consequences in regret, and "with no one to love her" (M 18 R). However, no consequences or blame was placed on the friend of the boyfriend; his role in the affair was notably absent from the narrative.

In cases of male infidelity, blame and even suffering was commonly expressed only for female characters. In one example, the female protagonist contracted HIV from her unfaithful boyfriend, but in the end he "rejected" her, and she was consumed by depression and regret (F 15 R). The narrator indicated that she should have listened to what her parents and friends told her, because "really patience pays" (F 15 R). Similarly, in a narrative featuring both a female and male protagonist, it was stated that the wife's failure to meet the sexual "demands" of her husband left him "fed up" and caused him to go to bars to find "'hot' beautiful girls" to sleep with (M 16 R). While the man died of AIDS as the result of his behavior, it was his wife's initial failure to meet his demands that was described as creating the situation. He also died quickly and laid "peacefully" in his grave while his wife suffered in his absence before her own death to AIDS years later (M 16 R). In a narrative about male infidelity featuring both a male and female protagonist, there was not only an absence of blame of the unfaithful male, but a statement in the end that the female was to blame for their likely HIV infection.

Underlying all the narratives with female blame was the belief that HIV/AIDS was a disease of the immoral. One got HIV because one engaged in 'bad' behaviors. For female characters, this 'bad' behavior was having premarital or extramarital sex. The only instance where this was unclear was a narrative in which the female protagonist succumbed to the peer pressure to have sex in order to "prove her superiority", but ended up contracting HIV (F 19 U). Here the narrator

stated that she had only "proven herself wrong" because she did not wear "protection as others did" (F 19 U). So while her sexual activity resulted in HIV infection, it was unclear if the narrator was placing the blame more on her failure to use a condom, or because she yielded to peer pressure and had premarital sex.

Blame of male characters for actual or potential HIV infection

Blame of male protagonists for their actual or potential HIV infection was less frequent and fundamentally different than it was with female protagonists. HIV infection of female protagonists was explicitly linked as the moral consequence of their 'bad' behaviors. In the instances of blame of male protagonists, this link was often nuanced or mitigating factors were presented for their behavior. Female characters were frequently depicted as vectors of HIV for male protagonists; they caused harm *to them*, rather than it being a result of their own behavior as was depicted with female protagonists. This representation was so pervasive that even in one male protagonist's dream, a girl transmitted HIV to him because he "didn't know anything" and was unable control his sexual desires (M 16 U). The only instances of unequivocal blame of a male protagonist or character were three narratives written by female authors, which are described below. Outcomes for male protagonists were also different than with female protagonists, as they were more likely to receive support and manage HIV through access to anti-retroviral therapy (ART). As with female protagonist narratives, blame was communicated through explicit commentary by the narrators and through negative outcomes. However, given the few instances of blame of a male protagonist, it is difficult to draw conclusions.

Some narratives expressing blame of male protagonists for their HIV infection, or near infection, described mitigating circumstances that were not seen in narratives with female protagonists. In the most negative portrayal of a male protagonist, blame for his “immoral behaviors” was placed on drugs, which were cited in the beginning of the narrative as a growing problem in Kenya (M 15 R). Despite his continual rape of women, including his own daughter, it was the drugs “that turned him to sex”, and in the end the narrator reminded readers of the disease and death that drugs can bring (M 15 R). In an instance where a male protagonist was said to learn a lesson from his behavior, he escaped HIV infection and the blame was nuanced. The engaged young man decided to “seduce” a girl he met, who stated the next morning that she was HIV positive (M 15 U). He prevented HIV infection through the use of PEP, and the narrator stated that he learns a “lesson”, but his lesson was not that he should not have had sex (as it was with female characters), but rather that he should not “have sex with any other woman in that manner” ever again (M 15 U). He also redeemed himself at the end through educating his peers about having only one partner and knowing their HIV status. In a similarly nuanced narrative, blame for the male protagonist’s death from AIDS was first placed on the “beautiful girls” he met, and secondly on his failure to abstain (F 17 U).

In the three narratives (written by female authors) that males were unequivocally blamed for their HIV infection, two featured male protagonists, and one featured a male character that was secondary to two female protagonists. The circumstances for blame in these narratives involved the similar themes of infidelity or multiple partners. These male characters were described by the narrators as “irresponsible” and as bringing “shame”, pain and “sorrow” to their families for their behaviors (F 16 U; F 16 U; F 19 U). Two of these males experienced negative outcomes

typically assigned to female protagonists: abandonment by their partners, and death due to AIDS. In contrast, one male protagonist experienced forgiveness from his wife for his infidelity that resulted in her HIV infection, and they were said to be happy and taking ARVs in the end. None of the narratives about female infidelity end with a hopeful outcome such as this one.

Access to ART was an important indicator of hopefulness post-positive HIV diagnosis. Narratives containing explicit blame for HIV infection rarely featured characters accessing ART. As male characters were less frequently blamed for their HIV infections, they accessed ART more than female characters. Furthermore, when female characters did receive ART, they either used it to conceal their disease to purposely infect men (and still died in the end), or died from AIDS because it was too late for the ART to be effective. In the only two instances where female characters successfully accessed ART, their male partners were said to access it as well, and in one of these narratives the male partner abandoned the female, and she was said to be miserable in the end. Conversely, there was only one narrative where a male character died despite taking "medications" (his wife died as well) (F 16 R); all other male characters successfully accessed ART. Male characters also received support from both female and male characters to manage their HIV infection or risk. In one example, the male protagonist continually tried to persuade his friend to go for an HIV test, and when his friend became very ill and finally agreed to get tested, he was said to be put on ARVs and was "going on well" (M 19 U). Absent from this narrative was any description of the behavior that put the male character at risk. What was present was support from a friend despite his belief that his friend was at risk, and acceptance once his friend tested positive. These story elements do not appear in narratives with female protagonists.

Positive Deviants

While the majority of narratives followed the gendered characterizations, risk factors, and representations of blame as presented in the previous sections, there were some narratives that presented positive deviants that are important to highlight. This was more common for narratives with female protagonists than for ones with male protagonists.

Female positive deviants

In narratives with positive deviance of female protagonists, the common characteristic was that of perseverance. While the other narratives present female protagonists that were unfaithful, scheming, or unable to mitigate HIV risks or peer pressure, these narratives present female protagonists that were strong and made positive life decisions, or decided to reform their 'bad' behaviors. Still, only two of the four female protagonists in these narratives avoided HIV infection. Three of these narratives were male-authored, and one is female-authored.

Perseverance by the female protagonists was presented differently in the narratives. In the two narratives where the female protagonists acquired HIV, character wrongdoing and blame was present. In a case where the female protagonist was put in a situation of early, forced marriage, she decided to run away, which revealed a form of personal agency. Although this decision put her into a position of extreme poverty and vulnerability, it was the only example of female protagonist who challenged traditional cultural norms and gender expectations. The narrator did blame the protagonist for her decision to use alcohol and drugs and engage in sex work, but also acknowledged the challenge of her situation,

> *"She had chosen a wrong path to follow though to escape the unfair traditional practices."*-M 17 U

The narrator further acknowledged the gender-specific nature of her problem, stating through the character's inner monologue, "she thought if she was a man, none of this could have happened to her" (M 17 U). After she experienced two different instances of male deception and violence that led to rape, she questioned, "why the world could be so unfair to a lady and woman like her" (M 17 U). This was the only narrative where the tension between gender norms and real-life hardships was explored and sympathized with. In the end, she was given a chance at redemption by becoming a peer counselor for other struggling youth, a rare occurrence for a female character. She also received treatment for HIV, and found employment with a group that "fights for women's rights" and aimed to stop violence against women (M 17 U). In one of the most hopeful endings for a female protagonist, the narrator concluded that, "She has found value in life and admitted that it is never too late to change. Life holds much than what one can think for" (M 17 U).

In a similar narrative that offered a female protagonist both redemption and a hopeful ending, a former 'bad girl' turned 'good'. The female protagonist started off with "immoral" behaviors including alcohol consumption, drug use, going to disco's, and sleeping with different men, but vowed to change her behaviors after she discovered that she was HIV positive. She created her own HIV/AIDS organization to educate the people in her community, which earned her a lot of respect and it expanded internationally. In the end, the narrator stated that she was "one of the important people in the world" (M 18 R). This narrative presented a particularly strong and

empowered female protagonist, and was the only example of a female holding a high-level work position.

While the last two examples depicted strong female protagonists able to persevere through challenging situations, they still did not avoid sexual risk taking and HIV infection. Only one narrative presented a strong female protagonist who was placed in a sexual situation and avoided sex and HIV risk. In this narrative, the female protagonist was at school late with some friends when her male friend tried to take her into an empty classroom stating that he "loved her so much" (M 17 R). When the male character put his arm around her, she pushed him away stating, "'Don't touch me like that!'" and that she did not want to be in a relationship with him because she wanted to accomplish her goals and was not ready to be a mother (M 17 R). She managed to deescalate the situation and walked home with the boy. This was the only example of a female character that said "no" to unwanted sex and was safe in the end.

The lone female-authored positive deviant narrative also presented a strong female protagonist who did not contract HIV. However, this character was never placed in a sexual risk situation. This female protagonist overcame the hardships of losing her parents to AIDS and living in poverty through being an obedient, religious, and studious girl.

> *"She was a very prayerful girl and followed her grandmother's tips. She studied very hard until she got to class eight."*-F 19 U

Even though at one point she was forced to drop out of school due to lack of finances, her previous hard work earned her a foreign sponsor, which allowed her to go back. The previous two narratives represent the rare instances of 'good' girls that made it through challenging

situations without falling into the 'bad' behaviors that were so common of the other female protagonists in the sample.

Male positive deviant

There was only one instance of a male protagonist who positively deviated from the typical male representation, and this was in a female-authored narrative. In this narrative, the male protagonist ignored the discrimination he received from the community for loving an HIV positive woman, and married her and adopted her children. This contrasted with the archetypical male character that immediately abandoned his partner when he learnt of her positive HIV status and/or pregnancy. This male protagonist knew her positive HIV status beforehand and chose to love her anyway. Furthermore, he supported her through her battle with AIDS, and continued to care for her children after her death.

This narrative was also unique for its questioning of the widely accepted social belief that HIV/AIDS is a disease of the 'immoral', and it was the only one to specifically link morality to religion. When a friend of the male protagonist was afraid to ask him the truth about his wife's HIV status, the protagonist stated:

> *"'Beside it is not like you've any thing to fear yourself. The last time I knew you were a hallelujah, drum beating Christian in the house of Miracle Tabernacle. AIDS is not the heaven bound, you know.' The sarcasm hit Peter like a blowing making him grimace."*-F 17 U

This quote challenges the belief that moral people are not at risk for HIV/AIDS. The narrative itself defies social norms and challenges how communities think of HIV/AIDS and stigmatize others.

V. Discussion and Conclusion

In seeking to better understand the contextual factors and cultural meanings that inform gendered vulnerability to HIV in Kenya, this research used quantitative and qualitative methods to analyze a stratified random sample of youth written narratives about HIV/AIDS submitted by young Kenyans to the 2014 Global Dialogues contest. Using both quantitative and qualitative methods to analyze the narratives allowed for a richer understanding of the data: the quantification of themes and outcomes highlighted patterns across the data, and the qualitative analysis allowed for an in-depth look at how the young authors engaged with those themes to portray gendered representations and HIV risk factors. More than three-quarters of the narratives (n=110) focused on topics of HIV infection and post infection. This finding was consistent among both female and male authors. Narratives in which characters prevent HIV accounted for just 10% of the total sample. A similar study of youth written narratives that compared symbolic stigma from five SSA countries also found that stories of HIV infection and post-infection were the dominant plot line in Kenyan narratives, at 75% (Winskell, Hill, et al., 2011).

In the current study, female characters were more than 2.5 times as likely to become HIV-infected than male characters. This finding is consistent with the latest epidemiological data, which shows that young women aged 15-24 are more than 2.5 times as likely to have HIV than males of the same age group (NACC, 2014a). The mode of HIV transmission in the narratives was overwhelmingly through heterosexual contact, which is also in concordance with national trends (NACC, 2014a). Around half of the narratives ended without hope for the HIV positive character. There was no remarkable difference in this finding between female and male authors, or by sex of the protagonist. However, the qualitative analysis of the 15-19 year-old strata (n=40)

did find that narratives with a female protagonist ended without hope more often than narratives with a male protagonist. Narratives ending without hope post-positive HIV diagnosis were almost always coupled with character blame for that diagnosis. Blaming of the protagonists for their actual or potential HIV infection was present in 36.7% of narratives (n=90), with a higher proportion of blame of female protagonists (43.2%) than male protagonists (32.1%). Blame for HIV infection was constructed in moral terms, as the overall depiction across the narratives was that HIV/AIDS is a disease of immorality.

Hopefulness post-positive HIV diagnosis

A previous analysis of HIV-related symbolic stigma in youth written narratives found particularly high proportions of stories ending in an HIV-related death or suicide in narratives from Kenya and Southeast Nigeria, as compared to those from other sub-Saharan African countries in the study (Winskell, Hill, et al., 2011). Although the majority of narratives in the current study still ended without hope, there may be promise in the proportion (42.1%) of infection narratives that do contain a hopeful ending post-positive diagnosis, however longitudinal research is needed to examine this.

Blame and punishment for HIV infection

Even in the absence of blame, or when circumstances were presented that served to mitigate blame for infection, HIV/AIDS was still presented as an immoral disease. This view was also prevalent in a study of social representations of AIDS in Zambia, where adolescents named the “immorality and sin” (p. 626) of pre-marital sex and infidelity as some of the factors that helped spread AIDS (Joffe & Bettega, 2003). Previous research on the 2005 Kenyan narratives found

that the narratives were "divided between a rigid sexual morality that blames individuals for infection and empathy with those who are infected, affected or vulnerable" (p.8) (Winskell, Hill, et al., 2011). This finding is in line with the current study, where slightly more than half of the narratives did not contain blame of a protagonist, and in a smaller proportion of narratives, blame was unclear. Longitudinal analysis is needed to ascertain whether the blame in the narratives is trending in the desired direction. It is hoped that more exposure to people living with HIV and increased access to ART may be shifting the stigmatizing stereotypes of HIV/AIDS and those living with the disease.

Still, the fact that female protagonists were blamed more for their HIV infections indicates that more work needs to be done to combat these stigmatizing views of HIV/AIDS and inequitable gender norms. The notion that women are to blame for their HIV infection and that HIV/AIDS is a result of immoral behavior is not new. Across sub-Saharan Africa, there is a "demonization of women" for the HIV/AIDS epidemic, relating to sexual expectations and gender roles (Catherine Campbell, Nair, & Maimane, 2006). A previous study of youth written narratives about HIV/AIDS from Southeastern Nigeria, found that the young authors (particularly female authors) blamed female characters for their "moral failings" that resulted in HIV infection, a blame that was not extended to male characters (Winskell et al., 2013). Furthermore, female characters were expected to be in control of their sexuality, as a lack of control over sexual desires was considered a male character trait, and female deviation from this gendered expectation was seen as a "moral outrage" (p.205) (Winskell et al., 2013). In the Zambia study previously referenced, Joffe and Bettega (2003) found that adolescent participants overwhelmingly attributed the spread of HIV/AIDS to girls' behavior, particularly their transactional relationships with older men.

This finding showed that female participants had a "strong tendency to implicate themselves" (p. 623) in the spread of HIV/AIDS in Zambia (Joffe & Bettega, 2003). These findings suggest that young women in these contexts are internalizing, reproducing, and thereby perpetuating the negative female stereotypes and unequal power relations that exist between men and women (Winskell et al., 2013). This is in line with the theory of gender and power, which states that gender is social construct that is constantly being informed, produced, and reproduced through the daily interactions of individuals and larger institutions within a society. In this way, differences in the power relationships between women and men are internalized and sustained (Gina M. Wingood et al., 2009).

In a study of AIDS stigma and sexual moralities in South Africa, Campbell, Nair and Maimane (2006) discussed the ways in which stigma is a covert form of power, called 'psychological policing', that serves to punish those women and youth that broke the established power relations. The researchers found that sex was stigmatized, especially the sexuality of woman and youth, which led to depiction of AIDS in these groups as the "fatal consequence" for their stepping "out of line" (p. 133) (Catherine Campbell et al., 2006). AIDS stigmatization was further propagated by the church, which often described HIV/AIDS as "God's punishment for sin and evil" thereby linking HIV/AIDS to "sex, sin and immorality" (p. 134) (Catherine Campbell et al., 2006). While references to God specifically are sparse in the current data, religious morality is very much present, and there is a clear link between young women's sexuality, immorality, and HIV/AIDS. In the narratives, female characters were commonly 'punished' with HIV infection for their sexually 'immoral' behaviors. Although not entirely absent, there was a notable lack of punishment for male characters that engaged in the same

sexual behaviors. Participants in the South Africa study also stated that it was "the weakness of women" (p. 134) that has driven the HIV/AIDS epidemic, as women were seen to be "responsible for promoting sexual morality" (p. 134) (Catherine Campbell et al., 2006). However, evidence has consistently shown that women in South Africa lack power in sexual relationships (Catherine Campbell et al., 2006). The belief that women are responsible for sexual morality was implicit in our findings, as the most common depiction of a 'good' girl was one that remained abstinent, while the 'bad' girl engaged in sexual activity.

Overall, the narratives included in the qualitative analysis did not depict either female or male protagonists in a positive manner. Negative representations were more clearly developed for female characters, which led to their higher blame for HIV infection. However, even if male characters were blamed less, they were still assigned negative characteristics, and there was only one example of a male positive deviant. These overwhelmingly negative representations of characters in infection narratives reinforce the depiction of HIV/AIDS as a disease of immoral people.

Representations and Risk factors for HIV/AIDS

The representations of female characters in this study echo the representations by Zambian youth in the 2003 study by Joffe and Bettega, where females were seen as the primary drivers of HIV due to their poverty, desire for wealth, sex work, intentional spread of the disease, and their ability to diminish a male's control over his sexual desires through "provocative" western dress (p. 624-5). Underlying these representations is the notion that females can control their sexuality:

> "In particular, female sexuality is represented as active, and serving non-sexual ends (having sex to allay poverty, to get extra pocket money or vindictively to spread HIV) and juxtaposed to the pervasive representation, primarily propagated by the males themselves, that men lack control over their desire and, therefore, inadvertently play a role in the spread of HIV. Male identity is protected, while female identity is disparaged…" (Joffe & Bettega, 2003p. 626).

In this study, female protagonists play an active role in their own and others' HIV infection, a characteristic that is not assigned to male protagonists. Even when a male character's unfaithful or deceptive behavior is being portrayed negatively, they are not blamed for their HIV infections nearly as often as female characters. These negative aspects are considered just a part of being a man; it is expected, uncontrollable, and therefore they are not faulted for it.

In the study of the sexual scripts of Kenyan youth, Maticka-Tyndale et al. (2005) found the same 'uncontrollable' description used for male sex drive, and that this forced boys into sex (p. 35). This study also found that once males gave females gifts – which could be anything from snacks to money – he expected sex in return, and would use force (including rape) if necessary. 'Force' after gift giving in the present study takes the form of pressuring, demanding, coercing, and to a lesser extent, raping. Females in this study saw males as a reliable source of income that either filled a basic need or a desire for material gain, which was also observed in the current study. Further challenging the youth was a cultural belief that once boys and girls reached adolescence, sexual activity was natural and expected. At the same time, parents of the youth in this study also referred to sexual activity as "bad manners" (Maticka-Tyndale et al., 2005). This dissemination of mixed messages surrounding adolescent sexuality was also observed by Secor-Turner, Randall, and Mudzongo (2014), who found that rural Kenyan youth experienced strong messages to abstain from sexual activity until marriage, yet also received messages that the adolescent

male sex drive was natural and uncontrollable, and that adolescent females were not allowed to refuse sex. When asked how they could protect their sexual and reproductive health, youth in this study were unable to provide examples beyond individualistic strategies (e.g. the 'Abstinence, Be Faithful, Condomize' method of HIV prevention), yet these strategies run counter to their self-described lived realities (Secor-Turner et al., 2014).

In a study of ecological risk factors for rural Kenyan youth, Harper et al. (2014) described how highly gendered sexual scripts led to uneven power dynamics between male and female youth, namely young women's lack of control over sexual decision making. This was especially prominent in the current research, as the qualitative analysis identified only one female protagonist that was able to negotiate her way out of an unwanted sexual situation and avoid HIV risk.[2] Both female and male participants in the previous study identified women's lack of sexual decision making as a significant HIV risk factor for young women (Harper et al., 2014). However, the highly gendered sexual scripts also placed young men at risk, as they promoted sexual activity, multiple partnerships, and impregnating a female. The young men reported feeling immense social pressures to conform to these sexual scripts. Participants of both sexes spoke of the significant peer pressure to engage in risky sexual activity, but some also noted that HIV/AIDS peer educators positively influenced behaviors (Harper et al., 2014). The high prevalence of peer pressure in the current research echoes these previous findings. Both positive and negative peer pressure was described in the narratives, however positive peer pressure never succeeded; characters always succumbed to the negative peer pressure in the end.

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[2] There were only two other female protagonists in the qualitative analysis (n=40) that did not contract HIV, and neither one was placed in sexual risk situations.

The significant role of peer pressure on adolescent sexual activity in Kenya has also been demonstrated quantitatively. An analysis of survey data about the timing of first sex of students aged 11-17 years in Nyanza, Kenya found sexual pressure factors to have the strongest effect on measures of sexual initiation (Tenkorang & Maticka-Tyndale, 2008). For males, sexual pressure influenced their odds of having engaged in sexual intercourse, and for females, sexual pressure influenced an earlier sexual debut. Male respondents with higher self-efficacy scores for abstinence had lower odds of having ever engaged in sex, as well as a later sexual debut. Importantly however, higher abstinence self-efficacy scores for female respondents did not equate to a later sexual debut, which the authors attributed to the high percentage of female respondents stating that their first sex was forced (Tenkorang & Maticka-Tyndale, 2008).

Underlying the sexual scripts of Kenyan youth are deeply embedded gender norms and expectations surrounding the acceptable expression of sexuality, which have increased adolescent HIV risk (Maticka-Tyndale et al., 2005). Changing the harmful gender norms surrounding sexuality and male-female relationships has been deemed essential for reducing women's HIV risk and lowering gender-based violence (Greig et al., 2008; R. Jewkes & Morrell, 2010). While initial gender and HIV interventions focused primarily on the empowerment and education of women, there has been an increasing recognition that such interventions also need to include men, and challenge norms of masculinity and femininity. Such interventions have been labeled "gender-transformative", as they seek to re-define traditional gender norms, and change them to be more gender equitable (Dworkin, Treves-Kagan, & Lippman, 2013).

An example of a gender-transformative intervention is Stepping Stones, which utilized participatory learning methods and skills building for participants to create safer and more gender equitable relationships in order to prevent HIV (R. Jewkes, Wood, & Duvvury, 2010). The effectiveness of Stepping Stones was tested by means of a cluster randomized controlled trial conducted in South Africa that showed a reduction in: herpes simplex virus type 2 (HSV-2) incidence in both male and female participants (HSV-2 incidence was used as a proxy for HIV incidence), male intimate partner violence (IPV), and men engaging in transactional sex. However, Stepping Stones reported no statistically significant impact on women's HIV incidence (Gupta et al., 2011; R. Jewkes et al., 2008; R. Jewkes et al., 2010). The researchers attribute this to several factors. Due to initial errors in sample size calculation, this intervention wasn't properly powered to detect changes in HIV incidence required for statistical significance (R. Jewkes et al., 2008). Furthermore, despite the intervention, the women that participated still lived within a large patriarchal system where they fundamentally lacked power over sexual relationships. Although some women demonstrated more assertiveness and agency in HIV risk reduction, most did not challenge their boyfriends or the existing gender norms, as their reported sense of self-worth and future hopes and dreams were tied to maintaining their boyfriends. It was suggested that combining Stepping Stones with an economic empowerment intervention for women may make it more successful at reducing women's HIV incidence (R. Jewkes et al., 2010). Still, this was the first randomized control trial of a behavioral HIV prevention intervention that showed impact on a biological marker. The reduction in HSV-2 is very important, as it indicates some level of behavior change among the participants. Furthermore, as HSV-2 is a cofactor in the transmission of HIV (people with HSV-2 have a three times higher

risk of HIV), the reduction in HSV-2 due to Stepping Stones may have an impact on HIV incidence over time (R. Jewkes et al., 2008).

Indeed, an important HIV risk factor for female characters in the current study was their poverty and economic dependence on male characters. Studies throughout SSA have shown that poverty and economic dependence on men increases HIV risk in women, as poverty is a driver of female sex work and economic dependence on men leaves women less able to negotiate when and how sexual activity occurs (Greig et al., 2008; Gupta et al., 2011; MacPherson et al., 2014). A number of small-scale interventions have sought to empower women and adolescent girls economically as a means of reducing HIV/AIDS risk, but have been met with mixed results. In a randomized controlled trial, the Microfinance for AIDS and Gender Equity (IMAGE) study combined a microfinance program with a participatory learning gender intervention and community mobilization targeting gender-based violence and women's HIV vulnerability (Gibbs et al., 2012; Greig et al., 2008; Wamoyi et al., 2014). The results showed that intervention groups had a 55% reduction in IPV, increased scores on empowerment indicators, increased HIV knowledge and testing, increased HIV communication, and risk reduction practices among young women after the one-year follow-up. However, there was no difference in HIV incidence between the intervention and control groups (Gupta et al., 2011; Kim et al., 2007; Wamoyi et al., 2014). The link between economic empowerment and reduced IPV (a known HIV risk factor) found in this intervention is promising, but the lack of effect on HIV incidence highlights the "complex and context-dependent" (p. S373) nature of HIV risk and poverty (Gupta et al., 2011). Furthermore, the researchers acknowledge that more time for the dissemination of ideas from intervention

participants into the larger community would need to occur before changes in HIV incidence could be observed (Pronyk et al., 2006).

Finding a microfinance intervention that is effective for young women has also proved challenging. In the IMAGE intervention, positive sexual behavior changes for women under 35 were minimal, and the average age was 41 years (Gibbs et al., 2012). The Tap and Reposition Youth (TRY) program, a microcredit and savings program targeted specifically at out-of-school young women living in the slums of Nairobi, Kenya, saw mixed results. Although TRY used a group-based approach and had a mentorship component to encourage success, there was a 66% drop-out rate, no improvement on reproductive health knowledge, and only slight improvements in gender attitudes. There was however, a significant increase in the participant's ability to insist on condom use, and improved ability to refuse sex (Gibbs et al., 2012; Gupta et al., 2011). Researchers suggest that vulnerable young women may not respond to entrepreneurial microfinance interventions until they first have their more basic needs met, such as social support and physical safety. Furthermore, providing microcredit for young women without adequate mentorship has the potential to place the young women at further risk of HIV infection if they struggle with loan repayment (Wamoyi et al., 2014).

One intervention, the Zomba Cash Transfer Program, avoided the potential issues with entrepreneurship and loan repayment by giving young Malawian women aged 13-22 direct cash transfers (Gibbs et al., 2012). The main goal of the intervention was to increase school attendance by reducing the economic barriers, and thereby also reducing HIV risk (Wamoyi et al., 2014). This intervention saw a 31% reduction in the onset of sexual activity, a 64% relative

reduction in HIV prevalence, a 76% reduction in HSV-2 prevalence, and slight reductions in the age of sexual partners and frequency of sex (Gibbs et al., 2012; Heise, Lutz, Ranganathan, & Watts, 2013). As hopeful as these results are, Heise et al. (2013) note that this intervention was only measured in the short term (18 months), and it did not increase condom use or include components to increase HIV/AIDS knowledge, or contain gender empowerment activities. Additionally, Gibbs et al. (2012) point out that this intervention fails to address "the ways in which schools produce and reinforce gender inequities" (p. 7), and that it has no effect on young women who remain out of school or those that drop out of the program, arguably the most vulnerable.

Despite attempts to address both the inequitable economic position and gender roles of women, reductions in population level HIV incidence have not been observed. This is partially due to the large sample size (and therefore funding) needed to show statistical significance, but there are two other major problems are at play. They are: the lack of understanding of women's context-specific vulnerabilities to HIV, and the limited scale of interventions focusing on gender and HIV (Auerbach et al., 2011; Greig et al., 2008). Gupta, Ogden and Warner (2011) argue that the HIV/AIDS programmers have "failed to fully understand sexuality and sexual interests as actually experienced by individuals in different social and cultural contexts and across the different phases of life" (p. S375). Similarly, Auerbach, Parkhurst, and Caceres (2011) point out the need to avoid generalizing the social drivers of HIV:

> "Statements that particular social-structural factors 'do' or 'do not' lead to HIV transmission are almost always too simplistic; language should shift to discussing *how, in what circumstances*, *and for whom* particular combinations of factors contribute to HIV vulnerability (or, conversely, resilience)" (p. S305).

Despite its limitations and limited scope, it is hoped that this study has helped to highlight some of the complex socio-cultural and structural factors, including gendered sexual expectations and social norms that influence HIV risk for young women and men in Kenya. Further research is needed to better understand women's socio-contextual and embodied vulnerability to HIV.

In order to truly curb the devastating effects of HIV epidemic on young women, interventions that address the multiple social and cultural drivers need to be embedded into national HIV plans and implemented on a large scale (Greig et al., 2008; Hardee et al., 2014). Addressing the issue of scale, a new President's Emergency Plan for AIDS Relief (PEPFAR) initiative is being launched in ten sub-Saharan African countries (including Kenya) that aims to reduce HIV infections in adolescent girls by addressing the multiple structural drivers that are placing them at risk. Targeted structural drivers include poverty, gender inequality, sexual violence, and lack of education. Using evidence-based interventions, and partnering with multiple organizations, the goal of this initiative, coined DREAMS, is to "help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women" (PEPFAR, 2016). It is clear that despite the lack of evidence of impact of gender-transformative interventions on reductions in overall HIV incidence, PEPFAR still believes that there is much promise in the ability of these interventions to do so, if implemented at scale. DREAMS itself is not a research study, however, but a programmatic initiative and therefore its impact on biomarkers such as HIV incidence will not be measured. Nonetheless, DREAMS is an ambitious and promising initiative that aims to fill a large gap in the response to HIV/AIDS in sub-Saharan Africa.

Limitations

This research has some important limitations. The data source, namely youth written narratives entered into a script-writing contest, cannot be considered representative of the youth population in Kenya. Youth who enter the Global Dialogues contest are likely more motivated and have some degree of education. Furthermore, young authors may be influenced to tell a story about HIV/AIDS that they think will win the contest, which may not reflect how they would otherwise represent HIV/AIDS in the context of their own lives and communities (Winskell, Hill, et al., 2011). However, the detailed and creative nature of fictional narratives provides a distinctive data source for understanding social representations of gender and HIV/AIDS (Winskell, Hill, et al., 2011). Understanding of these representations can inform the development of HIV prevention programming or communication campaigns in Kenya.

Conclusion

Through their writing of fictional narratives, Kenyan youth have provided a unique look into the specific gender norms and structural constraints that shape young women's vulnerability to HIV, and how the youth make sense of these gender disparities. The results of this analysis show a strong presence of stigmatization of women's sexuality and blame for HIV infection. This blame was present even when larger socio-cultural structural constraints (such as extreme poverty or forced marriage) were acknowledged as playing a key role in the female protagonist's HIV infection. The fact that such blame was largely absent for male protagonists, and that they were more likely to access ARVs and have more hopeful outcomes, indicates deeply embedded gender inequities. Females were disempowered in the narratives when it came to sexual relationships, decisions about their livelihoods (e.g. education and marriage), and economic abilities; all

aspects that are fundamentally linked to HIV risk. Furthermore, with little exception, female characters were either demonized or victimized in their representations. This blame and stigmatization of females for their HIV infection only serves to further disempower them.

The lack of female characters that exercise agency in their sexual relationships or in matters concerning their future is concerning. If the youth cannot imagine a female who exercises such agency in her life, it seems less unlikely that such a characteristic will be adopted or accepted. Still, there is promise in those narratives that do engage with the role that larger cultural and structural constraints may be playing a role in women's vulnerability to HIV infection. Given the discrepancy of the results in the quantitative study (n=110) and the qualitative study (n=40) in terms of the number of narratives containing blame of a female protagonist for their HIV infection, further qualitative research into the 10-14 and 20-24 age stratums is recommended.

These narratives provide a point of departure for future youth HIV programming and communication efforts. Getting the youth to critically reflect on the larger social and cultural constraints faced by young women may be an essential component for an effective intervention. The harsh economic barriers that young women experience should also be addressed, and if interventions such as the Zomba Cash Transfer Program can be adapted to include mentorship and gender-transformative components like those used in Stepping Stones, then there is evidence to suggest that such a program could be successful. Because of the Kenya-specific nature of this research, it has the potential to inform the future creation of gender-transformative interventions and communication campaigns targeted at Kenyan youth. Specifically, the narratives provide youth-focused ideas that could be used as critical thought scenarios and role-play exercises in

gender transformative curricula, for example. The narratives also provide insight into the language used by and the circumstances of HIV risk faced by Kenyan youth, which could be used to guide the creation of community-based and mass media communication campaigns (Winskell, Obyerodhyambo, et al., 2011).

VI. Implications/Recommendations

This study supports previous studies with Kenyan youth that revealed the heightened vulnerability of young women to HIV infection due to inequitable gender norms. Inequitable gender norms have created a lack of power for women in their sexual relationships, in decision-making about their own livelihoods, in their ability to access education, and in their lessened ability or complete inability to participate in economic activities.

The results of this research bring several recommendations for public health practice. The disempowerment of women at every ecological level (intrapersonal, interpersonal, institutional, sociocultural and political) of the social system calls for multi-level HIV interventions. Interventions should seek to challenge and deconstruct existing gender norms and gendered sexual scripts in participatory ways with young women and men. Interventions that are ‘gender-transformative’ in nature are recommended. Microfinance interventions for young women should also be explored, and should include a mentoring component to help ensure success.

Further research into how young Kenyans make sense of gendered risk disparities in the context of HIV/AIDS is also warranted. The current study found discrepancies in the assignment of blame of female protagonists in the 15-19 age stratum as compared to the entire sample. Qualitative research of the 10-14 and 20-14 age stratums is recommended to help clarify the symbolic representations of blame and stigma of females observed in this study. Understanding the symbolic representations of gender and HIV/AIDS can give insights into cultural blame and stigma, which is key to understanding how to deconstruct harmful social norms and gendered sexual scripts that increase HIV risk for women.

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