RESEARCH UPDATE
Research Update

Horizons

Evaluating the Kenya Girl Guides Association's HIV/AIDS Peer Education Program for Younger Youth: Baseline Results

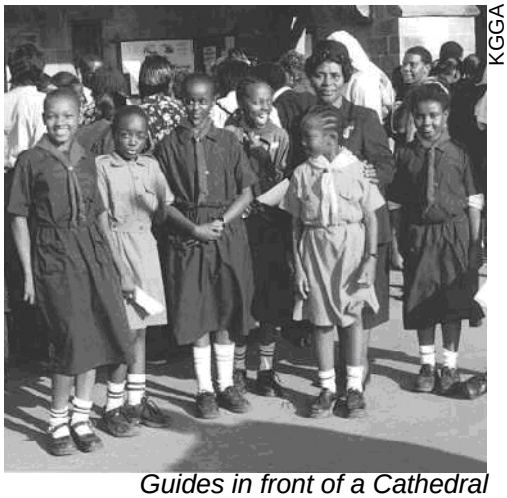
In Kenya, like in many other African countries, it is estimated that half of all new HIV infections occur among youth between the ages of 15 and 24 (CBS, MOH, and ORC Macro 2004; NASCOP 2003). However, many of these individuals are much younger when they initiate sexual activity. Survey data show that 13 percent of girls and 31 percent of boys have had sex by age 15 (CBS, MOH, and ORC Macro 2004). Unfortunately, few prevention programs exist to help younger youth, specifically those between the ages of 10 and 14 years, to delay their sexual debut and develop communication and relationship skills that will keep them uninfected.

In response to this need, the Kenya Girl Guide Association (KGGA) and Family Health International (FHI)/Impact began a program, which was developed by PATH, in 1999 to train young Girl Guides as HIV peer educators in their schools. The project aims to improve knowledge and skills related to HIV prevention and care among Girl Guides and their peers. In collaboration with KGGA and FHI/Impact, the Horizons Program is currently conducting a study to evaluate the effectiveness of this intervention model in achieving the objectives of the peer education program. This research update presents baseline findings from the intervention study.

Description of the Intervention

KGGA has members between the ages of 6 and 25 years. Members are grouped in different cadres by age groups: Brownies (6 to 10 years), Girl Guides (10 to 14 years), Rangers (14 to 18 years), and Cadets (18 to 25 years). Each cadre is organized into groups of six to eight girls (patrols) headed by a Patrol Leader of the same age. Each school has a teacher acting as a Guide Leader who is in charge of Guide activities.

KGGA has integrated HIV/AIDS peer education into all of its cadres. Guide Leaders are trained to use an HIV-prevention curriculum to train Patrol Leaders as peer educators. The peer educators then disseminate information to their patrols, schoolmates, and community members on a variety of topics, including gender roles and gender equality, self-esteem, communication, adolescent development, relationships, and HIV/AIDS and STIs. In addition, Girl Guides are offered the opportunity to earn a badge by carrying out community education activities, such as writing a letter to the editor


KGGA

Guides in front of a Cathedral in Nairobi after a prayer session for the guiding movement

Horizons is implemented by the Population Council with the International Center for Research on Women, the International HIV/AIDS Alliance, the Program for Appropriate Technology in Health, Tulane University, Family Health International, and Johns Hopkins University.

of the local newspaper about HIV/AIDS, assisting an orphan or a person living with HIV/AIDS with household chores, and talking to peers on values that help to reduce the risk of infection.

Methods

The study is being conducted in primary schools with ongoing Girl Guide programs in two provinces of Kenya—the Rift Valley and Coast. In each province, schools in one selected community will implement the HIV/AIDS peer education program for Girl Guides while schools in another community will not; the Girl Guide programs in these comparison sites will implement the HIV/AIDS peer education component after the completion of the study.

In the Rift Valley, the HIV peer education program is being implemented in Naivasha (intervention site), but not in Kericho (comparison site). Kericho and Naivasha are communities dominated by large plantations (tea and horticulture, respectively). Adults are mainly migrant workers, and 46 percent of the population is 15 years old or younger. Primary school enrollment in Kericho and Naivasha for both males and females is about 67 percent. Adult HIV prevalence in the Rift Valley province is estimated to be 5.3 percent (CBS, MOH and ORC Macro 2004).

In Coast province, Malindi is the intervention site and Kilifi is the comparison site; both sites are mainly tourist areas. Just over 40 percent of the population is 15 years old or younger, and primary school enrollment ranges from 53 to 59 percent, with higher enrollment rates for boys. Adult HIV prevalence is estimated to be 5.8 percent (CBS, MOH, and ORC Macro 2004).

Between September and November 2004, the researchers collected data from students at 57 primary schools (19 intervention schools and 38 comparison schools) in the four study sites using an interviewer-assisted, self-administered questionnaire. The questionnaire was originally pre-tested as a self-administered instrument, but many questions remained unanswered because the respondents did not know how to respond to them. The researchers then decided to have two interviewers in each classroom with the young people: one interviewer read each question and all the possible answers in both English and Kiswahili while the other researcher walked around the classroom to answer any questions that the respondents had. The whole group of respondents answered each question at the same time. Although it was time-consuming, the students were comfortable with this method that allowed them all to answer questions at the same time and to finish together. The approach also helped the students understand the questions and to avoid leaving any questions unanswered.

In each school, all the Girl Guides and an equal number of peers were selected to complete the survey. The peers were randomly selected from classroom registers and, along with the Girl Guides, were given consent forms for their parents to read and sign. Pupils in Standard Eight, the final class in Kenya primary schools, were excluded from the study because they were preparing for national examinations.

This report is based on an analysis of 2,444 young people (1,252 Girl Guides and 1,192 peers) between the ages of 10 and 15 from the four sites. The sample of peers includes more males (n = 649) than females (n = 548), because more males returned the parental consent forms, without which a pupil could not participate in the study. Similarly, more students returned the consent forms in Naivasha (694) and Kericho (647) than Malindi (553) and Kilifi (550), which explains the differences in the sample sizes by site.

In addition to the survey, a total of 24 focus groups were conducted with Girl Guides (8), male peers (7), and female peers (9). A follow-up survey and focus groups will be conducted in the same schools one year after implementation of the Girl Guides HIV/AIDS peer education program.

Horizons researchers held two meetings with Girl Guide Leaders to present the baseline findings. At each meeting the Guide Leaders gave their interpretation of the data, examples of which are presented in this report.


KGGA

Girl Guides reciting a poem on self-esteem and negotiation skills

Limitations of the Study

The study is not a representative sample of youth because subjects were in school and not all participated because of the requirement of parental consent. Despite using methods to ensure confidentiality and that students understood the questions, some questions could have been misunderstood, and risky behaviors could have been under-reported because respondents may have wanted to provide socially acceptable answers.

Characteristics of the Sample

Most respondents in the sample (73 percent) are female, with a mean and median age of 13 years. Almost all the respondents (97 percent) are in primary classes 4 to 7. Christianity is the dominant religion (86 percent); the vast majority of respondents who are Muslim are from Coast province. Sixty-nine percent live with both parents, 20 percent live with only their mothers, and 95 percent and 84 percent have living mothers and fathers, respectively. Profiles are similar for males and females as well as for Girl Guides and their peers.

Key Findings

Study participants have incomplete knowledge about HIV/AIDS.

As shown in Table 1, when asked to self-assess their knowledge, fewer youth in Coast Province say that they have adequate knowledge about HIV/AIDS compared to youth in the Rift Valley. In fact, young people in both regions report similar answers to questions about HIV/AIDS, which highlights the fact that both groups are equally knowledgeable about some issues and have similar knowledge gaps in others.

When asked about ways to prevent HIV, the vast majority of young people in the sample know that HIV is transmitted through unprotected sex and that HIV can be transmitted from mother to child. However, when asked about misconceptions about HIV transmission, a substantial proportion of respondents in all sites responded incorrectly that you can always tell if someone has HIV by the way they look, and that you can contract HIV from sharing eating utensils and from a mosquito bite. There was no statistically significant difference in any of the HIV knowledge variables between sites, between males and females, or between Girl Guides and their peers.

Table 1 Knowledge about HIV/AIDS (percentage who agree with statements)

	Rift Valley				Coast			
	Naivasha		Kericho		Malindi		Kilifi	
	Males n = 188	Females n = 505	Males n = 197	Females n = 450	Males n = 140	Females n = 412	Males n = 124	Females n = 426
Knowledge self-assessment								
I have good knowledge about HIV/AIDS	62	59	47	41	19	25	28	31
Correct modes of transmission								
HIV is transmitted through unprotected sex	84	88	88	80	83	75	95	87
HIV can be transmitted from mother to child	81	83	72	71	78	82	79	76
Transmission misconceptions								
You can always tell someone has HIV/AIDS by the way they look	50	39	23	32	43	42	54	50
You can get HIV from sharing eating utensils with someone who has HIV/AIDS	16	17	17	15	21	23	21	15
You can get HIV from mosquito bites	16	20	13	17	31	28	13	22

Most respondents, including those who have had sexual intercourse, do not feel they are at risk of HIV infection.

More than half (57 percent) of respondents believe that they are not at risk of HIV infection and 25 percent do not know if they are at risk. Only 18 percent think that they are at risk. Responses are for males and females, and for Girl Guides and their peers.

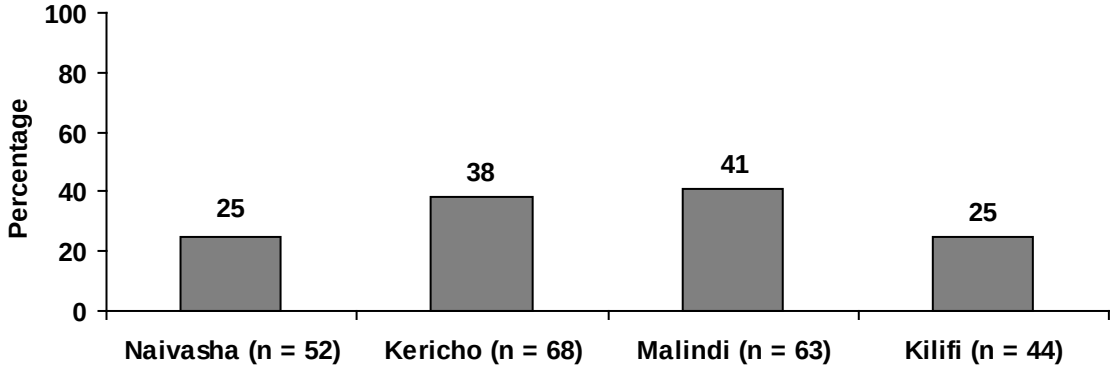
For the sample as a whole, males are more likely than females to report having had sexual intercourse (27 percent vs. 5 percent). This disparity is consistent across age ranges: 17 percent versus 2 percent of 10- to 11-year-olds; 27 percent versus 4 percent of 12- to 13-year-olds; and 34 percent versus 9 percent of 14- to 15-year-olds. Levels of sexual experience are similar for Girl Guides and their female peers.

Among males ages 14 to 15 years, Malindi respondents report the highest level of sexual experience (41 percent; see Figure 1); Malindi Guide Leaders were not surprised by the result. Because Malindi is a tourist destination and there is casual sex among vacationers, the Guide Leaders speculate that young people, particularly males, are exposed to sexual opportunities at an early age.

Seventy-eight percent of males report having had a girlfriend and 71 percent of females report having had a boyfriend. The proportion of males and females who have had sexual intercourse outside of a self-defined boyfriend-girlfriend relationship may suggest the possibility, particularly among girls, of a coercive or abusive sexual experience.

The vast majority of males and females who have had sex say that they are not at risk or do not know if they are at risk of HIV. Eighty-one percent of the 176 males and 80 percent of the 90 females who have had sex believe that they are not at risk or do not know if they are at risk.

Figure 1 Proportion of boys ages 14-15 years who have had sex by region



In focus groups, young people note that social functions that take place at night, such as discos, videos, parties, funerals, and overnight prayer meetings, may facilitate risky sexual behavior among young people by giving them an opportunity to meet privately. Alcohol and drug use were also mentioned as risk factors.

> *You find that boys and girls go to the discos or any club in town where there is alcohol, drugs, cigarettes and bhang (marijuana). So they may go there at night and infect each other with that disease.*
>
> Male FGD participant

The vast majority of youth are confident they can say "no" to unwanted sex, but a substantial proportion say that friends are a powerful influence on their behavior.

Eighty-three percent of respondents are sure that they can say "no" to unwanted sex. Fewer Malindi respondents (73 percent) are sure they can resist unwanted sex compared to those from the other sites, a difference that is statistically significant ($p < 0.05$). There is no significant difference in this variable by sex or between Girl Guides and their peers.

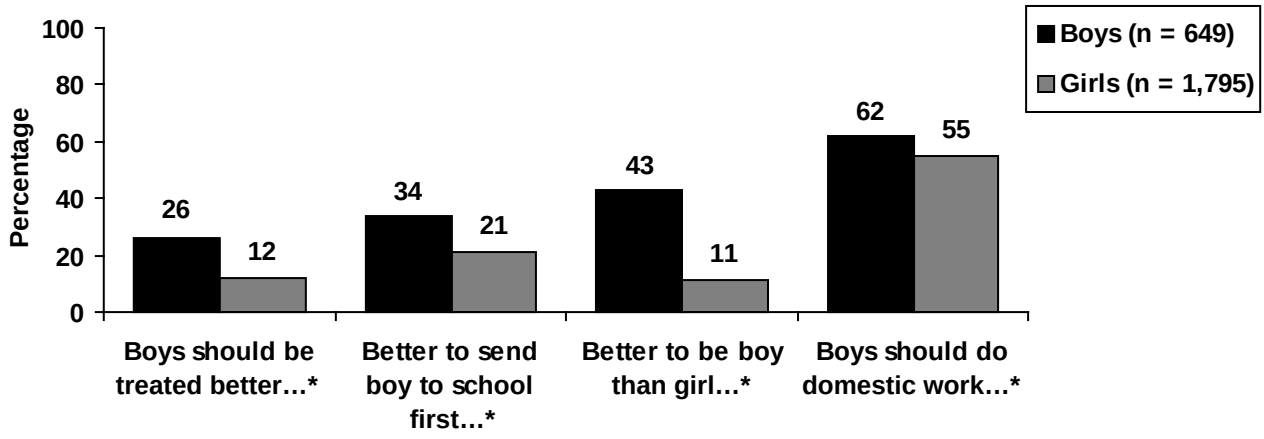
However, 38 percent of respondents do not believe that they can resist doing things that others are doing and the same percentage admit they would feel guilty if they did not do what their friends wanted. These results are similar between girls and boys, but more Girl Guides than their peers (42 percent vs. 35 percent) say they would feel guilty if they did not do what their friends wanted.

Boys and girls disagree about how boys should be treated and their social advantages.

In Kenya, as elsewhere, females are thought to be more vulnerable to unwanted sex than males because of norms that encourage an unequal power balance between the two groups (NACC 2002; UNAIDS 2004). To assess their attitudes about gender equality, respondents were asked whether they agreed with certain statements about gender roles and responsibilities.

As shown in Figure 2, a minority of males and females feel that boys should be treated better than girls and that they should be sent to school instead of girls if a family cannot afford to educate both their sons and daughters. Males are significantly more likely than females to support these opinions. Moreover, nearly four times as many males as females agree with the statement that it is better to be a boy than a girl. Interestingly, although the majority of youth feel that boys should do domestic work, slightly more males (62 percent) than females (55 percent) support male involvement in domestic chores. There are no significant differences between the opinions of Girl Guides compared to their female peers on these measures.

Figure 2 Proportion that agree with statements about gender roles



$p < 0.01$

When asked why boys should not be treated better than girls, females in focus group discussions report that such treatment makes boys look down on girls and fosters bullying. In addition, some note that because of preferential treatment, boys are more likely than girls to be disobedient and involved in drugs, alcohol, and other risky behaviors.

> *… if they are treated better, they will indulge in alcohol and drugs and see [us] girls as meaningless, they will in fact start bullying us.*
>
> Female FGD participant

Some females feel that girls should be treated better than boys because they help with domestic work and are more likely to help parents when older. Both boys and girls note that girls need more protection because girls are more vulnerable to sexual offences and exploitation. The minority of youth who feel boys should be treated better reason that boys do more hard work than girls, like building structures and cultivating land, and remain at home to inherit wealth and look after aging parents when girls get married.

> *...because it is the boy who will remain at home to take care of the parents but the girl will leave and get married. The boy will remain to look after family property.*
>
> Female FGD participant

Youth report having friends and caring parents, but many lack someone to turn to for advice.

The vast majority (89 percent) of young people report that their parents care about what is happening to them. Most (78 percent percent) also report having many friends. But a sizable proportion of young people (29 percent) feel that they have no one to talk to when they need advice. These results are similar for males and females, and for Girl Guides and their peers.

Boy-girl relationships, STIs, and puberty are difficult topics to discuss with parents, particularly fathers.

Parent-child communication about sex has been found to be an important factor in helping youth to protect themselves from HIV infection (DiClemente et al. 2000). When asked whether they had talked about certain

topics with their parents in the last three months, most mentioned education, (88 percent), personal hygiene (77 percent), friends (64 percent), and HIV/AIDS (56 percent). A minority of young people had talked with their parents about physical changes related to puberty (44 percent), sexually transmitted diseases (38 percent), and boy-girl relationships (31 percent). For all topics, more respondents say they talk with their mothers than with their fathers.

When asked about the difficulty of discussing sensitive issues, more adolescents report having trouble talking to their fathers rather than their mothers (see Figure 3). This was true for girls and boys, and for Girl Guides and their peers. Asked why they had difficulty discussing these issues with mothers and fathers, young people say that fear and embarrassment are the major barriers.

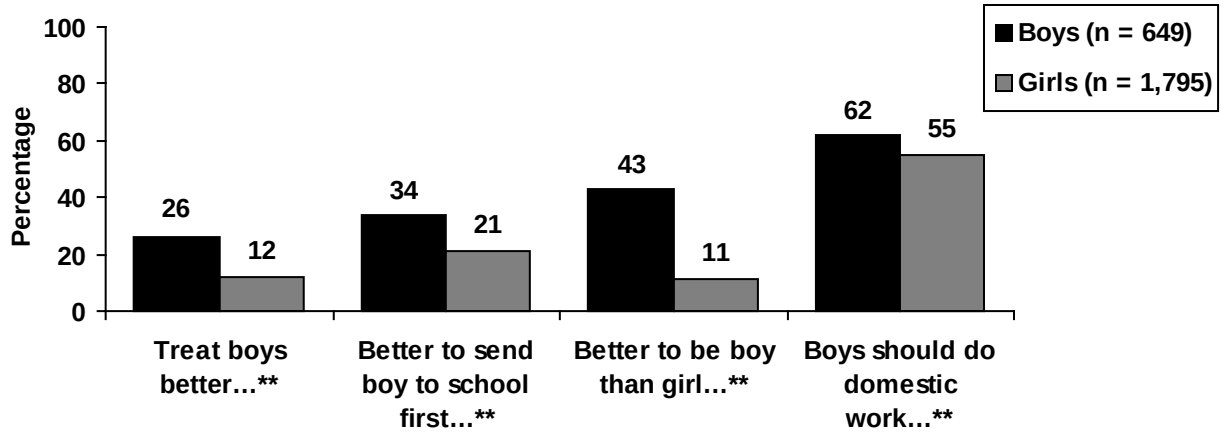
You know when discussing with your mother, you feel shy to ask certain questions.

Female FGD participant

In focus group discussions young people also say that parents do not want to discuss these issues. Some say that they do not want to make their parents suspicious; others say their parents are busy most of the time.

Although the peer education program does not focus on parent-child communication, Guide Leaders feel that promoting parental communication might strengthen the program.

Figure 3 Proportion of youth who report difficulty having discussions with fathers and mothers by topic



Most have discussed HIV/AIDS with a peer.

Sixty percent of respondents have discussed HIV/AIDS with a peer in the past six months. These results are similar for Girl Guides and their peers, but males are more likely than females to have discussed HIV/AIDS with a peer (67 percent vs. 57 percent; $p < 0.01$). There are also differences by site. A greater proportion of adolescents in Naivasha (67 percent) and Kericho (71 percent) have discussed HIV/AIDS with a peer than have adolescents from Malindi (44 percent) and Kilifi (53 percent). This difference may be attributed to greater exposure to HIV/AIDS communication in the home, school, or community, which could stimulate peer communication, or may be linked to self-assessment of less knowledge by respondents in these sites.

Many young adolescents fear infected people.

Many young people have negative perceptions of and stigmatizing attitudes toward people affected by HIV/AIDS. For example, about one-third to more than one-half of respondents, depending on the site, are afraid of people with AIDS (see Table 2). Negative perceptions are most prevalent among respondents in Malindi, a coastal site. For example, over one third of Malindi youth (36 percent of males and 42 of percent females) want people with AIDS to be isolated; seventy-nine percent of males and females are unwilling to buy food from an infected person. Focus groups with young people reveal that many are afraid that the person may infect them knowingly or unknowingly; they worry that the person's blood or wound may touch the food.

> *Because I wouldn't know if he cut himself and maybe blood soaked into say meat. That means that even if you washed the food thoroughly, blood with HIV still remains in the meat and so the virus could remain in the meat and could be transmitted to you when you eat the meat. It is not only meat but also even fruits like mangoes.*
>
> Male FGD participant

Young people in focus groups who do not worry about buying food from an infected person know that the virus is not transmitted through food, that well-cooked food kills the virus, and that good people do not maliciously use foodstuff or drinks to infect others. They also argue that infected people need their businesses to sustain themselves and divert their attention from worrying about their HIV status.

Table 2 Perceptions about people affected by HIV/AIDS

	Rift Valley				Coast			
	Naivasha		Kericho		Malindi		Kilifi	
	Males n = 188	Females n = 506	Males n = 197	Females n = 450	Males n = 140	Females n = 412	Males n = 124	Females n = 426
Not willing to buy food from a person with AIDS	44	42	46	52	79	79	57	68
Afraid of people with AIDS	41	46	34	40	57	52	39	49
Feel people with AIDS should be separated from others	25	16	18	16	36	42	15	15

Most youth are willing to care for HIV-positive family members and help orphans.

Most youth (88 percent) are willing to care for a family member with HIV/AIDS. In focus groups discussions, young people report feeling obliged to care for family members because doing so is a moral duty and because the sick expect them to help since no one else may be willing to do so. Most young people help HIV-positive family members in order to show love and compassion, to give hope, and to provide physical support and consolation to the patient.

Most young people (75 percent) say they are willing to play with an orphaned child, although a greater proportion in the Rift Valley (82 percent) are willing to do so compared to those in Coast province (62 percent). But only 38 percent of respondents have actually played with an orphan, and a similar percentage (36 percent) have helped an orphaned child with household work. Girl Guides and their peers respond similarly to the questions about playing with and helping an orphan. But more females (53 percent) report having provided some kind of help to an orphan in their community as compared to males (44 percent).

Program Implications and Next Steps

Although it is well recognized that programs need to focus on young adolescents to help foster behaviors that protect them as they transition to adulthood, efforts to better understand their knowledge, views, and behaviors, and how to obtain relevant data, have been limited. This study aims to provide information about this population to be used for evaluation purposes as well as to inform HIV/AIDS programming.

Not surprisingly, the data indicate that young people's knowledge about HIV/AIDS is incomplete, which implies that they need to receive additional information. Educating young people about HIV/AIDS so they can accurately assess their personal risk of infection is also needed, because some adolescents have incorrect notions about modes of transmission and others, particularly the sexually experienced, are unaware of the risks they may face.

Peers play an important role in the lives of the young people in this study. They are a source of information about HIV/AIDS, but they are also powerful influences on behavior, given that many youth say they would feel guilty if they did not do what their friends were doing. Therefore, efforts are needed to help young people resist peer pressure and feel good about the decisions they make.

Findings suggest that night events such as discos, parties, and overnight prayer services may foster risky behaviors. Therefore HIV-prevention programs need to equip young people with life skills to avoid risky behaviors that may be practiced by others in such situations. Youth should also be educated about the negative effects of drug and alcohol use.

Only a small percentage of females report having had sexual intercourse. However, under-reporting may mask a higher figure. Not surprisingly, a greater proportion of males report sexual experience compared to females, so HIV-prevention programs for young adolescents may need to develop gender-specific messages that promote abstinence and other protective behaviors among those who have and have not initiated sexual activity.

Additionally, the findings show regional differences in sexual experience among males. Thus, it is important that programs take into account the context within which sexual behavior is occurring among young people in different sites. For example, in the case of Malindi, programs need to address opportunities and norms that may be fostering risky behavior because of its location as a tourist destination.

Most young people who report having had sexual intercourse have had a boyfriend or a girlfriend, but some report having had sexual intercourse outside of the context of any self-defined boyfriend-girlfriend relationship. In addition to stressing the value of abstinence to this age group, interventions need to address sexual coercion and abuse as potential realities in the lives of younger adolescents.

A positive finding is that a minority of young adolescent males and females feel that boys should be treated better than girls; however, males still lag behind females in opposing preferential treatment for boys. Because norms that encourage gender inequality and foster unequal power dynamics between males and females can limit women's ability to practice HIV-protective behaviors, HIV programs need to encourage and enhance positive gender roles from an early age.

Although most young people have parents who care about them, a substantial number feel that when they need advice, they have no one to talk to. In addition, they report that talking about sensitive topics, such as boy-girl relationships and puberty, with parents, particularly fathers, is difficult and embarrassing. This suggests the need to integrate activities to foster parent-child communication into programs that target younger youth.

Fear of HIV-infected people and negative perceptions about them exist among some study respondents, indicating that stigma-reduction activities need to be part of programs for this age group. Such activities can build on overall positive feelings about AIDS-affected children, as the vast majority are willing to assist a child orphaned by AIDS and many have already done so. Moreover, this willingness to assist vulnerable children could easily be taken into consideration when HIV/AIDS programs for younger youth are designed.

These findings have been used to strengthen the KGGA peer education program, which is currently being implemented in the intervention sites. Follow-up data collection, which occurred in October/November 2005, will determine the impact of the peer education program on the Girl Guides and their peers.

November 2005

References

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, MD: CBS, MOH, and ORC Macro.

National AIDS/STD Control Programme. 2003. *HIV and AIDS in Kenya 2003: Lessons from Epidemiology and Implications for Programs*. Nairobi: NASCOP.

National AIDS Control Council. 2002. *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2000-2005*. Nairobi: NACC.

UNAIDS. 2004. *AIDS Epidemic Update: December 2004 Women and AIDS*. http://www.unaids.org/wad2004/EPIupdate2004.

The study investigators are Milka Juma and Karusa Kiragu of the Horizons Program; Margaret Mwaniki, Naomi Zani, and Beatrice Mwaniki of Kenya Girl Guides Association; and Charity Muturi, MaryStella Baraza, and Simon Ochieng' of Family Health International/IMPACT.

For further information about the study, please contact Milka Juma (mjuma@pcnairobi.org), Margaret Mwaniki (kgga@skyweb.co.ke), or Charity Muturi (CMuturi@FHI.or.ke).

Suggested citation: Juma, M., M. Mwaniki, and C. Muturi. 2005. "Evaluating the Kenya Girl Guides Association's HIV/AIDS peer education program for younger youth: Baseline results," *Horizons Research Update*. Nairobi: Population Council.

Population Council
The Population Council, Inc.

This publication was made possible through support provided by the Office of HIV/AIDS, Bureau for Global Health, U.S. Agency for International Development, under the terms of HRN-A-00-97-00012-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

For more information, contact:

Population Council/Horizons
General Accident House
Ralph Bunche Road
P.O. Box 17643
Nairobi 00500
Kenya
Tel: +254 20 271 3480
Fax: +254 20 271 3479
Email: kkiragu@pcnairobi.org

Population Council/Horizons
Communications Unit
4301 Connecticut Ave. NW
Suite 280
Washington, DC 20008
USA
Tel: +202 237 9400
Fax: +202 237 8410
Email: horizons@pcdc.org

www.popcouncil.org/horizons