THE ROLE OF YOUTH PEER EDUCATORS IN THE CONTROL AND PREVENTION OF HIV/AIDS IN MATHARE

BY

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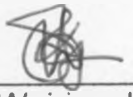
DECLARATION

This thesis is my original work and has not been presented for a degree in any other University.



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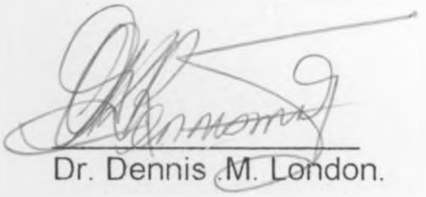
This thesis has been submitted for examination with my approval as a University Supervisor.



Dr. Dennis M. London.

15/11/2007 Date.

Dedication

This thesis is dedicated to my late mother Mary Wahito for her undying love, care and support throughout my studies, yet she did not live long enough to see my dream come true.

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ABSTRACT

This study was designed to investigate the role played by the youth peer educators in the control and prevention of HIV/AIDS. The fieldwork study was conducted between November 1998 and February 1999. To elicit the data, the study utilized library research, interviews, and focus group discussions. A total of 130 respondents were interviewed and five focus group discussions held. The data obtained was analyzed using qualitative and quantitative methods.

The study was based on the following assumptions: Youth peer educators provide youth with information on reproductive health issues; Member's perception of the information determined their adoption; Youth peer educators encounter constraints which hinder the effectiveness of peer education and youth peer education has had an influenced on youth's sexual behavior.

The study revealed that the youth peer educators provided information on drugs, adolescence, STD's and HIV/AIDS. However, information on drugs and AIDS was ranked as most important by a vast majority of the respondents. The information was perceived to be useful, relevant and practical to youth.

The research also revealed that the youth in Mathare start engaging in sex at a very early age. Although abstinence was rated as an effective prevention measure to counter HIV/AIDS infection the following were cited as major obstacles towards abstinence among the youth: influences of pornographic videos popularly known as "ponos", intake of alcohol and drugs and influence of friends.

Youth peer educators encountered several constraints in the course of their work. This includes among others, ignorance from peer, lack of time and lack of motivation.

On the basis on the findings, the study recommends that the youth peer educators devise a new approach to their education to make it more interesting and appealing to the peers. On the same line educators should continue educating their peers for there is misconception on methods of transmission and prevention of HIV/AIDS. Furthermore, more information is needed on STDs for only a small proportion of respondents had received the same considering STDs are very prevalent among the young people.

ABBREVIATIONS

AIDS	- Acquired Immune Deficiency Syndrome
HIV	- Human Immune Deficiency Virus
WHO	- World Health Organisation
GOK	- Government of Kenya
UNAIDS	- United Nations Aids
MYSA	- Mathare youth Sports Association
STDs	- Sexually Transmitted Diseases
SYGA	- Save Your Generation Association
PACT	- Peer Approach to Counselling by Teens
TEMAK	- The Teenage Mother and Girls Association of Kenya
FGD	- Focus Group Discussion
SPSS	- Statistical Package for Social Sciences
KDS	- Kenya Demographic Study

CHAPTER 1

1.0 Background Information of Mathare Valley

Mathare Valley is one of the oldest slums in Nairobi. It is located in Kasarani Division (**see map 1**) and has well defined physical boundaries enclosing 490 acres of land (**refer to map 2,3**). The origin of Mathare as a settlement can be traced back in 1910 when Nairobi was zoned. The history of its development can be categorized in the following: a period of uninterrupted growth, a period confrontation with city council, expansion and upgrading and finally the period of uncertainty.

The initial inhabitants were squatters allowed to cultivate on the valley owned by Indians living in the neighboring Eastleigh. In 1950's it become a center of Mau Mau activity provoking the wrath of the colonial government who detained most inhabitants and destroyed their houses. However, after the state of emergency and abolishment of Pass Law, rural urban migration was easier resulting to a rapid influx of migrants to the area. Moreover, even the old inhabitants drifted back to the area.

In the years between 1962 and 1967 the area expanded gradually along the southern slope of the valley. There were several confrontations and attempts to demolish the area owing to the increased government planning authority awareness of the growing squatter problem and cholera scare in 1967. However, through political interventions, pressures from various organizations like National Council of Churches such attempts were disbanded and strategies to upgrade the houses devised. Infact the City Council embarked on three low-cost housing schemes. Other plans to upgrade housing in Mathare in the recent past have been marred by violence between the Catholic Church and the residents. Meanwhile most residents continue to live in overcrowded shanties.

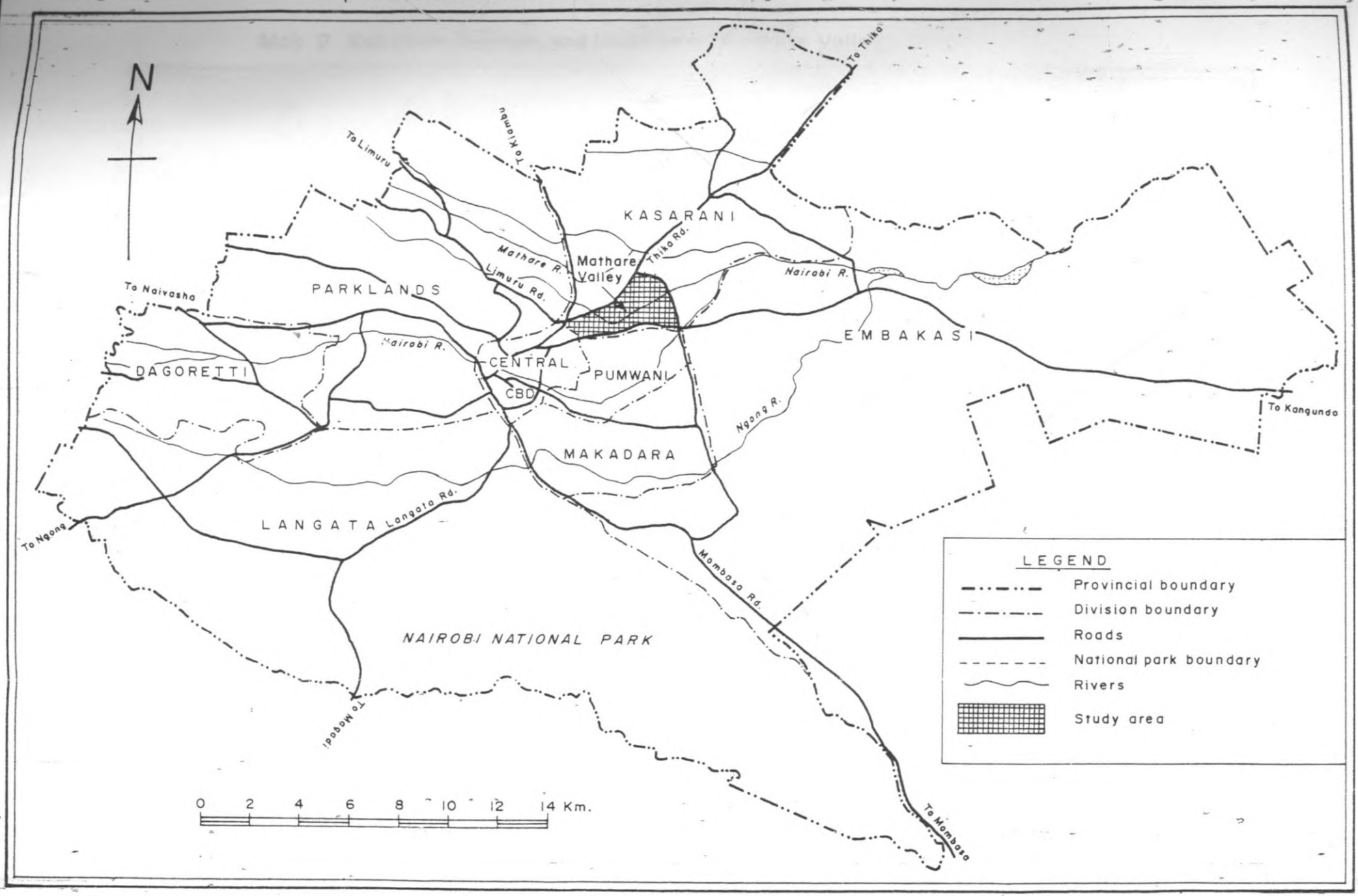
Mathare Valley persists as a habitation of the poor people. They live in ten villages that sprung along Mathare and Gatathuru rivers. The houses cram together in a haphazard fashion as dictated by the uneven terrain of the valley walls, some built of mud and wattle have roofs made of cardboard, flattened-out tin cans, or even metal sheets. Overcrowding in the existing houses is a serious problem facing the people in Mathare.

Many inhabitants of Mathare lack the necessary skills to find jobs in modern technology, while at the same time there are no meaningful rural alternatives to which they can turn. Some earn their living through petty commodity production involving provision of goods and services to people. Petty commodity production is advantageous for its flexibility in terms of working hours and working place.

During the early days of settlement almost all the residents were of Agikuyu origin but with increased housing problem and poverty in Nairobi people from other ethnic groups have also settled in the area. The poor opted for these cheap houses within a reasonable distance from town and Industrial area where they could walk to and from work. The brewing of illegal beer is a major occupation of most residents. Interestingly, brewing and selling is mainly done by women, few men are involved in either production or retailing of beer. The brewing and selling of these illegal brews makes the daily existence of many residents highly insecure due to constant threats of arrest and harassment by the police.

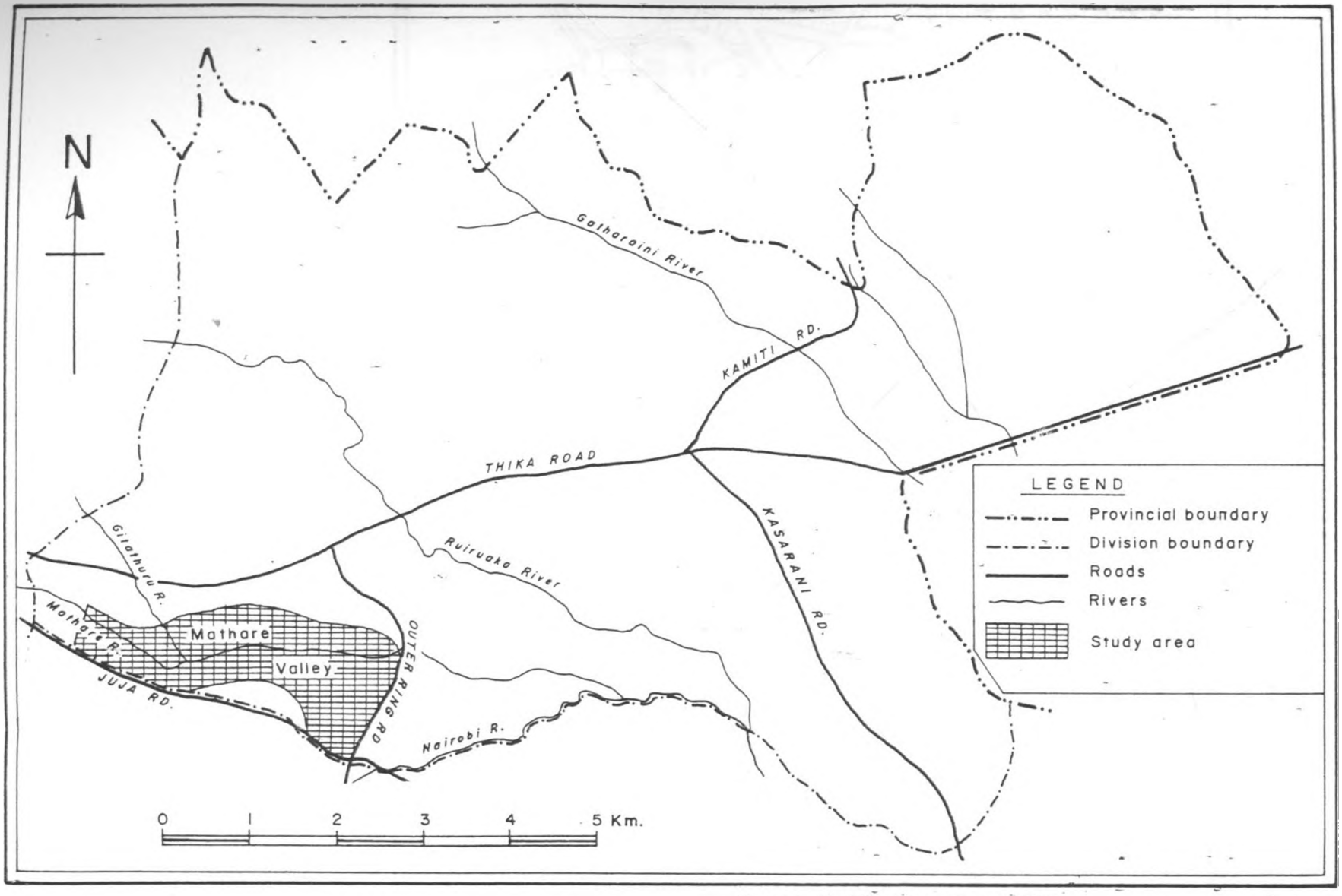
The community is highly organized and politically integrated. It has a clearly identifiable group of community leaders who direct the village committee. The committee act as a judicial body, a cooperative society based in the village. There is

Map I Divisions within Nairobi Province.



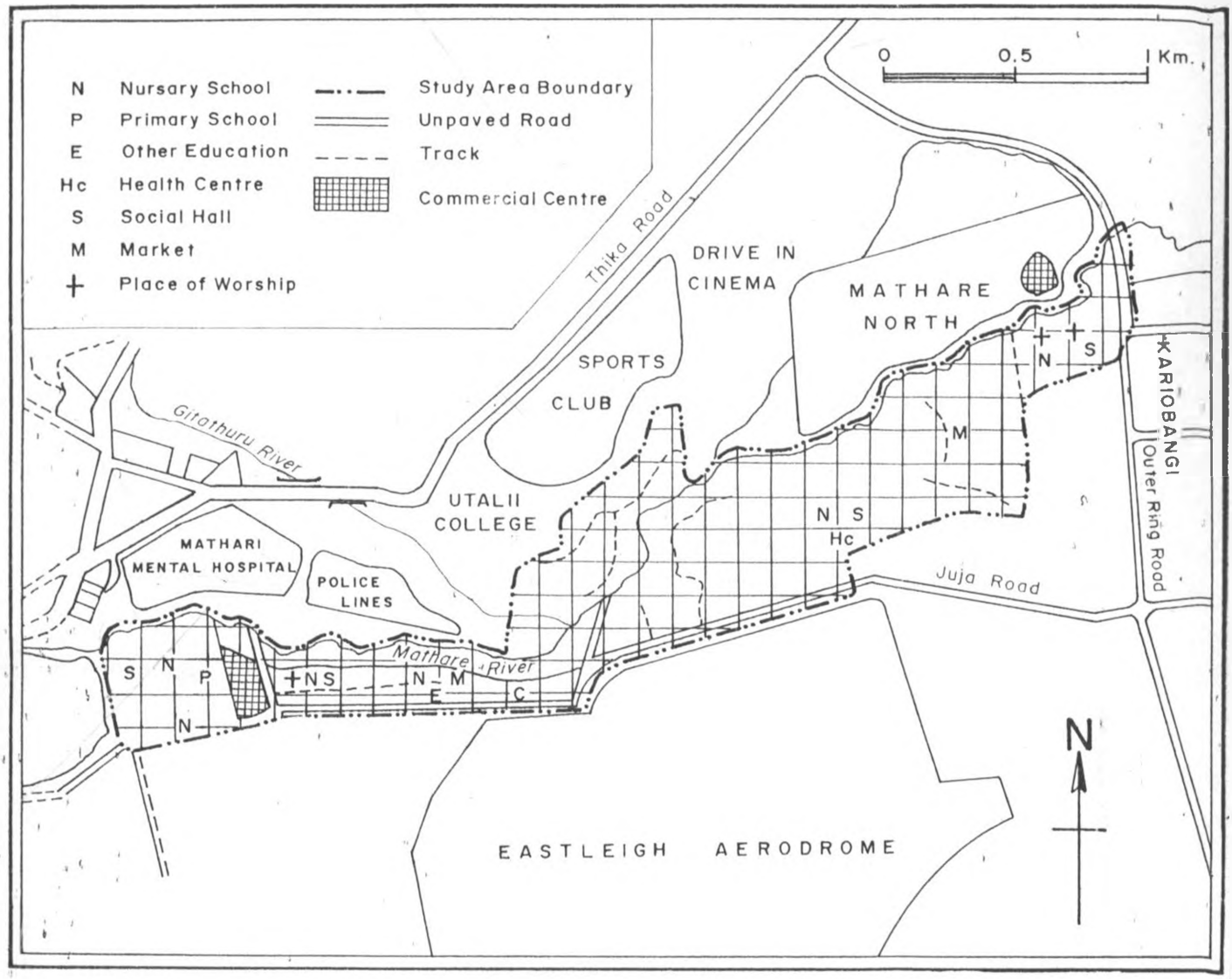
Source: Modified from Ngao, 1995.

Map 2 Kasarani Division and location of Mathare Valley.



Source: Modified from Ngao, 1995

Map 3 Location of and existing facilities in Mathare Valley.



Source: Modified from R.A. Obudho, 1987.

a youth wing that serves as the village security.

The social and economic conditions create a higher level of interdependence within the village. Individuals living in the area spend a greater proportion of their time in the area while their pattern of economic subsistence leads to close cooperation between neighbors as a result frequent pooling of their meager resources is the only viable means to survive.

1.1 Introduction

The Acquired Immune Deficiency Syndrome (AIDS) has become a global epidemic threatening life everywhere. Human Immune-deficiency Virus (HIV) which destroys the ability of the body to defend it-self against infections and cancer (Tuju 1996; UNAIDS/WHO, 1998) causes AIDS. HIV is mainly transmitted through sexual contact, contact with infected blood or blood products, and from an infected mother to the child. According to the World Health Organization (WHO) estimates, 30 million people have contracted HIV in the world while 6 million have died of AIDS (World Bank, 1998). Of all the infections, 90% have occurred in the developing countries while 2/3 of these are found in Sub-saharan countries (Cabrera *et al*, 1996; Shorter and Onyancha, 1998; Williams *et al*, 1997a).

In Kenya the first AIDS case was diagnosed in 1984, but the number has continued to increase since then (Government of Kenya, 1997). However, the number of reported AIDS cases may represent just a tip of the iceberg due to the missed diagnosis and underreporting (Government of Kenya, 1997; Shorter and Onyancha, 1998). The high prevalence and the fact that AIDS has neither a cure nor vaccine, makes prevention the preeminent objective in AIDS policy (NASCOP, 1996; World Bank, 1998).

The Kenyan government has tried to prevent and control the spread of HIV/AIDS through creating awareness, blood screening, and the establishment of sentinel surveillance which target the pregnant mothers (Government of Kenya, 1997; NASCOP, 1996). However, prevention is constrained by the scarcity of resources. With the rising prevalence rates the government can hardly cope with the epidemic.

The sexual transmission of the HIV implies that the sexually active people are at risk of contracting the virus. Studies on youth's sexuality reveal that most of them become sexually active between ages 15 and 19 years (Williams et al, 1997b). The high rates of abortions, teenage pregnancies and sexually transmitted diseases (STDs) confirm that young people are actively involved in unprotected sex (Williams et al, 1997a, b). It is no wonder then, that young people represent a majority of AIDS cases in the country (Government of Kenya, 1997). AIDS cause social and economic repercussions that go beyond the family, for they overset the hard-won gains of national development (UNAIDS/WHO, 1998). There are social and cultural factors that make the youth vulnerable and any comprehensive AIDS intervention must address these factors.

The government of Kenya has put efforts to curb HIV/AIDS spread among the youth. This is done through designing culturally, morally and scientifically acceptable AIDS prevention strategies, curbing anti-social behaviors like drug abuse and strengthening the capacity of teachers and the community at large to enable them lead and educate the young people about HIV/AIDS (Government of Kenya, 1997). However, the extent to which these efforts have been effective is questionable.

With HIV/AIDS claiming their numbers and conspiracy of silence maintained by the leaders, teachers and parents on sex education, the young people have taken initiatives to curb the spread of HIV/AIDS in their midst. It is clear that the HIV/AIDS infection is rampant among the youth, and that those not infected are affected when, parents, relatives and friends are infected. Moreover, many young people have been forced to take up the adults' responsibilities, caring for the infected parents and the younger siblings. This may have negative impact on their education in that, some

drop out of school for lack of fees or to take care of the infected parents and the other siblings.

The youth living in economically and socially underprivileged environments like the slums are even more vulnerable to HIV/AIDS infection. Crimes, violence, drug abuse, alcoholism and prostitution are common features in the slums (Maingi, 1995). All these create conditions, which help the spread of HIV/AIDS. The Mathare Youth Sports Association (MYSA) drawing it's members from Mathare slums seemed to have acknowledged the vulnerability of the youth in the slums. The Association is tackling HIV/AIDS prevention through providing youth opinion leaders with the aim of changing the values and attitudes of the young people (Williams et al, 1997a). Through trained peer educators, the Association is educating the members on AIDS prevention measures. This study was designed to investigate the role played by the youth peer educators in the prevention and control of HIV/AIDS among the youth.

1.2 Statement of the Problem

The number of confirmed HIV/AIDS cases in Kenya has continued to increase despite the many AIDS awareness campaigns through the mass media and public address (NASCOP, 1996; Shorter and Onyancha, 1998). The sexual transmission of the disease threatens the sexually active age group, which also coincides with the economic productive age group and the youth (Forsythe and Rau, 1996; NASCOP, 1996) The high rate of abortion, teenage pregnancies and prevalence of STDs among the youth indicates further that young people engage in unprotected sex (Njau 1993; Williams et al, 1997a). Worse still, the youth constitutes half of the Kenyan population (Kenya Demographic Study, 1993).

The high cost of treatment and prevention puts strains on the government's resources. Moreover, the AIDS epidemic has exploded during the era of structural adjustment programs (Cabrera et al, 1996). The government has been under great pressure from the donor agencies to reduce expenditure on social services, health sector included. This implies that the government is confronted with a task too big to handle. To intensify prevention at a minimum cost calls for concerted efforts in the community at all levels, including the youth.

The youth exhibit enormous diversities as a result of diverse socio-cultural, economic and individual diversities. However, a feature common among many youth is their vulnerability to HIV infection and other sexually transmitted diseases (UNAIDS, 1998; Williams et al, 1997b). The youth in the slum areas are even more vulnerable. Confronted with dire poverty, many resort to drug abuse, alcoholism and prostitution (Shorter and Onyancha, 1998). All these expose them to the risk of contracting HIV/AIDS. Maingi (1995) concludes that the chronic and the desperate poverty in Mathare slums make it one of the 'HIV high-risk' areas.

The technological revolutions of the modern society have been accompanied by a new package of challenge to the youth. Unfortunately the established patterns of behavior, the advice and the experience of the older generation is often irrelevant (WHO, 1993). Moreover, AIDS is a new disease in the history of mankind. This implies that much must depend on the creativity, strength and the commitments of the youth. This was echoed by a group of young people attending the International Conference of AIDS in Africa in 1995 (Shorter and Onyancha, 1998; UNAIDS, 1998).

Williams et al, (1997a, b) argue that many HIV/AIDS prevention strategies have

yielded little or no behavioral change. This is attributed to the failure of such strategies to address the concerns of the youth. The content of many AIDS awareness is wanting in terms of sensitivity to culture, lay beliefs and emotional needs of the target groups (Nzioka, 1994). This may explain why AIDS awareness has not measured to adoption of the recommended behavioral change. This implies that if information is structured to suit the target group and is discharged by the individuals sensitive to the group it would yield behavioral change. Specifically, this study was designed to answer the following questions.

- What kind of information do the youth peer educators provide to the youth?
- How do the members perceive the information?
- Does youth peer education have any impact on the sexual behavior of the youth?
- What constrains do the youth peer educators encounter?

1.3 Objectives of the Study

1.3.1 Overall Objective

To investigate the role played by youth peer educators in the prevention and control of HIV/AIDS.

1.3.2 Specific Objectives

1) To find out the type information provided by the youth peer educators.
2) To examine the members' perception of the information disseminated by youth peer educators.
3) To investigate the extent to which the youth peer education has patterned youth's sexual behavior.
4) To find out the constraints encountered by the youth peer educators.

1.4 Rationale of the Study

Although lots of resources in terms of manpower and money have been invested towards AIDS prevention, the epidemic has continued to spread alarmingly among the youth. This has had negative implications on country's development because the resultant death robs the nation a future generation.

The youth forms a large proportionate of the urban migrants where they migrate to in search for jobs and training opportunities. Their exposure to films, pornographic literature, and peers pressure with little parental guidance may explain why the youth constitute the majority of AIDS victims in Nairobi. The high rate of drug abuse and alcohol intake in slum areas like Mathare makes the youth in such areas even more vulnerable to HIV/AIDS infection, as it may make them fail to take precautions for prevention. The findings of this study may help inform organizations interested in the prevention of the epidemic in the slum areas.

The study recognizes that the best meaningful way of achieving sustainable behavioral change among the youth is through involving the youth who best understands their concerns and needs (WHO, 1993; Williams *et al*, 1997a). Therefore, the outcome of this study may help inform and guide organizations and groups committed to community- based approaches to AIDS prevention among the youth. Moreover, the findings may help improve the quality of information provided by the youth peer educators as well as the methods of disseminating the same.
This study will also update the studies on youth initiatives. Furthermore, youth-to-youth is a new approach and little has been documented. Therefore, this study will extend the existing knowledge on the youth initiatives.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter is divided into four sub-sections. Existing literature on HIV/AIDS prevention and the youth initiatives have been reviewed with the aim of establishing the existing gaps and to help in the formulation of the working assumptions. The theoretical framework guiding the study is also highlighted. The working assumptions of the study and definitions of the key terms are also outlined.

2.1 Background Information

Currently AIDS is one of the deadliest diseases ever experienced in the history of humanity. It has become a major threat to global health (Helman, 1994). AIDS was first diagnosed in America in the early 80's among the homosexuals and drug injectors (Cabrera et al, 1996; Government of Kenya, 1997; Tuju, 1996). Consequently, people assumed that AIDS was a disease of the homosexual.

The spread of HIV/AIDS is influenced by biological, social, cultural, economic and political factors. This explains why different regions exhibit diversity in the prevalence rates and modes of transmission. In Africa and Asia HIV/AIDS is mainly transmitted through heterosexual sexual contacts, while in Latin America, and Eastern Europe it is mainly transmitted through drug injecting (UNAIDS, 1998; UNAIDS/WHO, 1998). It is, therefore, important that each region address the behaviors and practices that make the youth vulnerable. But a more comprehensive approach must address the social, cultural, economic and political factors that expose the youth to HIV infection.

2.2 Awareness

Although there are factors that expose young people to HIV/AIDS infection, there is need to inform them on how best, they can avoid infection. Shorter and Onyancha (1998) argues that education for behavior change is the only positive combat against the epidemic. An effective AIDS prevention measure must include the promotion and distribution of condoms, treatment of STDs and broad AIDS education in schools and through mass media.

The Kenyan government is in the process of introducing AIDS education in schools (Nduati and Kiai, 1996). This is aimed at creating awareness among the school children. Kamau (1996), Maingi (1995) and Williams et al, (1997a) point that general awareness about AIDS is achieved through mass media, posters, public speech, street banners and general talks. All these are geared towards behavioral change. However, according to Map international (1998) this general awareness is incomplete if it fails to focus on the individuals.

Williams et al, (1997a) observes that there is a high level of awareness among the youth but this has yielded little or no behavioral change. Kamau (1996) concludes that there is minimal relationship between AIDS awareness and behavioral change, though many girls are aware about the dangers of HIV/AIDS they have hardly changed their sexual behavior. A survey carried on the youth in Nairobi shows that AIDS awareness has not deterred over 30% youth from having sex while only 18.1% would fail to have sexual intercourse for fear of contacting HIV/AIDS. (Daystar University, 1998)

Nyamongo (1996) observes that though adolescents in rural and urban schools are

well informed about the HIV/AIDS, this knowledge has not been translated into behavioral change. Government of Kenya (1997) attributes this failure to the diverse socio-cultural and individual factors inherent in the society and the individuals. However, Williams et al, (1997a) argues that the prevention strategies failed because they had ignored the needs and the concerns of the young people.

On the other hand, Muturi and Nzyuko (1988) attribute the increase of AIDS infection despite increased awareness to the fact that the knowledge has failed to confront individuals with concrete evidence of the consequences of the diseases. Nzioka (1994) attributes the failure to content of message propagated in the AIDS campaign. He argues that the message is insensitive to the lay beliefs and traditional values of the target groups. On the other hand Ngugi and Plummer (1988) attribute this failure to the intimacy of the behavior whether it has to do with sex or intravenous drug use.

2.3 Condom Use

So far condom use is one of the most effective measure of preventing HIV/AIDS transmission. However, condom use has been hampered by several factors such as the high cost, breakage and the myth that it reduces sexual pleasure (World Bank 1998). Henry (1997) argues that many young people fail to use condoms because they feel embarrassed to buy them fearing that people who know them will discover that they are sexually active. The adoption of condom use is a necessary step towards prevention against HIV/AIDS infection especially among the sexually active youth. This is because they cannot be expected to start abstaining from sex immediately. However, for condoms to be effective they must be used consistently and correctly (Tuju, 1996).

Although many youth are sexually active, religious leaders in Kenya have opposed the promotion of condom use among them (Shorter and Onyancha, 1998). They, for example, believe that promoting use of condom encourages immorality among the youth. The Catholics and Muslims demonstrated their fury against the promotion of condoms by burning condoms at Uhuru Park in 1996 (Shorter and Onyancha, 1998). However, rejecting the use of condoms among the sexually active youths is condemning them to HIV infection.

While condoms may reduce the risk of contracting HIV/AIDS, breakage and slippage may put the user at risk of contracting HIV/AIDS (Albert et al, 1995). Breakage is attributed to improper use, poor quality, and vigorous sexual activity. There is, therefore, a need to improve the quality of condoms to avoid breakage and inform people on proper use and storage of condoms (Albert et al, 1995; World Bank, 1993).

The lack of discussion on sexuality even among adults has hampered the use of condoms among many sexual partners. The status of women and their prescribed gender roles in sex has left them with little say in the use of condoms even when they know that they are at risk (Cabrera et al, 1996; Tuju, 1996). This implies that whether a wife or a friend, women lack the social skills to demand the use of condoms. The initiation of condom use with a regular partner is not easy for either gender since it sends signals of mistrust and unfaithfulness. This undermines the use of condom among many couples.

World Bank (1998) argues that, if condom use is going to be a popular and effective prevention strategy, reduction of price, promotion of condoms social acceptability

and improvement of the quality of condoms is a must. Dadian (1997) observes that the reduction of the price of condoms led to an increased use of condoms in Haiti and Rwanda. She continues to say that the recipient countries should either reduce or remove custom duty on imported condoms since most of the condoms are imported. This was the secret behind the reduction of condom price in Haiti and Rwanda where the former removed the custom duty and the later reduced the custom duty (Dadian, 1997).

Rumors and myths about condoms act to hinder their use, for example, some people argue that using condoms is like "eating unpeeled banana " or "showering in clothes" (Tuju, 1996). Others doubt the effectiveness of condoms in prevention (Kamau, 1996; Shorter and Onyancha, 1998). Some believe that condoms can be harmful to women causing infertility and gynecological problems if lodged inside the vagina (Shaopf, 1988). These rumors can only be countered by education. However, there is need to increase the quality of condoms, to lower the prices and increase their social acceptability. Where possible condoms should be distributed by the youth peer educators, whom the youth can access easily and without embarrassment (Henry, 1997). Shorter and Onyancha (1998) concludes that although condoms may reduce the chances of contracting HIV/AIDS, they are not a solution to the epidemic.

2.4 Abstinence

Abstinence means refraining from having sexual contact. It is the most effective method of prevention against HIV infection and the most recommended for the youth by parents and religious leaders who don't expect the youth to be sexually active (Shorter and Onyancha, 1997, 1998; Tuju, 1996). Most communities practiced abstinence as a method of birth control (Kamau, 1996; Kioli, 1996; Njau, 1993).

Periodic abstinence during pregnancy and after birth was also common in many African communities (Cabrera et al, 1996; Caldwell et al, 1989).

Njau (1993) observes that given the traditional restrictions placed on the individual, abstinence was possible. Kamau (1996) and Kioli (1996) argue that abstinence in the modern world is a virtue too hard to achieve given the breakdown of the traditional sanctions, urbanization and the influence of media. Tuju (1996) admits that abstinence is difficult to observe but determined people can make it. Kiiti et al, (1995) notes, that even among the Churched youths, abstinence is not the norm, for 49% of the youth had had sex days before the study. A study carried out by Suda (1993) revealed that many people were unwilling to abstain. They claimed that it was not only impractical but also impossible. This points clearly that this method of prevention is not applicable to many young people. After all values have changed and virginity is no longer revered and respected. Rather, it is seen by some as a sign of backwardness (Njau 1993).

2.5 Faithfulness in Marriage

Faithfulness in marriage is advocated for as a method of preventing the spread of HIV/AIDS. It seems to be the only method that does not compromise the purpose of marriage in the African set up, that is procreation. However, various cultural practices and socialization process seem to encourage men to engage in extra-marital relations (Tuju, 1996), hence challenging faithfulness in marriage. In many African cultures, women were prohibited from engaging in sexual activities during pregnancy and for a long period after birth (Cabrera et al, 1996 Caldwell et al, 1989). If these customs were to be observed, faithfulness might be impossible for many.

According to Cabrera et al, (1996) Caldwell et, (1989) and Tuju (1996) faithfulness in marriage is challenge by rural - urban migration. Cabrera et al, (1996) observe that men in East and South African countries work in the cities leaving their wives in the rural areas. Tuju (1996) points out that the salaries received by many workers in the urban centers cannot sustain them together with their wives and children in the urban centers, where basic necessities are more expensive. The separation of couples is worsened by the socialization that seems to encourage multi-partnership and the belief that a man cannot be satisfied with one woman (Cabrera et al, 1996; Tuju, 1996). However, unfaithfulness in marriage is not confined to migrant laborers, a study carried out by MAP International, for example, revealed that 32 Church elders had been unfaithful to their wives (Kiiti et al, 1995). Despite the many odds against faithfulness in marriage, it is just but a matter of choice by individuals.

It would be pointless to assume that pre-marital sex does not take place. Therefore, the sexually active youth are also encouraged to be faithful to one partner (Henry, 1997; Williams et al, 1997a) and this has been labeled as mutual monogamy. Unfortunately such relationships are fragile, such that one may have many partners in a span of one year. It is no wonder that mutual monogamy has been a major cause of the STD epidemic. Statistics equate the number of sexual partners in a lifetime with the probability of contracting STD irrespective of whether one is mutually monogamous at the time or not.

2.6 Treatment of STD's

Research findings indicate that there is a relationship between STD and HIV spread. It has been observed that untreated STDs aggravate the transmission of HIV (Shorter and Onyancha, 1998; Williams et al, 1997a; World Bank, 1996). Recent

findings of a Mwanza Tanzania research confirms that effective treatment lowered the incidence of HIV spread by 42% (World Bank, 1996). However, fear and embarrassment of exposing their sexual activities, treatment fee and unfriendly health clinics have hampered the prompt treatment of STDs especially among the youth (Kabatesi, 1996; Shorter and Onyancha, 1998; UNAIDS, 1998; Williams et al, 1997a).

To avoid stigmatization and embarrassment many youth resort to traditional medicine and advice from friends. The postponed and poor treatment may increase their vulnerability. The creation of youth friendly health clinics is an important step towards curbing the spread of HIV (UNAIDS, 1998; Williams et al, 1997a). There is need to strengthen the whole health care system by training the healthcare providers to make accurate diagnosis and treatment of STD's as well as giving appropriate counseling to the youth (World Bank, 1996).

2.7 Involvement of the young people in the prevention of HIV/AIDS

The involvement of the young people in Primary Health Care as a strategy of improving their own health and that of the community has been gaining recognition throughout the world (WHO, 1993). Several reasons have been advanced to explain why this involvement is essential.

The UNAIDS (1998) argues that although parents play a role in shaping the attitudes and the behavior of the young people, it is the group of close friends that shape the young people's understanding of social relationship enabling them to develop a sense of competence and responsibility. This implies that young people exhibits a worldview that is different from their parents. A proper understanding of this is

necessary to any effective prevention strategy. This can only be achieved through involving young people who best understand this worldview.

The involvement of the youth in the planning, designing and implementation of prevention strategies directed to them ensures that the programme is sensitive to their needs and concerns (Williams et al, 1997a). It also enables them to use their potential creativity, idealism, enthusiasm and numerical in combating the epidemic (UNAIDS 1998; WHO, 1993). Through involvement, the young people change from being passive recipients and become agents of behavior change among their peers and at household levels. This may boost their self-esteem, which is crucial in prevention (Williams et al, 1997a). Enhancing self-esteem is the basis for high-risk behavior prevention, for it's only when the young people are convinced about their self worth, that they can become receptive to suggestions that enhance health.

When young people are involved in AIDS prevention programs they are likely to give insights and guidelines to the adults, which may ensure the success of the project (WHO, 1993). This therefore, calls for planning with the youth rather than planning for them. Williams et al, (1997a) argues that many preventive projects directed to the youths fail because the adults assume that they understand the needs and the concerns of the youth. On the contrary young people have a different approach to life. They may engage in behavior that adults consider risky for the sake of solidarity, to express or receive love and for entertainment (UNAIDS/WHO, 1998).

WHO (1993) argues that any health education programme must be based on the understanding of the attitudes of the target group This implies that the understanding of the attitudes and the sexual behavior of the youth is necessary.

Apparently, no adult understands the youth better than the youth themselves. Because the youth understands the factors influencing their behavior, their attitudes and practices they are more likely to propose realistic options than the adults are (Williams et al, 1997a). The young people not only know how best to communicate with each other using current fashionable styles but are also more likely to be trusted by their peers not to have hidden agendas (WHO, 1994).

The young people have always helped their families and communities. They are often willing to help and are generous (WHO, 1993). This should prompt governments and organizations engaged in HIV/AIDS prevention programs to involve the young people in the prevention of the epidemic. WHO continues to argue that the young people have a freshness approach since many have not faced disappointments in life. Consequently, they are enthusiastic, idealistic and creative. All these characteristics can be channeled towards effective prevention of HIV/AIDS. Aggleton (1992) argues that any prevention strategy directed to the youth must begin with an evaluation of their daily concerns. It must start with identifying the needs and questions the young people have and proceed to provide information and resources needed for the prevention. This can only be achieved through giving the young people a hearing, understanding how they think and act, offering assistance and support without dictating the outcome.

The young people constitute a majority of HIV/AIDS cases in the world. According to UNAIDS (1998), young people constitute 60% of all AIDS cases in the world though they only constitute 20% of the world population (Shorter and Onyancha 1998; UNAIDS/WHO 1998; Williams et al. 1997a, b). In Kenya they constituted the majority of AIDS reported cases in hospitals throughout the country (Government of

Kenya 1997). Moreover, as the epidemic spreads and claims their parents, many are left as orphans (Forysthe and Rau, 1996). This means that those not infected by the epidemic are indeed affected by the consequences of the epidemic. The foregoing should prompt the government and other organizations involved in HIV/AIDS prevention to involve the youth in curbing the spread of this epidemic.

2.8 The Vulnerability of the Youth

There are many factors influencing the vulnerability of the youth as far as HIV infection is concerned. Some are biological, socio-cultural and economical.

2.8.1 Biological

Youth is a normal phase in human development, which is characterized by self-discovery, self-doubt, questioning and experimentation (Kumah et al, 1992). Moreover, it is characterized by increased awareness of self and the desire to discover sexual experience. This may cause them to experiment with relationships before settling with a steady partner. These experiments make them vulnerable to HIV infection. They may also experiment with alcohol and drug abuse with the adverse consequences.

Shorter and Onyancha (1997) points out that the sexual maturation attained during the adolescence leads to the awareness of sexual response which if mishandled may lead to sexual activities. This is one of the causes of sexual activities among the youth, which expose them to HIV infection. Due to the improved nutritional status in many countries, the age at menarche is declining and as such many youths are becoming sexually mature at an earlier age than the older generations (Shorter and Onyancha, 1997) In countries where HIV prevalence is high, young people

become vulnerable as soon as they become sexually active because of the pool of potential partners is often heavily infected (UNAIDS/WHO, 1998).

Although sex is a biological process, how, with whom, when and where are determined by socio-cultural and economic factors (Helman, 1994; Kioli, 1996). Therefore the biological factors do not function in isolation.

2.8.2 Socio-cultural Factors

The traditional sex education systems seem to have broken down (Njau 1993; Shorter and Onyancha, 1997, 1998; Williams et al, 1997b). Unfortunately these systems have not been replaced. It was these traditional sex education systems that prepared the puberty boys and girls to confront their sexuality, as well as educating them on their gender roles (Kumah et al, 1992). The breakdown of such a system without replacement means that the youth are confronting their sexuality with little or misguided information (Njau, 1993; Williams et al, 1997a).

Williams et al, (1997a, b) argue that it is lack of information about sexuality and reproductive health that has made the youth to be vulnerable to HIV infection. Unfortunately, attempts to introduce sex education in schools have been opposed by the religious leaders (Shorter and Onyancha, 1997, 1998; Williams et al, 1997a). These leaders believe that the introduction of sex education will encourage immorality among the youth. But this belief does not hold water for studies conducted by WHO in different parts of the world found no evidence to support this belief. On the contrary, sex education delayed the initiation of the first sexual intercourse, increased the use of contraceptives and promoted the adoption of safer sexual behavior (Williams et al, 1997b).

With the breakdown of the traditional sex education system and the failure to fill this gap. the young people learn about sexuality from the peers and the media with diverse implications (Kamau, 1996; Kioli, 1996; Njau, 1993). The information about sexuality they receive from the media and peers contradicts their parents' directions (Kumah et al, 1992). The media and the peers' messages reinforce the natural predisposition, viewing sexual activity as good and enjoyable. The parents on the other hand present sex as evil and threatening which is often inconsistent with their conducts (Kumah et al, 1992).

Not only have the traditional sex education systems broken down, but also the sexual taboos, and social sanctions that ensured the adherence of the community norms (Njau, 1993; Williams et al, 1997a). This leaves the young people with few or no sanctions to control their sexual behaviors. Moreover, there is a breakdown of the traditional age set/age groups, which sanctioned unacceptable behavior (Kioli, 1996). This implies that the youth's sexual behavior depends on personal principles, which are subject to pressure from the peers and the media.

In the traditional society members of the extended family provided great material and moral support to the young people (WHO, 1993). But because of influence from the Western cultures through the media and economic strains, there is a drift towards nuclear family. This has left the young people with little support and few or no role models to emulate (Kioli, 1996; Shorter and Onyancha, 1997; WHO, 1993). Moreover, the rates of divorces have continued to rise thus affecting the psychological and moral behavior of the young people. All these have left the young people vulnerable to drug abuse, alcoholism and hence HIV/AIDS infection.

The double standards applied on the gender predispose young people to HIV/AIDS infection (Kumah et al, 1992). Njau (1992) notes that boys are rewarded and encouraged to acquire and demonstrate sexual experiences. Girls on the other hand are supposed to maintain their virginity and are punished for sexual activities especially if they led to pregnancy. In this case then, the prescribed gender roles and expectations may expose either gender to the risk of contacting HIV.

Shorter and Onyancha (1998) argue that for a boy suffering from STD is a test of manhood. Such a view may cause a delay in seeking treatment for STD, which may increase the chances of contracting or transmitting HIV. Boys and girls engage in sexual activities for different purposes - boys to demonstrate their male prowess, maturity and control over girls; - girls to show love or are coerced but both are vulnerable to HIV infection (Kumah et al, 1992).

With the introduction of formal education early marriages have become impractical in many societies (Tuju, 1996). Many young people remain unmarried as they attend schools and colleges. Others may delay marriage as they search for job opportunities. This implies that though they may be sexually mature they are not economically ready to start families. The temptations to engage in casual sex are very high for these young people. Cabrera et al, (1996) notes that many young men in East and South African countries marry in their late 20s, which means that half of the post-pubertal males are not married. The prolonged age at marriage may increase the vulnerability of the young people for they are likely to engage in sexual relationships with different partners.

With technological advancement in mass media and the broken forum of

socialization, young people are exposed to sexual stimuli in magazines, television and movies (Kioli, 1996; Njau, 1993). Studies by Daystar University (1998) and Kamau (1996) reveal that most adolescents receive information about sex from media and peers. Tuju (1996) argues that the pop culture promoted through music, movies and advertisement seem to grant causal sex a license. Apparently this is crudely mixed with the traditional culture with negative implications.

2.8.3 Economic

WHO (1993) observes that a disproportionate number of urban migrants are young people. Most of them move to the urban centers in search for jobs and training opportunities. They often face hostile environment and new cultural patterns with little or no support from the parents. This may bring stress, making them liable to alcoholism and drug abuse and all these predisposes them to HIV infection. It has been established that alcohol and other drugs can influence the sexual behavior and increase the young people's vulnerability to HIV. The intake of alcohol may affect their ability to use important information acquired about AIDS prevention and consequently, influence their decisions about prevention (UNAIDS, 1998).

Shorter and Onyancha (1997) argues that when young people move to urban centres they stay with relatives. These relatives are not likely to supervise the lifestyles of the young people. This may encourage sexual activities among the youth. Kamau (1996), Kioli (1996) and Ogunleye (1994) argues that urbanization separates the youth from parents, who would instruct them on appropriate behavior and sanction unacceptable behavior.

Separation of the youth from parents due to urbanization leaves the youth with little

or no supervision from parents thus encouraging sexual activities. Even where youth are living with their parents the economic strains and busy schedules leaves them with little or no time to monitor their children (Ogunleye, 1994). Shorter and Onyancha (1997) points out that sometimes the young people in the urban share rooms as they pool their resources together, this may increase peer pressure and sexual activities as a result.

The high rate of joblessness in urban centres promotes hopelessness and idleness among the youth (Shorter and Onyancha, 1997). AIDS can be seen as a symptom of underdevelopment and reflection of widespread unemployment and poverty. Unemployment may encourage the young people to engage themselves in sexual activities to counter stress and idleness with the profound consequences (Shorter and Onyancha, 1998). Young girls may engage in sexual activities in order to obtain jobs or to receive material support (Kamau, 1996; Kioli, 1996). World Council of Churches (1994) observes that girls are often lured into sexual relationships by promises of material gain. Kioli (1996) concludes that poverty is often the direct cause of commercial sex among the youth who are at times forced to prostitution by their families.

According to the UNAIDS estimates half of 333 million STDs cases are found among the young people (UNAIDS, 1998). Studies have shown that untreated STDs increase the transmission of HIV. Yet, because of socio-cultural and economic factors young people fail to seek health facilities timely. Shorter and Onyancha (1998) UNAIDS (1998) and Williams et al, (1997a) attribute poor utilization of health facilities by the youth to treatment fee, stigmatization, embarrassment and judgmental attitude of healthcare providers.

The economic factors may also influence the young people's adoption of sexual behaviors. Lack of finances may hinder them from using condoms although they know they can reduce the risk of infection. This explains why the reduction of condom price promoted their use among the youth in Rwanda and Haiti (Dadian, 1997).

2.9 Youth Initiatives

2.9.1 The Mathare Youth Sports Association (MYSA)

The Mathare Youth Sports Association was formed in 1987 as a self-help project to organize the sports and clean up activities in Mathare slums (Maingi, 1995). By the end of 1988 the Association had already established 120 football teams 10 - 18 years old boys, and by the end of 1997 the Association had grown to be the biggest Youth Club in Africa comprising of 410 boys teams and 170 girls teams (Williams et al, 1997a). The Association is involved in clean up activities. Every week 20 - 30 teams clear the garbage and drainage ditches in Mathare slums (Maingi, 1995). Because of this involvement in environmental clean up, the Association was awarded a Global 500 award in 1992.

When AIDS claimed the life of one of their member, the leaders were prompted to ally with Norwegian Church Aid for the training of peer educators (Diakonia, 1997; Maingi, 1995; Williams et al, 1997a). It was believed that peer educators could impart positive change of attitudes and sexual behavior especially if selected from the best players. By the end of 1997, 76 boys and girls had completed the advanced peer-educators course while 50 boys and girls had completed the introductory course. The peer educators mainly work informally, coaching their team-mates,

friends and family members (Maingi, 1995).

The Association promotes abstinence but encourages the sexually active members to stick to one partner and use condoms for prevention. Abstinence is not merely encouraged just for the prevention purposes but as a positive commitment to achieving the highest level of sports prowess. Packets of condoms are kept in the office for distribution mainly to the senior players.

Through the trained peer educators the Association provides the youth with opinion leaders, information and communication skills necessary in reaching out to other youths (Maingi, 1995). Through sporting and engagement in community services the young people develop self-esteem and are able to enjoy friendship with members of the opposite sex without necessarily involving themselves with sex (Williams et al, 1997a).

The Association organizes AIDS awareness campaign through a public address by one of the peer educators before every football match. Over 30 matches are played every weekend in the different zones in Mathare slums. The Association also organizes workshops to explore issues relating to sexuality and gender roles (Maingi, 1995).

Diakonia (1997) points out that the youths in the slum areas face many problems ranging from poverty, family breakups, drug abuse, alcoholism, boredom, lack of recreation and low self-esteem. All these may increase their vulnerability to HIV infection. However, the Association has at least offered the members a lucrative activity to keep them busy and increase their self-esteem. To enhance discipline the

Association has laid down rules governing the members conduct. For example, members are not supposed to take drugs (Williams et al, 1997a).

2.9.2 Fish Group

This is another youth group that is taking HIV/AIDS prevention among the youth seriously. The group was started in 1985 with the aim of promoting Christian values, organizing community services, social and educational activities in Kisumu (Williams et al, 1997a). However, with AIDS becoming a reality in the area, the group started adopting prevention strategies as one of its activities.

In 1995 the group started a project called 'youth for behavior change'. Realizing that behavior change cannot be achieved instantly the group encourages members to go through three stages (Williams et al, 1997a). The first stage involves a personal acknowledgement of the individual's risky behavior. The second stage involves a personal commitment to adopting a new behavior, while the third stage involves taking action towards adopting the new behavior. This approach seems to give the individual a chance to make personal choices, rather than presenting prescribed choices.

By 1997 the group had 40 branches within Kisumu and it's environ with a membership of 600 youth. Through trained peer educators the group organizes and facilitates workshops for behavior change in schools and churches (Williams et al, 1997a).

2.9.3 Save Your Generation Association (S.Y.G. A)

Five university students in Ethiopia, who after witnessing their friend die of AIDS believed they had the virus for their sexual behavior was no better, started this organization. To leave a legacy before their anticipated death they devoted themselves to saving their generation through creating awareness among the out of school youth (Henry, 1997).

Through drama, video, puppet shows, sports events and other forms of entertainment they attract the out of school youth to their meeting where they pass the information about prevention (Henry, 1997). The Association's peer educators are involved in person-to-person out-reach through which they advice the youth how to use condoms properly and negotiate safer sexual behavior.

They promote all forms of prevention equally. This encourages the youth to make personal decisions and choices. Realizing that most youth are reluctant to use condoms for fear of embarrassment in purchasing, the peer educators gives youth tips on how to purchase condoms with least embarrassment (Henry, 1997). But the most effective method of distributing condoms among the youth is through peer educators whom the youth can approach with little or no embarrassment.

2.9.4 Peer Approach to Counseling by Teens (P.A.C.T)

P.A.C.T was started with the aim of empowering the Botswana youth with the knowledge and the skills to enhance their self-esteem (Williams et al, 1997b). This would ensure that young people developed to become responsible individuals with well-defined value systems, who are able to make informed decisions.

P.A.C.T recognised that teenagers receive most information about sexuality from peer whom they feel more comfortable to discuss these issues with (Williams et al, 1997b). As a result peers were trained to become peer educators able to educate their fellow teens on AIDS prevention and other issues on reproductive health.

2.9.5 The Teenage Mother and Girls Association of Kenya. (T.E.M.A.K)

This association was started in 1994. The main aims of the Association were:

-To rehabilitate the teenage mothers and to strengthen their capacity to sustain themselves and their children.

- Change the community's attitudes towards teenage mothers.
- Provide the health education and care through the establishment of health out-reach centres (Williams et al, 1997a).

The organization encourages teenage mothers to go back to school, offering to pay the fees only if their efforts to persuade the relatives to do so are fruitless. The organization informs the members about HIV/AIDS through workshops and individual counseling (Williams et al, 1997a). Condoms are distributed during workshops while the Association keeps packets of condoms in the office for easier access to members. No systematic evaluation of the impact of the Association on behavioral change has been done, but TEMAK staff and volunteers believe that significant changes have taken place. However the working of the association is constrained by lack of adequate resources (Williams et al, 1997a).

2.10 Theoretical Framework

Health Belief Model

The study was guided by the Health Belief Model (HBM), which was advocated for by (Cobbs 1966, Kasl 1966, Rosenstock 1966 and Suchmann 1966 cited in Rosenstock, 1974). It is derived from social-psychological theories and it's so far the most popular approach to health behavior (Bloor, 1995). The Health Belief Model was developed to explain why patients failed to accept preventive or screening tests for detection of asymptomatic diseases like cancer and dental diseases. (Rosenstock, 1974) In recent times, the Model has been applied to explain the sexual behavior of the gay in relation to perceived susceptibility (Vincke et al, 1993). Other researches that have employed this Model include the works of Mulemi, 1995 and Mwanzo, 1994.

The Health Belief Model hypothesis that a person seeks or adopts preventive care or screening when the following conditions are met:

- They possess minimal levels of relevant health and knowledge.
- They see themselves vulnerable and are convinced that the condition is threatening.
- They are convinced that the preventive strategy is efficient and see few difficulties in adopting the strategy.

More specifically the belief model contains the following elements:

- The individual's readiness to take action is determined by perceived likelihood of susceptibility to illness and severity of its consequences.
- A cue to action triggering the appropriate health behavior. The knowledge about

the seriousness of a condition and its consequences may trigger health action. Such knowledge may come through mass media, advice from others, illness of a family member or a friend. Therefore the stimulus to taking a health action can be proximate, such as having seropositive friends or they can emanate from distal and probably less stressful sources like media AIDS campaign (Vicke et al 1993).

- The individual's evaluation of the feasibility and efficaciousness of the advocated health behavior weighed perceptions of psychological, physical, financial and other costs or barriers involved in the proposed action. An alternative is likely to be seen as beneficial if it relates subjectively to the reduction of ones susceptibility to or serious of an illness. It is a person's beliefs about availability and effectiveness of various courses of action that determines the action he/she takes. An individual may believe that a given action is effective in reducing the threat of a disease but also see it as being expensive, inconvenient, unpleasant or upsetting. As a result such negative aspects of a health action may serve as barriers to action and arouse conflicting motives of avoidance.

2.11 The Relevance of the Theory to the Study

The Health Belief Model is relevant to the study in that it helps explain the sexual behavior of the youth in relation to the information obtained from the youth peer educators. It is argued that for individuals to engage in health behavior, such safer sex an individual has to perceive himself/herself as vulnerable to a health threat, that health threat has to be perceived as having serious consequences. The protective action that is available has to be perceived as effective, and the benefits of action have to be perceived as outweighing the perceived cost of action.

To understand the sexual behavior it became necessary to understand the information passed on by the youth peer educators. If the information stresses on personal susceptibility the sexual behavior of the youth were bound to change. On the other hand if the youth peer educators are helped in eradicating or reducing the inconveniences, the pain and the price of adopting the prevention measures the youth were bound to adopt the prevention strategies. To ascertain this, questions related to the type of information, perception of the information and the application of the information were asked. It was expected that the information would delay the first coital incidence, reduce the number of partners or increase the use of condoms among the youth.

2.12 Working Assumptions

1 The youth peer educators educate the youth on reproductive health issues.

2. The member's perception of the information determines their adoption of the prevention measures.

3. The youth peer education has influenced a positive sexual behavioral change on the youth.

4 The constraints encountered by youth peer educators hinder the effectiveness of peer education.

2.13 Definition of the Terms

Independent Variables

Youth peer educators. This referred to those youth who had undergone training and were involved in guiding or instructing their fellow youth on AIDS prevention measures as well as other health related issues.

Peer education: This refers the process of instructing the youth through formal and

informal ways, for instance through informal discussions, public address, videos and drama presentations.

Members' perception: This refers to youth attitudes towards the information. Here the researcher investigated the youth understanding of the information. Did they see the information as relevant, practical, applicable or even necessary?

Constraints encountered by peer educators: This referred to problems encountered by the peer educators.

Dependent variables

Reproductive health: This referred to information on STDs, HIV/AIDS, adolescence, and abortion.

AIDS awareness information: This referred to known facts about AIDS causes and prevention strategies

Sexual behavior in this study the term encompassed the following: number of sexual partners, use of condoms and abstinence.

Adoption of prevention measures: This referred to the acceptance and/or utilization of condoms, reduction of the number of partners and abstaining from sexual intercourse.

CHAPTER 3

METHODOLOGY

3.0 Introduction

This chapter describes the research site, population sample, and methods of data collection and analysis. Also highlighted in this chapter are the problems the researcher encountered in the process of data collection and solutions advanced.

3.1 Research Site

The study was conducted in Mathare Valley in Kasarani Division, between November 1998 and February 1999. Kasarani Division is one of the eight Divisions of Nairobi Province. Kasarani Division borders Parklands Division on the West, Embakasi Division on the West, Central and Pumwani Divisions on the South **(see Map 1).** Mathare Valley is located on the southwestern part of the Kasarani Division **(see Map 2)**. The area has a well-defined boundary, which encloses 490 acres of land. It borders Juja Road on the South, Outer Ring Road on the East, and Thika Road on the North **(see Map 3).** Other neighborhoods of Mathare Valley includes Mathare Mental Hospital, Police Lines and Drive-in-Cinema.

The area has a population of 103, 469 people (GOK, 1989), from different ethnic communities. Most of the inhabitants of Mathare Valley are unskilled and semi-skilled labourers. They engage in various activities including small unlicensed retail shops, butcheries, hotel and prostitution. Others engage in illegal distillation of local brews like chan'gaa, muratina and buzaa (Wasike, 1991).

Although the area has a vast population and lies within the scope of the Nairobi City Council it does not have a single health clinic run by City Council. However, there

exists a myriad of private clinics run by individuals and organizations including among others, Marie Stopes and Upendo self-help clinic. The National Council of Churches' of Kenya (NCCK) also provides antenatal and maternal-child healthcare services under the family life education. The services offered include, advising residents on better health habits, importance of a balanced diet, childcare issues and providing inoculation jabs to infants (Wasike, 1991).

3.2 Study Design

The study was designed to investigate the role played by youth peer educators in the prevention and control of HIV/AIDS. It sought to explore the content of information provided by the peer educators, how the members perceived the information and how peer education had influenced the sexual behavior of members of MYSA as well as constraints encountered by youth peer educators. Methods utilized in data collection included focus group discussions, in-depth interviews and administration of a standard questionnaire.

3.3 Population Sample and Size

The study focused on individuals as the unit of analysis. Since Mathare Valley was the study area, only teams within the area were considered for the study. The area has 140 football teams, each comprising of 16 members with a total membership of 2240. Twenty-six teams were sampled and five members from each of the sampled teams recruited for the study. A total of 130 members were selected 40 girls and 90 boys.

The study also included the key informants who were drawn from the following categories, community leaders, MYSA leaders, community health workers, and

church leaders.

3.4 Sample Selection

At the time of the study Mathare Youth Sports Association had enrolled 746 football teams, 570 for boys and 176 for girls. Only teams within Mathare Valley were considered for the study, 140 teams with a total membership of 2240 met this specification. A simple random sampling procedure was utilized to obtain 26 teams from which members participating in the study were drawn. Five respondents from each of the sampled teams were selected using simple random sampling. A list of members in each of the sampled teams was obtained from MYSA office acted as the sampling frame. Forty girls and 90 boys were sampled for the study making a total of 130 individuals. A standard questionnaire was administered to each of the selected individual. However, three questionnaires had incomplete data, which was not utilized in the analysis.

The nature of the study also required the application of purposive sampling in selecting key informants. Eight key informants were involved in the study three were leaders in MYSA, two community leaders, two community health workers and one church leader. In addition, ten youth peer educators were purposively selected out of the 80 active youth peer educators.

3.5 Pre-testing Data Collection Tools

Prior to the commencement of the data collection process the researcher pre-tested the research instruments with a number of respondents and key informants from the study area. This was done to enhance accuracy in the flow of questions and the wording of the same.

3.6 Methods / Instruments of Data Collection

Various methods were used in data collection in order to obtain secondary and primary data in the study.

3.6.1 Secondary Data Collection Method: This involved reviewing literature from books, dissertation, theses, seminar papers and journals. The information obtained was used for identifying existing gaps as well as acting as the yardstick to measure the findings with what has been documented.

3.6.2 Primary Data Collection Methods: The structured interviews, key informants, in-depth interviews and focus group discussions were utilized to obtain primary data used in the study. These methods formed the core of the study.

3.6 2.1 Structured Interviews: The structured interview involved administering structured questions to the respondents. The researcher formulated close-ended and open-ended questions. In the open-ended questions the respondent was expected to answer questions in his/her words, while in the close-ended questions the options were provided from which the respondent made choices (**see appendix I**). The researcher conducted face to face interviews with the respondents. This method was found appropriate considering that some respondents were either illiterate or semi-literate.

3.6.2 2 Key Informants: This involved gathering data from individuals who are well versed with the topic under study. In this study the key informants were drawn from Association leaders, community leaders, community health workers, and church leaders. A standardized interview guide was used to elicit information from the

various key informants (**see appendix** II).

3.6.2.3 Focus Group Discussions: A total of five focus group discussions were organized in-groups of 7-15 people. The author designed two focus group discussion guides with themes to be covered in the course of discussions (**see Appendix III and Appendix IV**). Two focus group discussions involving boys and girls of ages between 13 and 15 years were organized separately. Two other focus group discussions involving boys and girls aged between 16 and 18 years were organized separately. The last focus group discussion was organized for the youth peer educators. The participants sat together and discussed amongst themselves issues of interest to the research. The researcher facilitated the discussions while a research assistant took the notes to supplement the authors notes. In essence this was designed to bring clarity to issues arising in the course of interviews.

3.6.2.4 In-depth Interviews: The researcher conducted in depth interviews with 10 youth peer educators 5 girls and 5 boys. This was to try and establish the constraints they encountered in the course of their work, as well as elicit data on types of information given by youth peer educators.

3.7 Data Analysis: Qualitative and quantitative methods of data analysis were employed. The data obtained from the questionnaire were coded and entered using a Statistical Package for Social Sciences (SPSS), frequencies and percentages were run and presented in tables for discussions. On the other hand the data obtained through in-depth interviews with peer educators and key informants, and from focus discussions were discussed and presented in quotation and verbatim.

3.8 Problems Encountered by the Researcher in Data Collection and How they were Resolved

The researcher encountered some problems in the field that threatened the process of data collection. First, the research was conducted when the informants were busy preparing for the end of the year league matches. This implied that they were extremely busy. At first it seemed an impossible task. However, after convincingly conversing with the program manager he agreed and assigned a lady to assist the researcher. Unfortunately, the anticipated assistance from the lady assigned was not forthcoming since she was also a busy staff who could not delegate her duties. As a result the researcher had to work entirely on her own or liase with any cooperative member for each day of the fieldwork.

The league matches ended in the process of data collection and as such the researcher had to suspend field-work until January 1999 when teams were to resume their training sessions.

Organizing focus group discussions with youth peer educators seemed impossible when two appointments failed to materialize. The researcher was forced to arrange focus discussions with the educators after their weekly meeting on Sundays. Even convening the focus group discussions with players was problematic because of the venue and time schedules of these players. Booking appointments with members and organizing focus group discussions in the playing ground solved the problem. Time to cover all the sampled members was another anticipated problem. Designing a time schedule outlining everyday activities was necessary.

CHAPTER 4

PRESENTATION OF RESEARCH FINDINGS

4.0 Introduction

This chapter provides the background information of the respondents showing their age, gender, religion, level of education and source of information on HIV/AIDS. A description of information given by the youth peer educators and how the youth perceive it is also outlined Finally, the chapter outlines the sexual behavior in regard to youth peer education and the constraints encountered by the youth peer educators.

4.1 Background Information of the Respondents

4.1.1 Age

The distribution of respondents by age is presented in Table 4.1 below

Table 4.1: Age Distribution of the Respondents

Age(yrs)	No of respondents	Percentage (%)
13	12	9.4
14	32	25.2
15	27	21.3
16	32	25.2
17	12	9.4
18	2	1.6
19	2	1.6
20	8	6.3
Total	**127**	**100**

The information in Table 4.1 above shows that slightly more than 4/5 of the

respondents (81.1%) were aged between, 13 and 16 years. Only 18.9% of the respondents were aged 17 and above years.

4.1.2 Gender

Out of the 127 respondents 89 (70%) were male while the remaining 38 (30%) were female. This was understandable and predicated before hand since football, which is the main activity of the association, is a male domain.

4.1.3 Religious Affiliation

The frequency distribution of the respondents according to their religious affiliation is shown in Table 4.2 below.

Table 4.2: Religious Affiliation of Respondents

Religion	No. of respondents	Percentage (%)
Atheist	1	0.8
Catholic	68	53.5
Protestant	47	37.0
Muslim	11	8.7
Total	**127**	**100**

As seen from Table 4.2 above, slightly more than half of the respondents (53.5%) were Catholics, 37%, Protestants, 8.7%, Muslims while the remaining one respondent (0.8%) was an atheist.

4.1.4 Educational Background

At the time of the study 69.3% of the respondents were schooling while the remaining 30.7% were not. Among those in school 35.4% of them were in primary while the rest 33.9% were in secondary schools. For those out of school 19.7% of the respondents dropped in primary while 9.4% dropped in secondary schools. Only two (1.6%) had no formal education.

4.2 Sources of Information on HIV/AIDS

Questions relating to youth's source of information on HIV/AIDS were asked. Table 4.3 provides summary of the proportions of respondents by sources of information.

Table 4.3: Youth's Sources of Information on AIDS

Source	No. of respondents	Percentage (%)
Radio	11	8.7
Youth Peer Educators	90	70.9
Parents	3	2.4
Teacher	15	11.8
Friends	4	3.1
Videos	1	0.8
Workshops	3	2.4
Total	**127**	**100**

The data in Table 4.3 above shows that a large proportion of the respondents (70.9%) had obtained information on AIDS from youth peer educators. Parents and teachers accounted for 14.2% while media accounted for less than one tenth (9.5%) of the respondents.

4.3 Methods of HIV/AIDS Transmission and Prevention

Attempts were made in the study to investigate the youth's understanding of the possible modes of transmission and prevention methods. Sex was the most predominate mode of HIV transmission as was cited by 85% of the respondents either independently or together with other methods. The use of unsterilized objects was also popular among the respondents since it was mentioned by nearly 4/5 of the respondents (79.3%) either singly or together with other methods. More than three in every five of the respondents (63%) cited the sharing of toothbrush as a possible mode of transmission while another 44.8% of the respondents claimed that HIV/AIDS could be transmitted through deep kissing. Slightly less than one tenth of the respondents (9.4%) mentioned that HIV/AIDS could be transmitted through mother to child either through breast-feeding or at birth while 27.6% quoted blood transfusion as a possible mode of transmission. Only two respondents (1.6%) claimed not know how HIV/AIDS is transmitted. Another two respondents (1.6%) said that AIDS could be transmitted through sharing food or utensils.

On prevention, most of the respondents (90.6%) believed that prevention was possible. Of those who saw prevention as possible 67.7% cited abstinence as a method of prevention either singly or in conjunction with other methods. Blood screening as a method of HIV/AIDS prevention was named by 18.9% while use of condom was mentioned by 29.2% of the respondents either independently or in addition to other measures. Some respondents (40.0%) cited sterilization of incision objects as a measure. A few of the respondents (3.1%) mentioned the use of personal items, while 0.8% maintained that quarantine of HIV/AIDS victims and avoidance of deep kissing each as possible prevention measures.

4.4 Description of Information

To get an understanding of information provided by youth peer educators for the purpose of description the researcher interviewed individual members and youth peer educators. The focus group discussions also addressed the issue. The information ranged from HIV/AIDS transmission and prevention, drugs, social life, adolescence and STDs.

4.4.1 Information on HIV/AIDS

The findings revealed that the youth peer educators gave youth information on HIV/AIDS transmission and prevention. Most of the respondents (70.9%) had received information on AIDS from the youth peer educators. The respondents pointed that they had been told that AIDS is transmitted through sexual intercourse, use of unsterilized incision objects, blood transfusion, from mother to child and deep kissing if the two had cuts or wounds on the lips. Sharing of toothbrush was uniquely identified as a possible avenue through which HIV could be transmitted.

Attempts were also made by youth peer educators to demystify HIV/AIDS transmission and prevention measures through dismissing the beliefs that AIDS could be transmitted through physical contact, sharing utensils and clothes.

Respondents pointed out that they had been encouraged to avoid casual sex, sex with many partners, to use condoms and to maintain one faithful partner. Interviews with youth peer educators revealed that they laid emphasis on abstinence from sex for both boy and girls.

The focus group discussions showed that youth peer educators tried to explain the origin of AIDS and it's impact on the community. Although youth peer educators emphasized abstinence, they could not ignore questions about the effectiveness of condoms in AIDS prevention. The educators explained that condoms could prevent pregnancy, AIDS, sexually transmitted diseases (STDs) but they were not 100% effective.

4.4.2 Other Types of Information

The study further wanted to establish other forms of information propagated by the youth peer educators. The findings are presented in Table 4.4 below.

Table 4.4: Other Forms of Information Disseminated by Youth Peer Educators Information

Information	No. of respondents	Percentage (%)
Drug	49	38.6
Adolescence	6	4.8
Drug & adolescence	4	3.1
STDs	5	3.9
STDs & drugs	11	8.7
Social life & drugs	7	5.5
Social life	4	3.1
N/A & Can't remember	41	32.3
Total	**127**	**100**

From the data in Table 4.4 one can infer that 55.9% of the respondents had received information on drugs either singly or in addition to other information. Some of the respondents (12.6%) had received information on STDs singly or in addition to other information. Another less than 10% of the respondents had received information on social life and adolescence singly or in addition to other information, (8.6%), and (7.9%) respectively.

On drugs, the respondents asserted that youth peer educators taught them about the harmful effects of drugs, like glue, bhang, cocaine, heroine and cigarettes. The educators encouraged those who had been hooked to drugs to withdraw their use. The educators also discouraged the intake of alcohol among the youth. One of the youth peer educators informed the researcher that when discussing about drugs with youth he normally cites cases of renown football players who have fallen from glory because of drug intake.

The (12.6%) respondents who confessed to have had information on STDs indicated that they had been taught the symptoms and effects of STDs like syphilis and gonorrhea. The cited effects of STDs were infertility and the health of unborn child if one became pregnant while still infected with STD. In response to question on the importance of information on STDs one respondent said that STDs were very common among the youth in the area. He further pointed that the information on STDs had helped him advice a friend who showed signs of STD. The participants of one focus group discussion argued that it was important to learn about STDs from educators because they were very common among the youth. Moreover, such information was hardly available elsewhere, for many parents were unwilling to provide the same.

Youth peer educators also taught the youth on reproduction. In this case issues like adolescence and abortion were addressed. In reference to adolescence the educators highlighted the bodily developmental changes that take place at puberty such as menstruation, development of breast for girls and broadening of shoulders, deep voices for boys. Also addressed were emotional changes, wet dreams and masturbation.

As shown in Table 4.4, some respondents had received information on social life (8.6%) either exclusively or inclusive of other information. The issues addressed in social life included relationships with parents, elderly, age-mates and boy-girl relationships. The youth peer educators also advised the youth on how to avoid crimes and encourage parents to stop being alcoholics. One youth peer educator claimed that social relationships were problematic in the area and many youth did not know how to relate with parents, elderly or even age-mates. It therefore, became a crucial area with an urgent need for attention.

4.4.3 When and How the Information was Passed

Through the focus group discussions with members and youth peer educators separately it became clear that group discussion was a popular tool in educating the youth. Probing the reasons for this, the educators claimed that through group discussions the youth were empowered to make informed decisions. Through group discussions the educators learnt from the participants and vice versa. Moreover, in group discussions youths were free to ask questions through which they learnt from each other. Other modes of disseminating information to youth included lectures, individual talks, puppet shows and dramas.

The researcher asked the respondents how often they received the information from the youth peer educators. A summary of the findings is presented in Table 4.5, below.

As shown in Table 4.4, some respondents had received information on social life (8.6%) either exclusively or inclusive of other information. The issues addressed in social life included relationships with parents, elderly, age-mates and boy-girl relationships. The youth peer educators also advised the youth on how to avoid crimes and encourage parents to stop being alcoholics. One youth peer educator claimed that social relationships were problematic in the area and many youth did not know how to relate with parents, elderly or even age-mates. It therefore, became a crucial area with an urgent need for attention.

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The researcher asked the respondents how often they received the information from the youth peer educators. A summary of the findings is presented in Table 4.5, below.

Table 4.5: Frequency of Information

When	No. of respondents	Percentage (%)
Once a week	59	46.4%
Anytime there's a match	32	25.2%
Once a month	15	11.8%
Don't Know	2	1.6%
N/A	19	15.0%
Total	**127**	**100**

Table 4.5 reveals that slightly less than half of the respondents (46.4%) received the information once a week while slightly more than one in every four respondents (25.2%) said that they received information anytime there was a match. Only two respondents (1.6%) did not know how often the information was provided.

It was established through focus group discussion the information was passed before the football match. This was further confirmed from discussions with youth peer educators, who confessed that they advocated for youth peer education before the matches since after matches many players dispersed to their homes.

It's clear that a majority of the youth preferred being taught by youth peer educators. They pointed that many parents failed to teach them supposing the teachers had taught them in school. One female participant scoffed at parents who failed to teach them on sexuality only to confront them when pregnant or infected with AIDS. She wished that parents could put off the mask and face the scourge of AIDS and the vulnerability of youth and teach them.

Some of the participants suggested that seminars be held to sensitize parents on youth vulnerability to AIDS and to teach them how to reach to the youth with information on sexuality and AIDS. Most participants were of the view that, it was the silence of parents that made them switch to age-mates for information, who misadvise them at times either for fun or because of ignorance.

On the other hand all key informants admitted that youth needed information on AIDS, and that this information should be given early enough before the onset of sexual activities. Noteworthy is their conflicting view on how the information should be given. Out of the ten key informants eight felt that anybody with relevant information could educate the youth. The two other informants (a community leader and religious leader) scoffed at the idea of youth peer education. In particular, the argument of the religious leader is worth noting for he argued that the youth in the area needed information on AIDS and sexuality. He observed that education on AIDS and sexuality should start as early as 8 years for some young people become sexually active before they were 10 years. He claimed youth peer education would provoke sexual activities among the youth. He was of the opinion that social workers should teach the youth for parents in the area were too busy to do so.

The participants of focus group discussions concurred with the key informants' view that education on sexuality should start early not only because of early onset of sexual activities among the youth but because once started it was hard to stop.

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4.5 Perception of Information

To determine the youth's perception of information obtained from youth peer educators questions relating to usefulness and practicability of information were asked. The results of the usefulness of the information are presented in Table 4.6 below.

Table 4.6: Usefulness of Information by Sex

Usefulness	**No. of respondents**	
	Male	**Female**
Very useful	66(75%)	30(78.9%)
Fairly useful	6(6.8%)	2(5.3%)
Not useful	2(2.3%)	0
Don't know	0	1(2.6%)
N/A	14(15.9%)	5(13.2%)
Total	**88(100%)**	**38(100%)**

From Table 4.6 above it is evident that a vast majority of the respondents from either gender found the information to be very useful, 75% of male respondents and 78.9% of female respondents. The two respondents who claimed that the information was not useful were male. They observed lack of behavioral change as the reason for their answer.

Those who said that the information was useful argued that the information had helped them abstain or maintain one partner. The later was quoted by 19.8% while the former was quoted by 41.3%. Other respondents 18.3% said that the information helped them become more cautious and self controlled.

The perceived important information obtained from youth peer educators is

presented in Table 4.7 below.

Table 4.7: Perceived Important Information Obtained from Youth Peer Educators

Information	No. respondents	Percentage
AIDS	56	44.4
Drugs	20	15.9
Social life	6	4.8
STDs	3	2.4
AIDS &Drugs	15	11.9
Reproduction & Drugs	1	0.8
Not applicable	24	19.0
Total	**126**	**100**

Table 4.7 above indicates that a vast majority of the respondents (72.2%) ranked information on drugs and AIDS as the most important information they had received from the youth peer educators. However, 19% of the respondents did not state the most important information either because they hadn't received any information from the youth peer educators or they had, but could not rank any as most important.

Further analysis based on the gender of respondents showed that over half of the girls 22 (57.9%) ranked AIDS information as the most important. Comparatively more male respondents (31.8%) ranked information on drugs as compared to 21% of the female respondents.

Concerning the practicability of information provided by youth peer educators, only two respondents (1.6%) indicated that the information was impractical. Some 17.3%

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Concerning the practicability of information provided by youth peer educators, only two respondents (1.6%) indicated that the information was impractical. Some 17.3%

and 62.7% of the respondents claimed that the information was fairly practical and very practical respectively. Those who claimed that the information was impractical noted that it was hard for boys to abstain from sex. Moreover, it was not possible to use condoms in every sexual encounter due to non-availability of finances and time to purchase or obtain condoms from health centers.

From the focus group discussions with the 'older boys' (boys above 16 years), it was evident that the information seemed relevant. But they seemed to see the information to be relevant to the 'younger boys' (boys below 16 years), who were less likely to have engaged in sexual activities. This was propounded by the belief that once they had engaged in sexual activity it was hard to abstain. On the other hand, the younger boys perceived the information to be relevant and would be useful in future. This view was echoed in a statement by one boy "Habari yenyewe ni nzuri na nitaitumia nikikuwa mkubwa " meaning that the information is good and I will use it when I grow up. Participants of the focus group discussions concurred on the importance of educating the youth on AIDS, drug abuse, STDs before they start engaging in sexual activities or drug intake for once started it was hard to stop.

The respondents were also asked to state their opinions on the usefulness of youth peer educators in providing information on condom use. The results are presented in Table 4.8 below.

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The respondents were also asked to state their opinions on the usefulness of youth peer educators in providing information on condom use. The results are presented in Table 4.8 below.

Table 4.8: Usefulness of the Youth Peer Educators in Providing Information on Condom Use.

Usefulness	No. of Respondents	
	Male	**Female**
Very useful	36 (40.5%)	24(63.2%)
Fairly useful	14 (15.7%)	5 (13.2%)
Not useful	16 (18%)	1 (2.6%)
Not applicable	19 (21.3%)	4 (10.5%)
Don't Know	4 (4.5%)	4 (10.5%)
Total	**89(100%)**	**38(100%)**

The results in Table 4.8 indicate that a majority of the respondents said that the youth peer educators were useful in providing information on condom use. In fact more than three-quarters of the female respondents quoted youth peer educators as useful in providing information compared 56.2% of the male counterparts. Moreover, male respondents accounted for a larger proportion of those who cited educators as not being useful in providing information on condom use (18% and 2.6% for male and female respectively).

When respondents were asked to state the most important information they had received from youth peer educators on condom use 20% of the respondents stated that condoms were not 100% safe. Slightly less than 45% stated prevention of pregnancy, STDs, and AIDS as the most important information they had received from youth peer educators.

4.6 Sexual Behavior

The research study attempted to establish the sexual behavior of the respondents to ascertain if information obtained from youth peer educators had brought positive changes in youth's sexual behavior. The results indicated that slightly more than half of the respondents (50.8%) had never indulged in sex before study. In reference to abstinence, girls accounted for 20.6% and boys for 30.2% of the respondents. Of the 47.6% who had had sexual intercourse before the study, the researcher sought to establish the age at first coital experience. Table 4.9 below shows the distribution of the respondent's age at first sexual intercourse.

Table 4.9: Respondents Distribution of Age at First Sexual Intercourse

Age	No. of respondents	
	Male	**Female**
Below 10 years	4 (8%)	1 (8.3%)
10-12 years	14 (28%	0
13-15 years	26 (52%)	8 (66.7%)
16-18 years	6 (12%)	3 (25%)
Total	**50(100%)**	**12(100%)**

The data in Table 4.9 indicates that a large proportion of male respondents (80%) had had sexual intercourse between 10-15 years of age while 91.7% of the female respondents had had their first sexual encounter between 13-18 years. Noteworthy is the fact that a majority of the respondents from either gender had had their first sexual encounter before they were 16 years.

Of those who had experienced sexual intercourse before the study, the researcher sought to establish the number of sexual partners involved since the onset of sexual activity. The highest recorded number of partners was nine while a majority had only

one partner. The study proceeded to inquire about the number of regular sexual partners the sexually active respondents engaged with at the time of the study. The notion that a boy could have several partners still holds. Some respondents observed that having several partners proved one a conqueror. One respondent reasoned that a boy should have several girlfriends from which to pick a future wife. On the other hand girls were said to maintain several boyfriends for monetary gains. The findings indicated an increase in the number of those abstaining from 52.4% to 74.6% while 20.5% sexually active respondents had only one regular partner at the time of the study.

A probe in to sexual behavior through focus group discussions revealed that boys preferred girls who had moved from the rural area in the very recent past. One respondent said "Wasichina wakutoka ushagu ndio wazuri kuwa vile hawaja zoea mtaa, wana weza kuwa waaminifu", meaning that girls who moved to the area from rural areas are better for they are not so conversant with urban lifestyle and are therefore likely to be faithful.

In order to establish a deeper insight into the reason for abstinence, the respondents were asked to state their reasons of being sexually inactive. The results are presented in Table 4.10 below.

Table 4.10: Respondents Reasons for Abstinence

Reason	No. respondents	Percentage
Avoid AIDS	41	32.5
Maintain virginity	3	2.4
Sin	9	7.2
No partner	2	1.6
Avoid pregnancy	4	3.2
Not beneficial	7	5.6
Guys look down on one after sex	2	1.6
Still young	19	15
Prevent STDs	2	1.6
Fear pregnancy and abandonment by guys	1	0.8
Not applicable	36	28.6
Total	**126**	**100**

Table 4.10 shows that 32.5% of the respondents abstained from sex to avoid AIDS infection while only 15.0% of the respondents felt they were too young to indulge in sexual activities. Although 99.2% of the respondents were of Christian and Islamic faiths (see Table 4.2) which prohibit sex before marriage, only 7.2% of the respondents abstained because of their religious faiths. The fear of pregnancy and abandonment by the male partner was an identified reason for abstinence among female respondents (4.0%).

4.6.1 Condom Use

To establish whether the sexually active respondents were using condoms questions pertaining to use and non-use were asked. A majority of the respondents (91.3%) had never used condoms. Slightly less than three fifths (57.5%) of the respondents quoted abstinence as their reason of non-use of condom. A few respondents (4.7%) did not have any reason for non-use while another 4.7% felt that they were too young to use condoms. Two male respondents (1.6%) claimed that condoms reduced sexual pleasure. Only one male respondent (0.8%) quoted partner refusal as the reason for non-use of condoms.

Moreover, to obtain a deeper insight into the issue of condoms use among the youth, the issue was addressed during the focus group discussions. Some of the participants argued that the youth liked "nyama kwa nyama" meaning flesh to flesh contact during the sexual intercourse. They revealed that youth equated the use of condoms with showering with clothes or sucking sweets in wrappers. One female participant claimed that guys often say "Mimi siwezi lala na mpira" meaning that he can not have sex while wearing a condom.

The focus group discussions revealed further that condoms were associated with prostitutes and as such many girls refused to be treated like prostitutes. To many, condom use was an indication of lack of trust and hence demanded usage was always treated with a lot of suspicion. Some participants felt that there was no need of using a condom if one had a faithful sexual partner. Some objected the promotion of condoms among youth claiming that it would increase sexual activities and weaken abstinence among the youth.

Although 62.2% perceived youth peer educators as being useful in providing information on condom use, only 20.5% saw them as being useful in distributing condoms among the youth.

4.6.2 Abstinence

To determine the youth's attitudes towards abstinence the researcher asked them whether they agreed to complete sexual abstinence by young people. Slightly less than 70% agreed strongly, 19.8% agreed while 11.2% disagreed. The respondents were asked to state the factors that made abstinence hard for young people. The results are presented in Table 4.11 below

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4.6.2 Abstinence

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Table 4.11: Factors Making Abstinence Hard for Youth

Factor	No. of respondents	Percentage
Influence of mass media	26	20.6
Influence of friends	24	19
Lack of money	6	4.8
Lack of self control	16	12.7
Influence of drugs/alcohol/friends	13	10.3
Lack of money,/friends, drugs/ alcohol	6	4.8
Media/lack of self control/drugs/alcohol	12	9.5
Influence of drugs and alcohol	8	6.3
Lack of self control/ money/ of friends	9	7.1
Don't know	6	4.8
Total	126	100

From the results in Table 4.11 one can deduce that 30.1% ranked mass media as a first factor constraining abstinence among youth. Mass media implied by respondents was largely the videos shown in most 'video kiosks' in the area. Respondents confided that pornographic video dubbed, as 'ponos' in the area are shown in these 'video kiosks'. A source reasoned the temptations of youth trying out what they have seen in the 'ponos' are very high.

Although 19.0% ranked the influence of friends first, 22.2% ranked it second. Deeper analysis showed that out of the total 62.8% respondents who cited the influence of friend only 12.7% of them were girls. A probe in to this confirmed that boys discuss sex-related issues with friends than girls.

Lack of self-control was quoted by 29.1% either independently or in addition to other factors. Specifically, 19.8% respondents who cited lack of self-control were boys. In total, lack of money was quoted by 16.7% of the respondents. The participants of focus group discussions felt that some girls engaged in sex for monetary gains. According to one key informant, the prevailing poverty made girls 'sell sex' to survive. It was observed that the cheap available sex increased youth's vulnerability to HIV/AIDS infections since some boys paid for the cheap service just to gain experience.

The influence of drugs and alcohol was cited by 30.9% either independently or in addition to other factors. Key informants observed that most traditional brews are processed in the area and sold locally or distributed to other slum areas. Interestingly, members of the family, including the youth often do the selling of the brew within the residential premises. This endangers girls in such households because they may resort to drinking the brew while the male customers lure others into sex. Two of the key informants narrated a case in which a family of 'chang'aa' (traditional brew) seller was wiped out by AIDS. In this particular case a mother died with her six daughters and her sister. The source speculated that these eight women contracted the virus from their male customers who played a double role as chang'aa and sex customers.

The price of traditional brew is relatively cheap, hence many people including the youth can afford it. One of the key informants linked the high intake of 'chang'aa' and traditional brews to high incidences of rape cases in the area. Quoting an incidence where he questioned a number of youth following a rape case the source was quoted as saying "that man always rape women after drinking. We will not be walking with him after a drinking spree".

The intake of drugs is common in the study area among the youth. Key informants revealed that the peer pressure, idleness and frustrations made many youth resort to drug intake. The most common drugs used by youth in the area included: bhang, miraa and glue. The use of such drugs constrained abstinence in that, once an individual was under the influence of drug he/she could hardly control his sexual urge or even utilized information on prevention.

When the respondents were asked to state whether youth peer educators were helping youth resolve the constraining factors, 80.2% said that youth educators were helpful. They pointed advice, video shows and workshops as ways and means through which the educators were helping them.

The results of pieces of advice the youth would give to other youths with respect to the information they had received from youth peer educators are presented in Table 4.12 below.

Table 4.12: Advice Youth Would Give to Other Youth

Advice	No. respondents	Percentage
Abstain	76	60.3
Use condoms	5	4
Maintain one partner	18	14.2
Avoid bad company	6	4.8
Abstain or use condoms	9	7.2
Go for blood test before sex	3	2.4
Abstain or maintain 1partner	7	5.6
Maintain 1 partner or use condoms	1	0.8
Don't know	1	0.8
Total	126	100

Table 4.12 above shows that a majority of the respondents (73.1%) would advice other young people to abstain from sex either singly or in addition to other advice. Some respondents (14.2%) would advice them to avoid many partners and maintain one sexual partner. Over one tenth of the respondents (12%) would advice them to use condoms. The male respondents were more likely to advice friends to keep one sexual partner as indicated by the results in which 16.9% of the male respondents suggested this advice as compared to 8.1% of the female respondents. All in all it was clear that the most prominent advice the youth were ready to offer to their peers was abstinence.

4.7 Constraints Encountered by Youth Peer Educators

The information on the constraints encountered by the youth peer educators was obtained through interviews and focus group discussions with youth peer educators.

The youth peer educators though not restricted to educating during matches found it convenient to do so. More specifically, this was done to group(s) players watching an on-going match. Unfortunately they were constrained by lack of concentration. The noise and whistles in a playing ground interfered with the attention of the listeners while educators were distracted.

Sometimes talking about AIDS involves talking about sex. Unfortunately, sex is still regarded by many as a private affair which, should not be discussed in public. It follows that some the educators felt embarrassed during or after facilitation. It therefore, required that those trained to be youth peer educators be fearless. At other instances some youth failed to participate in discussions for fear that people would mistake them for evil, while others felt embarrassed.

Some of the educators claimed that they lacked time to facilitate, as some couches did not allocate ample time for facilitation. This could be backed by claims of some respondents who had pointed earlier that youth peer educators did not finish facilitating to them on STDs. An interview with project officers revealed that some educators especially girls were constrained by time as they had to perform domestic chores as demanded by parents and at times this coincided with the time designated for facilitation. Noting that most families cannot afford house-helps they rely on their children's labour in-put especially girls. This implies girls have tight schedules in trying to fulfil the demanded household duties, peer education and training sessions.

Ignorance was a common problem encountered by the youth peer educators. The problem was more prevalent among the under 16/18. Many educators claimed that these boys were ignorant and argumentative. A possible explanation to their ignorance as identified by some educators was the fact that the educators were age-mates with presumably little to offer. Some of the educators said that the under 16/18 boys assumed that they knew what the educators were teaching them. One youth peer educator claimed that he could not bother to educate the under 16/18 boys as they would ignore him for he was their age-mate.

Some female youth peer educators complained that the under 16/18 boys enjoyed them which made them feel embarrassed and ashamed. One female youth peer educator claimed that she disliked facilitating to the under 16/18 boys because of their arguments. She said that they at times ask questions such as "How do you know? Have you tried?" It is worth noting that boys facilitating to girls of similar age category did not encounter a similar problem.

The project officers pointed out that people with little understanding opposed or enjoyed the facilitators. Some members accused the male educators for dating the female educators. Moreover, the educators were accused of preaching water but drinking wine. These mistrusts, misunderstandings and suspicion constrained youth peer education. However, the project officer further pointed out that the character of some few educators challenged the credibility of peer education. Though they carefully took into consideration the character traits of individuals before training them, there had been cases where trained youth educators had inhibited youth education through their undoing behavior. This challenge youth peer educators

whose work demands that they lead exemplary lives portraying what they taught.

The in-take of drugs and alcohol, which are rampart among slum dwellers, constrains youth peer education. One peer educator claimed that it was hard to facilitate to drug addicts as some were hostile and could easily harass the youth educators. Although MYSA discourages the intake of alcohol and drugs the choice of withdrawing was individual and gradual in most cases. This implied that there were drug addicts who continued to participate in MYSA activities. The most common drugs used by youth in the area include bhang, glue, and miraa.

The high rate of semi-illiteracy was identified as a constraint to youth peer education. One youth peer educator claimed that it was sometimes hard to communicate to some listeners because of their low level of understanding. This claim seemed to hold water since some of the respondents had not gone beyond primary school while others had no hope of doing so because of the prevailing poverty. Furthermore, one respondent who said that he had never gone to school suggested that the youth peer educators should use a language that was understood by all, considering that some were illiterate.

Youth peer education was also done on voluntary basis and most of the youth educators especially those out of school needed a means of livelihood. This could have explained the lack of motivation for some and partially account for the high rate of drop out among youth educators. Some dropped out and went to look for greener pastures.

A SUMMARY OF MAIN FINDINGS

The study reveals that: -

1. Youth peer educators provided the youth with information on HIV/AIDS, social life, adolescence, drug abuse and STDs.
2. Group discussion was the most popular tool of educating the youth.
3. The youth acknowledged their vulnerability and suggested that sex education be taught to young people before the on-set of sexual activities.
4. A vast majority of the respondents perceived the information to be useful, relevant and practical.
5. Information on drug abuse and HIV/AIDS was ranked as the most important information received from youth peer educators.
6. Information on HIV/AIDS had helped some of the respondents abstain or maintain one faithful partner.
7. A large proportion of the sexually experienced youth had their first sexual encounter before they were 16 years old. More boys engage in sexual encounter at an earlier age than girls.
8. Abstinence among the youth was seen as being possible.
9. Condom usage was very low among the respondents.
10. Pornographic videos shown in 'video kiosks' in the area constrained sexual abstinence among the youth in the area, so did influence of alcohol, drugs, and friends.
11. The youth peer educators were constrained by:

- Lack of time to perform their role.
- Ignorance of some youth.
- Embarrassment for sex is private, which should not be discussed in public.

- Illiteracy which made communicating information with some members hard.
- High rate of drop out due to lack of motivation as it is done on voluntary basis.
- Failure of some youth peer educators to live as role models.

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CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0. Introduction

This chapter discusses the major findings of the study. Discussions of distinct assumptions are done separately, with conclusions and recommendations also made.

5.1. Description of Information

The study findings revealed that a majority of the respondents (83.5%) had received information from youth peer educators while the remaining (16.5%) had not received any information from youth peer educators. This could be attributed to absenteeism during facilitation or the duration in which one has been a member. Those who had received information cited AIDS transmission and prevention measures as part of information they had received. However, some few respondents still held misguided information on HIV/AIDS transmission and prevention. This could be attributed to forgetfulness and the desire by some to cite as many methods as possible. The study findings reveal a need for the continuity of peer education to cater for the 16.5% respondents who had not received any information and 5.5% who had forgotten. Moreover, there was need to provide accurate information HIV/AIDS transmission, and prevention measures to those who still held misguided information on the disease.

Some of the respondents seemed to have recognized that sex is the predominate mode of HIV/AIDS transmission as slightly more than 4/5 of the respondents quoted this mode of transmission. This concurs with studies by Cabrera, (1996), GOK,

many sexual partners exposed them to HIV/AIDS infection. The information on relationships is likely to help youth achieve self-esteem which, many youth seek through relationship with the opposite sex rendering them vulnerable to HIV infection.

It was evident that many youth had received information on AIDS, STDs, social relationships, reproduction and drugs but there is need for continuity to cater for youth, that have forgotten and the new members who keep joining the organization. Moreover, there are some respondents who still held misguided information on AIDS transmission and prevention while others were not sure whether prevention was possible.

From the study findings it became clear that the youth peer educators played a crucial role by providing their peers with information on HIV/AIDS, STDs, social life drug abuse, and adolescence. The fore-stated information is pertinent in HIV/AIDS prevention and control among young people. The assumption that youth peer educators educated their peers on reproductive health related issues was confirmed.

5.2. Perception of Information

As stated earlier most of the respondents (75%, 78.9%, male female respectively) felt that the information they had received from youth peer educators was very important. Some respondents cited information on AIDS as the most important information they had received from youth peer educators (see Table 4.7). It was expected that if the information provided by the youth peer educators was useful the sexual behavior of the youth was bound to change. In this respect 41.3% respondents claimed that the information had helped them abstain while another 19.8% had been able to maintain one faithful partner and 18.3% respondents had

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become more cautious and self controlled.

The information seemed to have zeroed in individual's vulnerability as revealed through the focus group discussions. Indeed one respondent claimed that he was not vulnerable because he was taking the necessary precautions by using condoms. To counter the incidents of breakage this particular respondent claimed that he used five condoms in every sexual encounter.

During focus group discussions the majority of the participants argued that the information was relevant to the youth. They cited the failure of parents to teach them issues on HIV/AIDS and sexuality as a reason for the relevance of the information. Many parents in the area cannot be trusted to teach the youth on sexuality because their credibility is doubtful. As pointed out by Mutie (1996) some parents disqualified themselves from their role as educators on sexuality issues because of their behavior while others failed, feeling that they did measure up because of their socio-economic status. Mutie (1996) further observes that many single mothers and commercial sex workers took their clients home exposing their children to promiscuity early and thus lose their legitimacy to instruct chastity to their children. Moreover, some parents as pointed by participants of focus group discussions were illiterate with little to offer on AIDS while others felt inadequate to teach their children as they thought that they were not ideal role models.

Some of the respondents claimed that although teachers were an alternative source of information even as quoted by 11.8% of the respondents they were inadequate. Kioli (1996) asserts that teachers were untrustworthy in sex education for some were notorious in making sexual advances to their female students. As stated in another

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study by Kamau in 1996, some respondents claimed that some teachers shied away from teaching topics related to sex. The fact that sex education is yet to be incorporated in the school syllabi further alienates teachers from discussing sex issues with the youth. In the present study participants of focus group discussions claimed that youth did not feel free to ask questions to teachers the way they would ask the youth peer educators for fear of intimidation.

As pointed earlier the information was seen as being very relevant and more so to the younger boys and girls. One respondent said it was important to teach the younger boys "kama hawaja onja" that is before they start engaging in sex because once started it was hard to stop. However, the younger boys felt that the education was relevant and more useful to them in future. One respondent said "Nitatumia habari hio nikisha kuwa mkubwa" meaning he will utilize the information when he grows up. This could be explained by the belief held by many youth that they are unique and invulnerable a characteristic of most youth (Moore and Rosenthal, 1995). Following such a belief is the unchanged behavior that depicts their thought of insusceptibility.

Mutie (1996) points out that if information on AIDS is to be acted upon it must be seen as practical. The study revealed that 80% of the respondents perceived the content of information as being practical of which 62.7 % and 17.3% as very practical and fairly practical respectively. Only a minute percentage (0.8%) did not see the information as practical. Those who felt that the information was not practical pointed out that boys could not stay without sex. This could be attributed to the socialization process which seem to encourage or reward boys for sexual activities (Njau, 1993). The double standard applied according to gender expects girls to abstain while boys

are encouraged to exhibit male prowess (Moore and Rosenthal, 1995; Tuju, 1996).

Although a majority of the respondents (80%) felt that the information was practical this could not compare to the 32% who were abstaining because of the information. But this could be explained by the fact that although youth peer educators advocated for complete abstinence they encouraged those who couldn't abstain to maintain one faithful sexual partner or use of condoms. Despite the fact that most of the youth saw the information as very practical there were other factors that worked against the practicability of the information such as lack of money, lack of self control, influence of drugs and alcohol.

Only slightly less than one quarter (22.4%) were satisfied with what was taught while the rest registered a desire for more information on AIDS, STDs, social life, reproduction and how to cope with peer pressure. As revealed through the focus group discussions the youth felt that youth peer educators were addressing their needs and concerns, through education and thus helping them make informed personal decisions. Nzioka (1996) argues that AIDS awareness fails when lay beliefs and traditional values of the target population are not addressed. As revealed by the findings the content of the information focussed on the lay beliefs and values of the target group. In addition Muturi and Nzyuko (1988) attributed failure of AIDS campaigns to confront individuals with concrete evidence and consequences of the disease.

Unlike in a study by Kamau in 1996 where the respondents saw youth's vulnerability as far fetched, the youth in the present study recognized their vulnerability. The present study records changes in behavior as some pointed that they had reduced

the number of partners while others had become more cautious in relationships to avoid infection. In addition, their suggestion that sex education be given to youth's as early as nine years, before they started engaging in sexual activities, points to their understanding of youth's vulnerability to HIV/AIDS infection. This seem to suggest that the youth engaged themselves in sexual actives due to lack of timely information on sexuality a view that concurs with that of William et al (1997a,b).

Based on the findings on an investigation into member's perception of information disseminated by educators the author concludes that the information was perceived to be relevant, useful and practical by a vast majority of young people. In fact the assumption that member's perception determined adoption was proved right.

5.3. Sexual Behavior

The findings of the study revealed that 49.2% had had sexual intercourse before the study. However, when asked to state current number of regular sexual partners the vast majority (74%) respondents were abstaining while one fifth of respondents (20.5%) had one sexual partner. Since youth peer educators advocate for abstinence and keeping one faithful sexual partner the increase of the number of those abstaining, could partly be attributed to the information.

Although a vast majority of the respondents (90%) were drawn from Christian and Islamic backgrounds which prohibit sex before marriage only 5.6% of respondents abstained because of their religious faiths. However, some acknowledged the importance of religion as one respondent stated "It is hard for youth to abstain from sex completely but those who are deeply religious can make it". Other respondents pointed that youth should be taught religious topics or saw the solution to youth's

vulnerability to HIV/AIDS as being 'born again'.

Some respondents (15.1%) felt that they were too young to engage in sexual activities and yet other respondents started engaging in sexual activities at a similar age or even earlier. This seem to suggest that some link sex with adulthood and maturity. Some of the youth seemed to back the adults' notion that youth are too young to engage in sexual activities a fact that made many reluctant to teach youth about AIDS (Kamau, 1996).

Other studies indicated that abstinence among the youth was a virtue too hard to maintain Kamau (1996) and Kioli (1996) that many were unwilling to abstain Suda (1993), but the current study revealed that most of the respondents (74%) were sexually inactive. As pointed by Moore and Rosenthal (1995) the major drawback to youth reproductive health education has been the notion that youth cannot abstain from sex. This can be attributed to sex revolution of the 19th Century that seem to logically assert that with the rising age at marriage youth could not be expected to abstain from sex till marriage. However, given timely information on how to abstain and a supporting environment the youth can abstain from sex. Interestingly, the study findings show that a vast majority of the youth would advice their peers to abstain from sex till marriage. This suggests a readiness of youth to abstain.

Boys are seen to be the prime actors in sexual advances, as a result lack of self-control was highly associated with them. It is no wonder then that the few who doubted the practicability of the information observed that "boys cannot abstain'. Likewise more boys were likely to be influenced by friends against abstinence. This finding is in line with a by study Kioli of 1996 which showed that boys discussed

matters related to sex with friends unlike girls. In comparison, the total number of boys who had had sexual encounter was higher than female respondents at all age categories. Eggleston et al (1999) explains that boys are likely to over-report their sexual experience while girls under-reported their experiences because of the prevailing social norms regarding sexual activities for each gender. It follows that the respondents in the current study may have followed their gender orientations.

The number of sexual partners in ones lifetime can be equated with probability of STD infection irrespective of whether one was mutually monogamous at the time or not. Moreover, it was likely that the youth would break relationships with current partners. This points to the vulnerability of these youth since many are reluctant to seek life histories of their sexual partners. Many of the relationships were resting on hope and belief that the partner was HIV negative and faithful for few had gone through the HIV blood test.

5.3.1 Condom Use

Most of the respondents (90%) had never used condoms even though only 10% had not received any information on the use of condom. Compared to the number of sexually active respondents and in addition to those who had had sex before the study this was a very small proportion. The reasons for non-use of condoms included; not engaging in sex, lack of adequate knowledge on how to use condoms, were too young to use, partner's refusal and the fact that condoms were not 100% safe. The reasons presented are in line with other studies on the use of condom, which reveal that condoms use is yet to be socially acceptable by many youth (Kamau, 1996; Mwendwa, 1997;Nzioka, 1994).

The lack of adequate know how on condom usage could be explained by the fact educators largely emphasized youth's sexual abstinence and only addressed condom use as peripheral issue to those who could not abstain or maintain one sexual partner. Furthermore, youth seem trapped by the fear that promoting condom use will increase sexual activities among the youth. The fear of accelerated moral decadence among the youth due to condom promotion as recorded elsewhere (Roper et al, (1993), and more so as cited by some youth in the study is undeniable.

Contrary to common assumption that it is male partners who refuse condom use, the study findings reveals that female partners do refuse condom usage. Noteworthy is the gender specificity in the reasons given for non-use, while male partners cite the reduction sexual pleasure female partners equate demanded use as being treated as prostitutes.

The concept of efficacy and effectiveness of condom was also quoted as a deterring factor in condom use. On the other hand, the notion by some that were too young to use condoms cannot be ignored. Specifically, this group felt that they could not get their sizes as condoms are designed for adults.

The cited low condom usage needs redress. The fact that only 20.5% of the respondents indicated that youth peer educators as being useful in distributing condoms could partially account for the low condom use among the youth. Hein (1993) suggests that condom use would only increase substantially if condoms are actively promoted and made easily available to the youth. Participant of focus group discussions confided that if condoms were distributed by youth peer educators more youth would use them. This is because some condom users/ potential users ranked

embarrassment while asking from shopkeepers/ health workers and lack of money as constraints encountered in their attempts to use condoms.

The findings reveals a need for increased education on the use of condoms as 8.7% of the respondents did not know how to use condoms and one tenth of the respondents (10%) had not received any information on condoms use. Similarly even as pointed out in the focus group discussions some ineffectiveness of the condoms could be attributed to lack of adequate knowledge on how to use condoms.

Conclusively youth peer education has had some positive influence on youth's sexual behavior. There was an increase in the number of youth abstaining from sex and a reduction of sexual partners by the sexually active youth. However, the number of sexually active youth using condoms continues to be low.

5.4. Constraints Encountered by the Youth Peer Educators.

Ignorance from the peer is a major constraint encountered by the youth peer educators especially from the older boys. This observation is in line with Henry (1997) documentation of problems encountered by youth peer educators in Ethiopia. It is hard to convince some youth of their vulnerability so that they can take the information seriously. Consequently, those who fail to see themselves as vulnerable ignore the youth peer education. This is compounded by the notion that "it cannot happen to me" a factor that breeds ignorance (Rosenthal and Moore 1993)

From the study it becomes clear that although many preferred being taught about AIDS by youth peer educators they yearned for education based on experience, respect and authority which is minimal in peer educators. Questions such as 'How

do you know? Have you tried?' justify this observation. Furthermore, some educators claimed that they could never facilitate to their age-mates for many peers dismissed the youth peer educators saying "They are age-mates what can they tell us?"

The youth peer education in the present study was constrained by the behavior of some youth peer educators who failed to maintain the standards they taught. As pointed by Mutie (1996) and Williams (1996) the channel of communicating information geared towards behavioral change must be considered trustworthy and exemplary. This explains why the behavior of some youth peer educators constrained youth peer education.

Lack of time is a constraint identified by educators in the present study. This is in line with a report on youth peer education by Williams (1996). However, in the present study lack of time is attributed to time allocation and the fact that peer education is not replacement but an additional task.

There were incidences where respondents seemed to be fed up with AIDS information, which prompted ignorance. Youth peer educators seem to view their work as mere presentation of information on AIDS. But there is need to recognize that the needs of the targeted audience are changing. Hence youth peer educators need to be sensitive to the changing needs and introduce new methods of conveying the information.

In addition, the youth peer educators and respondents acknowledged the need of introducing new methods of disseminating information to avert boredom, ignorance

and disinterest. This points to the evolution of youth peer education from mere dissemination to creating a supporting environment for changing sexual behavior.

From the foregoing discussion of there is no doubt that these constraints act as impediment to the effectiveness of youth peer education in Mathare.

SUMMARY

1. The youth peer educators played a major role in educating youth on HIV/AIDS, STDs, social life, drug abuse and adolescence.
2. Parents and teachers played a minor role in providing information on HIV/AIDS to the youth.
3. On the relevance of information the older boys (boys aged 16 and above years) felt that information was more relevant to the boys aged below 16 years while the latter felt that the information was applicable latter in life.
4. The double standards based on gender propagated through socialization process and which encourage sexual activity among boys are yet to be overthrown, since those who stated that the information was fairly practical or impractical argued that boys could not stay without sex.
5. Given timely information and a supporting environment the youth can abstain from sex.
6. The reasons for non-use of condoms was in line with studies done elsewhere and suggests that condoms are yet to be socially accepted among the youth.
7. The fear that the promotion of condom would increase promiscuity among the youth may have hindered active condoms distribution and consequently their use among the youth.
8. Role modeling is important in education and as such those educating the youth ought to be trust-worth and exemplary.
9. Some of the constraints encountered by youth peer educators are gender specific and a result of different socialization process.

Conclusion

Following the data obtained from the study, the author concludes that the youth peer educators have been playing a key role in educating the youth on HIV/AIDS, STDs, social life and reproductive health. However, since some of the youth have not received any information, youth peer education should continue. More information is required on STDs for only 12.6% of the respondents had received education on the STDs, yet they are very common among the youth. The fact that there were some respondents with misguided information on HIV/AIDS transmission and prevention points to the dire need for continuity youth peer education.

The information was perceived to be relevant, useful and practical by most of the youth in the study. To some the information had helped them reduce the number of partners or abstain. The timing of the education is imperative, most of the participants of focus group discussions and key informants felt that education on sex related issues should be provided to youth before the on-set of sexual activities. It is important to also note that, even though most of the youth preferred youth peer educators to teachers and parents they not only did so because the latter had failed to educate them but also because they (youth peer educators) covered the topic freely and factually.

Condom usage as a strategic prevention measure is yet to be marketed as confirmed by the low condom usage among the youth. This is attributed to the fact that condoms are not socially accepted by many youth. Moreover, fear that aggressive condom promotion will increase promiscuity haunts the program.

The ignorance by some youth of peer educators indicates the role of respect, trust,

experience and authority in education. There exists gender specific constraints with some experienced more by a particular gender. Youth peer education only compliments other avenues designed towards educating youth on reproductive health and other related issues but not replace them.

Recommendations

From the findings of the study the author makes the following recommendations.

1. Information on how to cope with peer pressure should be provided by the youth peer educators. This is because although only one respondent indicated a desire for information on how to cope with peer pressure, more than 40% of the respondents cited the influence of friends as an obstacle to youth's abstinence from sex.

2. More information on STDs is needed since only 12.6% had received information on STDs from youth peer educators. Moreover, even those who had received information on STDs were only familiar with two types of STDs (syphilis and gonorrhea) yet there are many other STDs.

2. The youth peer education should continue since 16.5% of the respondents had not received any information from the youth peer educators. Furthermore, some of respondents still held misguided information on HIV/AIDS transmission and prevention while others had forgotten.

3. New methods of educating young people should be incorporated to make youth peer education more appealing, counter disinterest and ignorance among them. Moreover, youth peer education should focus on gender roles

in sexual relationships and expectations that expose either gender to sexual activities.

4. Youth peer educators need to evolve from being mere disseminators of information or from basically creating awareness to supporting behavioral change among the youth. Distribution of condoms to young people by youth peer educators to make them readily available may promote condom use among them.

5. Information on how to negotiate safer sex with partners and how to use condoms should be provided to the youth. This will cater for those who failed to use condoms due to lack of know how.

6. The youth peer educators should encourage voluntary HIV testing among youth. This is because maintaining a faithful partner, as HIV prevention measure is only effective when HIV status are established.

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APPENDIX I

QUESTIONNAIRE

1. Age _____ years

2. Sex (1) Male (2) Female

3. Religion (1) Catholic (2) Protestant (3) Muslim

(4) Any other specify _____

4. Are you in school? 1) Yes 2) No

5. If yes what level? (1)Primary (2) Secondary (3) Post secondary (4) Any other specify _____

6. If No at what level did you stop? _____

7. Are you a resident of Mathare Valley? (1) Yes (2) No

9. Which team do you play for? _____

10. How long have you been a member of Mathare Youth Sports Association? (1) Less than an Year (2) Between 1-2 Years

(3) Between 2-3 Years (4) 3 Years and above

AWARENESS

11. Where did you learn about HIV/AIDS? (1) Through the radio/TV

(2) From youth peer educators (3) Print media

(4) Parents (5) Teachers (6) Any other specify

12. How is AIDS transmitted? Name all the methods you know?_____

_____

13. Do you think AIDS can be prevented? (1)Yes (2) No

14. If Yes how?

TYPE OF INFORMATION

15. Do you know of any peer educator in your team? (1)Yes (2) No

16. Have you ever received any information on AIDS prevention from the peer educators (1)Yes (2) No

17. If Yes **Q16** what did the youth peer educator say? Explain briefly

_____

18. Apart from AIDS prevention measures what other information do the youth peer educators provide? Explain

19. How often do you hear the youth peer educators give information? (1)Once a week (2) Once a month (3) Any other specify

PERCEPTION OT THE INFORMATION

20. How useful is the information you obtain from the peer educator(s)?(1) Very useful (2) Fairly useful (3) Not useful

21.If very useful what important message have you received from the youth peer educators so far? Explain.

22. In what ways has this information helped you in resolving sexual issues?

23. If not useful **Q20,** in what ways is it not useful?

24. How practical is the information you have received from the peer educators?

(1) Very practical (2) Fairly practical (3) Not practical

25. If it is impractical **Q24** in what ways is it not practical?

26. What information would you prefer the youth peer educators provided that is not covered presently?

SEXUAL BEHAVIOR

27. Have you ever had sex? (1)Yes (2) No

If **Yes** at what age did you have the first sexual intercourse?

(1) Between 10-12 (2) Between 13-15 (3) Between 16-20

(4) 19 and above

28. If **yes** above how many sexual partners have you had from the time you became sexually active?_____

How many do you have currently? _____

29. Currently are you abstaining from sex? (1)Yes (2) No

If Yes when and why did you decide you to abstain?

30. How often do you use condoms? (1) Always (2) Sometimes

(3) Never

31. Explain your answer Q30

_____

32. If your answer is always or sometimes, where do you obtain the condoms? (1) Buy from the shop (2) From MYSA office

(3) From friends (4) Any other specify _____

33. Where did you obtain information on how to use a condom?

(1) youth peer educators (2) From friends'

(3) Read the instructions on the condoms packet

(4) Any other _____

34. How useful are the youth peer educators in providing information about condom use? (1) Very useful (2) Fairly useful (3) Not useful

35. If very useful Q34 what important message, have you received from the youth peer educators?

36. How useful are youth peer educators in providing condoms to the members of Association? (1) Very useful (2) Fairly useful (3) Not useful

37. If very useful Q36 when did you last obtain condoms from youth peer educators?

_____

38. What constraints do you encounter in obtaining condoms?

If more than one factor rank them in order of importance.

1. Embarrassment while asking from the health workers
2. Harassment from health care workers
3. Fear that parents will know your sexual activities
4. Lack of money to purchase.
5. Embarrassment while buying from the shops or kiosks
6. Any other specify _____

39. Do you think the peer educators are helping you resolve the above? (1) Yes (2) No. If yes how explain. _____

_____

40. Young people should abstain from sex to avoid HIV/AIDS infection. (1) Agree (2) Agree strongly (3) Disagree (4) Disagree strongly

41. Which one of the following makes it very hard for the young people to abstain from sex? If more than one factor rank them in order of importance.

(1) Influence from mass media (2) Influence from friends

(3) Lack of money (4) Influence of drugs and alcohol

(5) any other specify _____

42. Do you think youth peer educators are helping the youth overcome this factor(s) Q41? (1)Yes (2) No

43. If yes how?

_____

44. With the information you have received from the peer educators what advice would you give to other youth concerning sexual relationships?

APPENDIX II

INTERVIEW GUIDE

1. Do you think AIDS is a problem in this area? Explain your answer.
2. Which age group is more susceptible to AIDS and how do you account for this observation?
3. In your view do you think it is the lack of information on sexuality issues and AIDS prevention measures that make the youth vulnerable to AIDS infection? Explain
4. Which people are more appropriate to provide information on AIDS prevention measures to the young people and why?
5. What message should be provided to the youth on prevention and how should it be provided?
6. What should be the criteria of choosing a youth peer educator? Do you think the type of peer educators determine the youth's adoption of the message provided? Explain.
7. Do you think youth peer educators equip the youth with relevant information? Explain.
8. In your view do you think the young people have changed their sexual behavior as a result of peer education? Explain.
9. What difficulties are the youth peer educators likely to encounter in this area? How can these problems be resolved?
10. What are some of the risky behavior patterns prevalent in this area?

APPENDIX III

THEME FOR FOCUS GROUP DISCUSSION

1. Groups vulnerable to HIV/AIDS infection and reasons for their vulnerability

2. Youth's sources of information on HIV/AIDS.

3. Types of information provided by youth peer educators.

4. Method by youth peer educators while facilitating peer education

5. The perceived relevance of youth peer education

6. Youth's perception of condom use and constraints encountered

7. Sexual behavior change and problems faced by young people in their attempts to change their sexual behavior.

APPENDIX IV

THEMES FOR FOCUS GROUP DISCUSSION (YOUTH PEER EDUCATORS)

1. Source of their training and materials.

2. Relevance of youth peer education.

3. Methods of educating their peer.

4. The types of information they provide.

5. Reactions of their recipients and the methods used in facilitating.

6. The constraints they encountered in youth peer educators.

7 What being youth peer educator demands