# UNIVERSITY OF NAIROBI

TOPIC:

YOUNG PEOPLES' PERCEPTIONS OF PEER EDUCATION AS A COMMUNICATION STRATEGY FOR PREVENTION OF HIV/AIDS: THE CASE OF GOAL KENYA'S PEER EDUCATION PROGRAMME IN MUKURU SLUMS, NAIROBI.

By

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A Research Project submitted to the School of Journalism in partial fulfillment of the requirement for the award of Master of Arts in Communication Studies degree of the University of Nairobi

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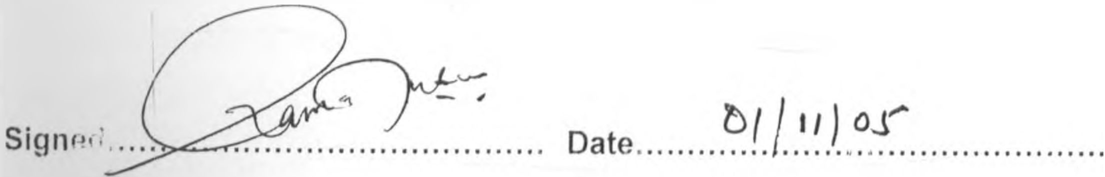
# DECLARATION

I, Justus A. Olielo, do hereby declare that this thesis is my original work and has not been submitted for consideration of award of any degree at any other university.

Signed.................................................................. Date ..............................

This Thesis has been submitted for examination with my approval as University Supervisor



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# DEDICATION

This work is dedicated to God Almighty who makes all things possible and to Moses and Daisy, my two children who urged me on.

## ACKNOWLEDGEMENTS

This work would not have been possible without the tireless efforts, encouragement and guidance of my teacher and mentor, Mr. Kamau Mubuu. To him I owe much thanks and gratitude.

I would also like to thank my good friend Margaret, for making the time and effort to organize the logistics of field work and mobilizing the young people to participate in the study and for bouncing ideas that shaped the concept for this study.

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Last but not least, I would like to thank my classmates, lecturers and staff at the School of Journalism for making SOJ a rich marketplace of ideas. In this regard I would like to thank Moses for all his support.

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## ABSTRACT

Key words: *perceptions, HIV/AIDS, peer education, young people*

This study examined perceptions of young people on peer education as a communication strategy for the prevention and control of HIV/AIDS with specific reference to GOAL Kenya's peer education projects in Mukuru slums of Nairobi. Current trends on HIV/AIDS prevention and control programming indicate that peer education has become an integral part of interventions that focus on young people. However little has been done with regard to how young people perceive peer education and peer educators, and ultimately little is known about how perception impact on effectiveness of peer education. The study therefore set to determine how young people perceive peer educators and peer education in the prevention and control of HIV/AIDS and to determine how young people's perception impact of GOAL Kenya's Peer Education Project on HIV/AIDS prevention and control among young people in Mukuru slums, Nairobi. The study also sought to establish the views of young people on required improvements/modifications that would make peer education strategy more responsive to their needs in prevention and control of HIV/AIDS.

The sampling frame were young people aged 14-24 years (51% male and 49% female,) residing within Mukuru slums and also participating in the

GOAL Kenya peer education project Primary data was collected through actual field visits using structured interview questionnaires, observations and focus group discussions (FGDs). The field study was carried out between October 24th-30th, 2005. The questionnaire was administered to 60 young people living in and working around Mukuru and who are direct beneficiaries of GOAL Kenya 's peer education project. Three focus groups (of ten participants each) were also held to probe for more details and gain more in-depth understanding of the situation.

Findings indicate peer education strategy provides important sources of information on HIV/AIDS especially on preventing HIV infections and how to support relatives and friends to cope with the pandemic. However, the depth of knowledge of peer educators, accuracy of content and diversity of information is limiting the effectiveness. Peer educators occupy a slightly elevated social status from their peers due to their role. It was nevertheless observed that not all peer educators live up to expectations with some engaging in risky behaviours themselves, such as drug and alcohol abuse and multiple sex partners.

The study recommends more comprehensive training to embrace new and emerging issues and reflect greater diversity in the issues affecting young people. It also calls for greater accountability by peer educators in the conduct of their work while at the same time urging peer education sponsors to be better involved in peer education work in the community.

The study also recommends a few follow up researches to be conducted in order to have a more comprehensive view of peer education in Mukuru.

Other recommendations also include better coordination between the young people, peer educators, the community and the sponsoring agency, GOAL.

# CHAPTER ONE

## 1.1 Introductory background

This study sought to examine the perceptions of young people on peer education as a communication strategy for the prevention and control of HIV/AIDS with specific reference to GOAL Kenya's peer education initiatives in Mukuru slums of Nairobi. Current trends in respect to HIV/AIDS prevention and control programming indicate that peer education has become an integral part of interventions focusing on young people. Evaluation studies that have been carried out demonstrate that indeed, peer education is an effective strategy in attaining tangible results in regard to behaviour change among young people. It is therefore very important that such a strategy is continuously reviewed and improved.

It seems however, that such evaluation studies have largely ignored the views of young people in terms of assessing their perceptions and views on peer education and peer educators in order to provide a sound basis for improvement of the strategy. Consequently, the views of young people have not been integrated into subsequent programming of peer education as a communication strategy, loosing out on the benefits that such views would contribute to enhance the strategy that aims at addressing the plight of young people. A study to fathom into young peoples' perceptions on peer education in general and, peer educators in particular by soliciting their views would suffice to enhance the basis

Existing evaluation studies of youth peer education programmes for HIV/AIDS interventions does show that it is not only an effective social and behaviour transformation strategy, it is also effective social mobilization strategy for working with young people. Indeed the increasing popularity of peer education has seen greater global efforts to further understand and improve both its processes and impact in HIV/AIDS prevention, care and support. For example, an AIDSCAP/FHI evaluation of twenty-one peer education projects in Africa, Asia and Latin America sort to "examine peer education strategies in AIDSCAP supported projects and clarify their definition and scope and describe factors that are essential to their sustainability". The study concluded that the effectiveness of peer education depended on the ability of peer education projects to "broaden their base to include related health issues" and the need for "ongoing and active follow-up and clearly understood role and expectations of peer educators". A similar study supported by World Health Organization(WHO), designed to "assist those working with young people to understand the basis and experience of peer approaches", concluded that peer education projects need to "ensure young people are active participants in project planning and implementation and that peer education projects need to provide continuous technical support to peer educators in addition to complimenting peer education with other approaches such as using mass and small media. A quantitative evaluation of effectiveness of peer health education in Cameroon showed increased use of modern contraceptive methods and increased condom use at most recent sexual act

among participants in a peer education programme than those reported among young people who were not involved in peer education efforts. Another evaluation of the West African Youth Initiative (WAYI) in Ghana showed that peer education significantly increased the percentage of youth self reporting condom use and other modern contraceptives by nine percent (9%) from 47% to 56%.

In what was perhaps one of the earliest hints that young people do not always take information given by their peers as the unqualified truth, a study evaluating the effectiveness of peer education in Zambia observed that young people often felt the "need to verify the information given by peer education with "expert" knowledge". The study assessed the effectiveness of peer activities including level of awareness of HIV/AIDS, accuracy of information provided to ensure realistic individual perceptions of risks and appropriateness of peer strategies to promote behaviour change. However, the findings were significantly similar on many other levels to the ones reviewed above: peer education was effective within a context of mutually supportive activities including provision of services like counselling, testing condoms etc.

## 1.2 Statement of the Problem

It is generally acknowledged that to large extent, the key to preventing and controlling the spread of HIV/AIDS depends on how individuals perceive the intervention programmes that target the pandemic. One of the latest UNAIDS report aptly demonstrates this fact by acknowledging that "people who perceive themselves as having the power and ability to act, are more likely to take

preventive measures than those who feel powerless to do so". Studies carried out in Ghana and Kenya indicate that young people who believe their peers are using condoms are also more likely to use condoms themselves compared to teens who don't believe their peers use condom.

A report of focus group discussions carried out by UNICEF in Malawi, indicated that 15-20 year olds, when asked what they thought they would be doing in five years time, unanimously agreed that most of them would perhaps "all be dead due to HIV/AIDS".

Perceptions are basically shaped by the individuals' beliefs, knowledge and attitudes in the context of the environment in which they live. It is therefore, critical that young people's perceptions be as consistent and in synch with the programmes that are designed to empower them against HIV/AIDS.

The high rate of infections among young people reflects their vulnerability and high risk profile that is consistent with their sexual and reproductive health behaviours associated with the transmission of HIV/AIDS. Such behaviours include unprotected/casual sex, multiple sex partners, unwanted pregnancies, early child bearing, and conformity with certain cultural and social norms. It is therefore, imperative that their perceptions on interventions that target them in respect to HIV/AIDS are reflected upon and improved accordingly to make them more effective. Peer education programmes fall under this category of interventions.

Despite the conclusions many previous studies concluding and making the recommendations that peer education should involve young people's participation in the design , planning and implementation of peer education programmes, as a necessary ingredient of peer education, the views of young people is hardly evident, neither in the evaluation studies nor in the actual implementation of peer education projects.

In many instances, study methods have relied on key informants usually in the form of staff from government and non governmental organizations, community opinion leaders, and youth leaders of peer education projects as the primary source of information in assessing effectiveness. The perceptions of young people in the process that target them, is largely ignored. The focus on quality of information has largely been limited to assessing peer educator's ability to remember basic facts about HIV and AIDS including how HIV is transmitted and how it is not, signs and ]\symptoms and basic prevention methods reduced to its bare minimum of abstinence, be faithful or use a condom (ABC) matrix.

Evaluation studies have also recommended better capacity building efforts of peer educators including better training, motivational factors like provision of allowances and improved logistical support (like provision of bicycles) etc, in order to enable them better meet project objectives. However non of the studies reviewed have attempted to examine the interaction between peer educators and their peers, and most importantly, young people's perceptions of peer education

programmes, that are designed to address their HIV/AIDS information and service needs

On the basis of the aforesaid, this study seeks to illuminate how perceptions of young people may have influenced peer education processes and outcomes in regard to HIV/AIDS prevention and control among them. It focuses specifically on their perception of peer educators and the peer education process and how these determine how seriously they take the information and services offered and how this impact on their ability and willingness to take preventive and other relevant action against HIV/AIDS.

The study was guided by the following questions:

- How do young people perceive peer education and peer educators as a communication strategy that is aimed at preventing and controlling HIV/AIDS?
- What are the views of young people on improvements/modifications that require to be effected to make peer education programmes more effective in prevention and control of HIV/AIDS in Kenya?
- What is the impact of GOAL Kenya's Peer Education Project in HIV/AIDS prevention and control among young people in Mukuru slums, Nairobi;
- On the basis of the findings thereof, what measures should be taken to enhance peer education as a communication strategy, make it more effective in prevention and control of HIV/AIDS?

It is hoped that this study will not only give suggestions on how to improve peer education as a strategy in prevention and control of HIV/AIDS among young people, but also a basis for further research in interpersonal communication processes to improve planning and implementation of peer education programmes.

## 1.3 Objectives of the study

### *1.3.1 Overall Objective*

The overall objective of this study was to examine how young people perceive peer educators and peer education as a communication strategy for educating young people on HIV/AIDS prevention in Kenya using the example of GOAL Kenya's peer education project in Mukuru Slums, Nairobi

### *1.3.2 Specific Objectives*

The specific objectives of the study were to:

- Determine how young people perceive peer educators and peer education in the prevention and control of HIV/AIDS with specific reference to GOAL Kenya's peer education project in Mukuru;
- Determine young people's perception of the impact of GOAL Kenya's Peer Education Project on HIV/AIDS prevention and control among young people in Mukuru slums, Nairobi;

- Establish the views of young people on required improvements/modifications that would make GOAL Kenya's peer education strategy more effective in prevention and control of HIV/AIDS; and
- On the basis of the findings thereof, suggest the measures should be taken to enhance GOAL Kenya's Peer Education Project a more effective communication strategy in prevention and control of HIV/AIDS

### 1.4 Study Assumptions

The study was guided by the following assumptions:

- That young peoples' perceptions of GOAL Kenya's peer educators have not been considered in the evaluation of the peer education strategy. Consequently, their views have not been incorporated in subsequent implementation activities that aims at preventing and controlling HIV/AIDS. This applies to other similar intervention programmes countrywide;
- That any negative views young people hold on GOAL Kenya's peer educators impact negatively on their willingness to act on information and services offered by peer educators, thus compromising their ability to adopt safer practices and behaviour for HIV/AIDS prevention, care and control.
- That the impact of GOAL Kenya's peer education project on HIV/AIDS prevention and control among young people in Mukuru slums has not

been comprehensively determined in the absence of considering their perceptions on the project and especially peer educators.

### 1.5 Rationale/ Justification of the Study

The face of HIV/AIDS is getting "younger' by the day as more and more young people increasingly become vulnerable to the pandemic. Greater emphasis therefore has been focused on interventions that directly address the needs of young people. UNICEF and UNAIDS for example, have placed "primary prevention of HIV/AIDS infections among young people" as a key component of their mid term strategic plan (MTSP) priorities. Peer education is one such strategy that is being used to reach out directly to young people and help them adopt safer, healthier lifestyles.

Because of its strategic position in the fight against HIV/AIDS, peer education has gained in prominence in recent years. As illustrated above, many studies have been carried out to evaluate its effectiveness and how to improve it (e.g. the AIDSCAP/FHI study and the West African Youth Initiative Study). These studies have largely focused on outcomes, such as number of young people using condoms as a consequence of peer education.

This study attempted to make contribution to the body of knowledge on how young people's perception of peer education processes and on peer educators themselves, influence their adoption of safer practices to prevent and control HIV/AIDS infections.

The findings are expected to provide insights on perception of young people on the role of peer education in reinforcing accurate and consistent information about HIV/AIDS, and on how peer education and peer educators can be improved to enable young people better and more efficient access to necessary services such as condoms and voluntary counselling and testing. The findings could help better inform and guide agencies involved in provision of youth friendly services.

The study is also expected to provide some insight into the design of subsequent peer education projects, including why it is important to and how to involve the views of young people in planning and implementing peer based projects for HIV/AIDS. This could provide further basis for a review of or enactment of new policies on youth and HIV/AIDS interventions in Kenya.

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Lastly, the study is expected to shed some light on the views of young people on monitoring and evaluating peer based interventions, especially with regard to their views factors and indicators of an effective peer education project.

## 1.6 Definition of Key Terms

### 1.6.1 Peer Education

A peer is described as a similar other, peers are persons who share common characteristics on the basis of shared experiences, profession, age, gender, culture etc. Peer education is the skilled use of peer relationships to help individuals or groups cope more effectively with a given situation by sharing information, exploring feelings, behaviour and options in order to better interpret and understand the situation, so as to make appropriate decisions and take action. Peer education is viewed as reaching out through social networks on the basis of like –to like and shared experiences. Peer programs embrace a youth development concept that provides young people with the knowledge, skills, and experience necessary to become responsible, caring, contributing citizens.

Peer programs prepare young people with ongoing formal and informal training and supervision to provide a variety of school and community-based helping and support services. These services can include peer and cross-age academic tutoring, HIV/AIDS prevention education, personal support, conflict resolution, and mentoring. In the context of HIV/AIDS, youth peer education is the training and use of young people in the skills of peer education to offer information, education and communication support to their peers in order to enable them cope with the challenges of HIV/AIDS prevention. Among the most notable of these challenges include the need to assess and understand personal risks, how

to take preventive action to protect self and others, where to obtain services related to prevention including condoms and counselling and testing, personal choices and responsibility in sexual matters especially when and where these appear to be in conflict with dominant and normative group behaviours and beliefs, etc.

### *1.6.3 Perception of young people*

#### *1.6.3.1 Young people*

The World Health Organization's (WHO) definition of young people as those in the age group 10–24 years. However, for purposes of this study, the terms, young people and youth(s) have been used interchangeably to refer to persons between 14-24 years. While age has been used as the criteria for definition, the study takes cognizance of the fact that young people are not a homogeneous group; their lives vary enormously by age, sex, marital status, class, region and cultural context and that HIV and AIDS does not affect them in a similar manner. As noted by the Population Council, the tendency to homogenize the experiences of young people "neglects the great diversity that exists across regions and in terms of school, work and marital status, social environment"

#### **1.6.3.2 Perception of young people**

The new Encyclopedia Britannica defines perception as "the process whereby sensory stimulation is translated into organized experience...that experience being the joint product of the stimulation and of the process itself". Young

people's perception refers to the sum effect of what they young people hear, see and do inform their attitudes, views and behaviours.

In the context of this study youth perceptions refer to the views and attitudes of young people on peer education and peer educators, based on their observations and interactions with the process and outcome of peer education.

# CHAPTER TWO

## LITERATURE REVIEW AND THEORETICAL FRAMEWORK

### 2.1 Introduction

This study should be viewed in the context of previous and present communication scholarship and global trends in the field of HIV/AIDS interventions. The reviewed literature on the prevalence and magnitude of the HIV/AIDS pandemic on global and national scales, has been done with specific reference to the young people of Mukuru in Nairobi. Various theoretical frameworks have also been reviewed to assess how peer education fits into interpersonal communication studies. Peer education strategy is looked into in the context of existing communication interventions in Kenya on HIV/AIDS prevention, care and support among young people .

### 2.2 HIV/AIDS and young people: A global overview

HIV/AIDS has become a disease of the young. Globally an estimated 7.3 million young women are living with HIV/AIDS compared to 4.5 million young men. Sub-Saharan Africa is the region of the world that is most affected by HIV & AIDS where an estimated 25.4 million people are living with HIV and approximately 3.1 million new infections occurred in 2004. In 2004 the epidemic has claimed the lives of an estimated 2.3 million people in this region. Around 2 million children under 15 are living with HIV and more than twelve million children have been orphaned by AIDS. Two thirds of newly infected youth aged 15-19 in sub-

Saharan Africa are female. Among women, the peak age for HIV prevalence tends to be around age 25, 10 to 15 years younger than the peak age for men.

Young people are at an age when they feel least vulnerable to anything and less to a problem with no immediate, observable consequences as HIV/AIDS. They tend to underestimate, downplay or deny their own risk to HIV infection. Case studies by the World Health Organization (WHO) indicate that only between one fifth and one third consider themselves at personal risk. Many young people do not recognize that their partner's behaviour also puts them at risk. Still others may perceive HIV as something that happens to other people (not themselves) especially those who display behaviours traditionally considered non–normative, like sex workers, drug users or men who have sex with other men. A feeling of invincibility, combined with the lack of psycho-social life skills, makes young people much more vulnerable to HIV infection and may make them less likely to take precautions to protect themselves. Young people's desire to express intimacy, physical closeness and commitment is in direct conflict with their fear of contagion and the need for self preservation presented by HIV/AIDS epidemic, the implications are many fold.

According to the United Nations Population Fund (UNFPA), young adults in the 15-24 age bracket account for slightly over 50% of the world's approximately 5 million new cases of HIV infection each year. UNAIDS, the (The United Nations joint programme on AIDS), estimate that nearly six thousand (6,000) young people get infected with HIV/AIDS everyday, —one every 14 seconds, the

majority of them young women. At the end of 2001, an estimated 11.8 million young people aged 15-24 were living with HIV/AIDS, one third of the global total of people living with HIV/AIDS. Only a small percentage of these young people know they are HIV-positive.

## 2.3 HIV/AIDS and young people: The situation in Kenya

Young people are in the frontline of the HIV/AIDS crisis in Kenya. They are not only the most vulnerable, they also form the bulk of HIV/AIDS casualties with over 50% of all new infections in Kenya today being of young people below 25 years.

The Ministry of Education estimate that 20% of all secondary school students are HIV-positive while the Kenya Demographic and Health Survey estimate that 80% of Kenyan adolescents between 15-19 years do not perceive themselves to be at high risk of contracting HIV/AIDS while 70% still engage in high risk sexual behavior.

A national survey of the demographic distribution of HIV/AIDS infections by age and gender conducted by NASCOP indicate that peak ages of HIV/AIDS infections are 25-29 for females and 30-33 for males but young women of ages 15-19 are the most vulnerable group with their chances of infection being six times more likely than males in the same age group.

According to NASCOP, the major constraints that hinder faster and firmer control of AIDS in Kenya is the slow pace of change in sexual behavior, cultural practices, resource limitations including general poverty among the population and lack of clear policy framework to guide intervention efforts.

The high rate of infections among young people reflect their vulnerability and high risk profile consistent with sexual and reproductive health behaviors associated with the transmission of HIV/AIDS including unprotected /casual sex, multiple sex partners, unwanted pregnancies, early child bearing, conformity with certain cultural and social norms. Among some of the underlying and basic causes of teenage sexuality problems include experimentation, peer pressure, poverty and ignorance.

A United Nations Children's Fund (UNICEF) study in 2001 showed that many young people in Kenya lack psycho –social life skills and competency necessary for effective behaviour development that would enable them effectively protect themselves against HIV infections. These include lack of self esteem, self-awareness, assertiveness, coping with emotions, making effective decisions including risk assessment, critical thinking, negotiation skills and resisting peer pressure.

A number of interventions and strategies have been put in place to try and stem the tide of HIV infections among the young people. Among the most promising and consistent is youth peer education. All over the world peer education is

gaining prominence as a preferred strategy in addressing complex developmental, professional as well as psycho-social needs of individuals, communities as well as corporate enterprises.

## 2.4 An Overview of some peer based communication interventions in Kenya

It has been pointed out that the main sources of information, education and communication among young people are their peers, the popular media including music, radio, and the visual media especially TV, video, and the performing arts. However, what young people see and hear from these sources is often misleading, incomplete or distorted. For example, casual sex and having multiple sex partners is often depicted as fashionable and risk free on popular TV programmes in Kenya today *(The Bold and the Beautiful, Sex in the City, le Revancha, Camilla, 7th Heaven* etc*)*. When these images are constantly repositioned and reinforced, they have the cumulative effect of appearing to validate and present as true, what in reality could be more harmful to the impressionable youth. It is important that focus be maintained on these same sources to inform, educate and communicate with young people to enable them have correct assessment and perception of their risk and vulnerability to HIV/AIDS and to enable them to relate to that risk in a direct way that would ultimately lead to preventive action.

Quite a few attempts have been made to use television a medium for engaging with young people around HIV/AIDS, sexual reproductive health issues. Most recently, the Population Service International (PSI) has effectively used television to promote behaviour change among young people through its social "*Kunywa Zaidi, Teleza Zaidi*" ("the more you drink, the deeper you sink") campaign. The series of television spots graphically demonstrates the link between irresponsible alcohol taking (a popular pop culture among young people) and irresponsible sexual behaviour. PSI has also used television spots to promote condom use through its social marketing strategy that has also contributed towards breaking the conspiracy of around sexuality and young people. Other notable attempts include "*Keep it Real*" a TV talk show produced by Ukweli Video Productions with young people as participants, asking and answering questions around and about HIV/AIDS. The series was shown on both Kenya Broadcasting Corporation (KBC) and Kenya Television Network (KTN) channels in the 2002-2003 but has since phased out.

The radio has also been extensively used with young people. The most noteworthy radio program targeting young people with HIV/AIDS messages has been the *Youth Variety Show.* This is a Family Planning Association of Kenya managed and UNFPA funded youth radio program and broadcast by KBC (KBC) English Service every Saturday at 10:00 am. The program has employed interactive and participatory radio techniques such as call-ins, interviews, studio audiences, subject experts and radio listening groups to solicit views and answer

questions from young people. The program has also established listening centers/sites in which trained youth coordinators mobilize young people both in rural and urban areas to listen to the program, facilitate discussions and help clarify issues raised and, when a topic is not adequately covered, encourage write back to the program director with their views and concerns. Other radio programmes include the UNICEF produced 13 part radio drama that poses and invites young people to discuss possible different scenarios that put them at risk of HIV infection and how to overcome them. The series has been broadcast repeatedly on both KBC English and Kiswahili services since 1999.

Video documentaries and full-fledged films have also been produced and or broadcast to help HIV/AIDS prevention care and support among young people. Earlier ones tended to explore the personal histories and testimonials of young people who had been infected. These include *Life at Stake-the story of Lydia Wangechi*, or Uganda's *Born in Africa – the story of Philly Lutaya*. Others include, *The Young Faces of AIDS, It is Not Easy, The silent Epidemic, Brave Response* or full fledged films like *Everyone's Child, Yellow Card* and the *Sara Communication Animated series.*

Mass circulation newspapers have also been used to try and reach the youth with HIV/AIDS messages with "*The Nation*" and the "*East African Standard*" taking a leading role. *The Nation Group* has *Young Nation, Buzz and Straight Talk* (produced by Kenya Association of Professional Counsellors) while

Standard Newspapers has *Society, Life and Pulse* devoted to covering pertinent issues related to young people including HIV/AIDS. *Straight Talk's* strategy of encouraging write backs and profiling of individual youth experiences have encouraged lively debates and exchange of experiences among young people and professionals about the subject of HIV/AIDS prevention, care and control.

Posters, brochures, flyers, flip charts, comic strips, stickers among other items have been popularized over the last few years as information, education and communication (IEC) materials and have been used extensively in HIV/AIDS awareness raising and prevention campaigns. IEC materials are often distributed and or placed in strategic places where they are supposedly likely to be seen by most of the people. However in practice most of them hardly get distributed beyond urban and peri-urban areas and even then, one is most likely place to find them in offices, and health facilities, shops and other commercial structures. This already makes them inaccessible to a large number of people who have no business in the said premises. Even within the premises, posters have the tendency of being pasted on the inside of windows, doors walls etc, ostensibly to keep them safe from the elements. However, this means that fewer (young) people get to see and read them as they are accessible only during official business hours. Many IEC materials are produced in standard English and then occasionally translated into local languages without much thought for the local idioms, low literacy levels and cultural sensitivities. A good example is the Program for Appropriate Technology (PATH) produced wall-chart, *Signs and*

*symptoms of STDs* which have been translated into Luo, Kisii and Kuria languages. Most translations have been derided as uncouth and insensitive to local culture of talking about sex and sexuality. This trend seem to be changing with FPAK's *"Tuliza boli uwanja mdogo"* (literally, control the ball, the field is small) posters that used the language of football to encourage safer sexual practices among the youth. Centers for Disease Control (CDC) and PSI have taken up this trend with the *Chukua Control* (take control of your life) billboards and flyers.

Folk media is another popular communication channel widely used by development agencies to target young people with HIV/AIDS messages. The term is used loosely to describe many forms of the ad hoc and formal theatre performances like drama, skits role plays, songs, dance and puppetry. Its popularity is in part due to its flexibility in adapting to local realities but also because of its effectiveness as a social mobilization tool bringing in different target groups for experience sharing, materials distribution and service delivery including condom distribution. It is estimated that every sub location in Kenya has at least one group engaged in one form of in folk media activity around HIV/AIDS or another. Among the better known folk media practitioners in Kenya include Artnet Productions, Betta Theatrix (Nairobi) Misango Arts Ensemble (Kisumu), Kizingo Youth Group (Mombasa)

The effectiveness of folk media lies in the chosen art form's ability to show how characters make choices and decisions on situations and the challenges they face and how this choices and decisions affect their lives generally and in relation to HIV/AIDS in particular, for better or for worse. Audiences, with or without help from facilitators, are encouraged to draw their own their own conclusions on what decisions to make and set of behaviors to adopt.

For young people, with a heavy dislike for preachy messages and short attention spun, theatre has the added advantage of an active and interactive media as they can not only join an on going performance (drama, song, skit etc), they can also enact their own experiences through role plays, skits etc.

However a few constraints have been noted that hamper the effective use of folk media as a communication strategy for HIV/AIDS interventions with young people. These include the fact that folk media pieces , especially drama, skits and role plays, tend to follow predictable story lines with the "bad" characters often depicted as ignorant, undesirables or social misfits who engage in obviously risky behaviours (multiple sex partners, non use of condoms etc) despite several warnings, information or counselling sessions from the enlightened others. Their tragic and sad end is almost always a foregone conclusion. The "good" characters, usually in the form of peer educators and counselors, are often depicted as benevolent, messiah- like figures out to help "the sinners"- those who engage in multiple or casual sex without condoms, the

poor or the ignorant, thus reinforcing (sometimes inadvertently,) the notion that HIV/AIDS only infect the "bad" people.

The "change or perish" theme, seem to be a dominant characteristic of the content of many of the messages and is perhaps one of the most significant draw backs to the effectiveness of communication strategies targeting young people. Fear of HIV/AIDS has also been used extensively IEC materials targeting young people, often in the mistaken belief that by presenting the grimier, gory effects of HIV/AIDS, they would be too scared to engage in risky behavior such as unprotected sex, drug abuse, injections and cultural practices. Messages of doom including images of death and graves, sorrow and deprivation are all too often associated with anti HIV/AIDS campaigns on TV, radio, newspaper articles, posters and within folk media storylines. Yet, it is now generally acknowledged that fear based messages never really had an impact in changing people's risk perceptions and subsequent behavior as it can easily "lead to complacency and indifference as people respond to frightening messages by laughing them off and denying them".

Although most HIV/AIDS messages and materials have been produced with varying objectives and to address different communication needs, their production and subsequent distribution is often not followed up by any significant attempts at dissemination and engagement with young people, especially with regard to facilitating discussions around the issues raised and with opportunities

where young people can give their interpretation of the messages and how they fit with their own reality. They have been considered largely ineffective due to their failure to recognize the "powerful influence of the psycho- social context in which high risk behaviour occurs". Many of the HIV/AIDS messages intended for young people often tend to be generic, top down, moralistic and prescriptive. For example there is a large body of materials focusing on the "Say No" theme with emphasis on sexual abstinence (e.g. *"Say no to sex", "say no to sex before marriage", say no to casual sex", "say no to sex without condoms-stand up for your life", "smart girls say no to casual sex" etc).* These messages have also failed to take into account the peculiarities of individual young people and the social and environmental circumstances in which young people live and have to make decisions in.

For example, an adolescent boy living in an environment in which having more than one girl friend, or not using condom is perceived as referent group norm may have little inclination or motivation to the message of abstinence. Similarly, a young girl in love and under pressure to express intimacy and commitment inevitably finds that the message of abstinence is in direct conflict with her perceived psycho - social needs. In the same breadth, young girl who depends on selling sex for survival finds conflict in the message of abstinence with her need for self-survival.

## 2.5 Peer Education in the context of interpersonal communication

UNICEF's Eastern and Southern Africa (ESAR) HIV/AIDS Network meeting in 1997, observed that " ...interpersonal communication (IPC) actually 'makes or breaks' progress in HIV/AIDS programming... and is one of the most difficult to improve in our programmes". At a minimum, interpersonal communication is the use of face to face interaction to inform, discuss and get spontaneous feedback. It allows for direct interaction among and between audiences giving them the opportunity to ask questions, encourage information giving and sharing and foster learning by acknowledging what young people know, the beliefs they hold and what they still need to know or do in order to adopt safer, healthier behaviors and to make those adopted behaviours part of their daily living norms. Interpersonal communication skills are cross cutting and have wide and direct relevance and application to HIV/AIDS and youth interventions including in workshop training and seminars, counseling, home visits, facilitation, peer focus group discussions etc. Interpersonal communication for HIV/AIDS interventions usually takes the form of adult to youth, youth to adult, child to child, and peer to peer education and interactions. The effectiveness of peer education therefore depends to a large extent on the ability of practitioners to develop and deploy a

nuanced understanding of the social-cultural context in which peer education takes place.

## 2.6 Theoretical foundations of Peer Education

Researchers argue and many concede that peer education is a "method in search of a theory rather than a practice a rising out of a scientific theory" . Available literature does seem to suggest it is better to view peer education as an evolving science grounded in communication persuasion theories. Among the more relevant theories include Albert Bandura's Social Learning theory, and Everett Rogers diffusion of innovation theory.

Social learning theory focuses on the significance of observing and modeling the behaviors, attitudes, and emotional reactions of others. In Bandura's own words, *"learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action."*. Social learning theory explains how human beings acquire behaviour patterns in a series of interactions between cognitive, behavioral, an environmental influences, but particularly by observing others. Similarly peer education seems to suggest that young people who live under similar environment tend to behave

in a similar manner, adopting and modifying their behaviour through modeling with their peers.

On the hand, Rogers' Diffusion of Innovation theory suggests that there will always be innovators who come up with or adopt new behaviours or ideas and that these ideas eventually get communicated and adopted over time among members of a social system through a trickle down effect. Four main elements of the diffusion of innovation system include the innovation itself, the idea or behaviour to be adopted, the communication channel through which the innovation is diffused, the time it takes including in making decisions to adopt the innovation and the social systems and environment under which the innovation is to be realized.

In the case of peer education, the structures seem to reaffirm peer educators as both innovators and channels of communication, at once bringing the idea of HIV/AIDS prevention messages to their peers while at the same time adopting the behaviours themselves, thus becoming the innovators.

However, it is the Social Network Theory that seems to appropriately underpin peer education for HIV/AIDS processes. Social Network defines and provides rationale for people who are in contact with each other and over which issues. In the context of HIV/AIDS, the theory suggests that youth who believe that their friends are taking measures to protect themselves from HIV/AIDS are also more likely to take preventive action themselves. The theory asserts that young people place different importance on members of the social network depending on the

issues being addressed and how well they think it is being addressed. The ability of an individual network member to cope effectively with a particular issue is a significant factor on how seriously the others would take his or her actions and suggestions towards addressing the issue. The size, closeness and demographic composition of a young person's peer network affect his or her overall effectiveness and ability to cope. Generally, peer educators tend to reach people similar to themselves especially with respect to gender, age, education, marital status, religion and ethnicity. To reach specific populations and to effectively address their issues through peer education, it is imperative that recruitment of peer educators be from the same target groups. These characteristics seem to have been adopted as the minimum standard principles in peer education among the institutions and organizations currently involved in youth peer education and counseling activities in Kenya. These include GOAL Kenya, Kenyatta University's Peer Counseling and Education Program (K.U. Peer), University of Nairobi's ICSA, Egerton, Maseno, Moi and United States International University peer education and counseling programs. Others include Mathare Youth Sports Association in Nairobi, The Fish Group in Kisumu, The Kenya Society for People with AIDS (KESPA), FPAK's Mombasa Youth Counseling Center, Anglican Church sponsored Eastleigh youth Center in Nairobi, Nyawita peer counseling center in Kisumu, The Teenage Mothers and Girls Association of Kenya (TEMAK) in Kisumu, Catholic Diocese of Kitui supported Youth Program, Kitui, Homa Bay youth Group, among others. International agencies supporting peer

education programmes include Family Health International (FHI) and PATH through the IMPACT project*

## 2.7 GOAL Kenya peer education programme

GOAL is an international non-governmental development, rehabilitation and emergency relief organization. The organization is non-denominational and non political. Resources are targeted towards the poorest and most vulnerable members of society, primarily in the developing world. GOAL believes that every human being has the right to the fundamentals of life, i.e. food, water, shelter, medical attention and literacy.

GOAL became operational in Kenya in 1992 when a project office was established to coordinate a variety of development initiatives in Kenya, and also to act as a base for emergency work around the Horn of Africa. GOAL started addressing the needs of street and vulnerable children with the establishment of a drop-in centre in 1995 close to the city centre of Nairobi.

In April 2000 this became the HIV/AIDS Education Project (HASEP), in response to HIV/AIDS epidemic amongst street and slum youth.

This has developed into the Programme of Support for Children and Youth in Difficult Circumstances, which comprises five projects, including HASEP. The other projects are: a Community Children's Education Centre (CCEC), Vocational

Skills Training Centre (VSTC); a Rescue Centre and a Mobile Health Clinic. The Programme has been designed so that all projects are mutually supportive and work towards a common GOAL

The main thrust of GOAL's HIV/AIDS interventions in Kenya is the Action Through Capacity Building (ABC) Programme, which addresses the prevention and care needs of GOAL Kenya staff and the HIV/AIDS Education Project (HASEP). HASEP is currently working with children and youth in slum communities of Mukuru, Korogocho and Dandora, three GOAL centers and four Government Street Families Rehabilitation Centers and four other Government rehabilitation institutions for children and youth, all in the greater Nairobi area.

HASEP tackles HIV/AIDS, STIs and reproductive health issues with street and slum children and youth to ensure that this group has access to their fundamental human rights, in particular healthcare and education. Since its inception, the Project has evolved from doing general HIV/AIDS awareness work with street children, to a much more comprehensive intervention, centered on empowering young people with relevant psycho-social life skills to make their own decisions, and reaching not only street children but a broad range of beneficiaries on the streets, in the slums and in various Government institutions.

Street and slum children and youth are amongst the least empowered to make informed decisions about sexual and reproductive health issues such as:

abstinence; safe sex practices; and accessing treatment, all factors which play a major role in the spread of HIV/AIDS. The project pays particular attention to the plight of girls, who are the most vulnerable and abused of the group, with specific activities to ensure that these girls are not only reached but retained as beneficiaries.

HASEP's implementation strategy consists of three main components namely the Peer Educator's training with the objective of providing needed psycho-social support including HIV/AIDS related information, education and communication, to other young people in their respective communities and institutions. The GOAL is mitigate the spread and impact of HIV/AIDS through positive attitude and behaviour change among children and young people. So far (May, 2005), GOAL has trained about 330 (three hundred and thirty) peer educators. The other is the Peer Support through individual engagement and participatory behaviour change education activities, undertaken by the Project team and peer educators. They conduct 8,948 (3,844 female) individual contact sessions per month, based on the current project figures of 1,925 (807 female) per week. The last component is the home-based care and support for people living with HIV/AIDS including the training and support to eighty (45 female) volunteer community caregivers.

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Among the main activities undertaken by peer educators include providing HIV/AIDS information, education and communication to young people in the project area, including basic facts about HIV and AIDS, how to avoid infection,

risk avoidance and coping with peer pressure, provision of services like condoms and referrals for specialized services like voluntary counselling and testing (VCT), treatment of opportunistic infections, peer support etc.

Monitoring and evaluation of peer education activities is done through weekly reporting including number of contacts, topics discussed, services provided, number and type of referrals for specialized services. Monthly review meetings and quarterly monitoring and evaluation meetings are carried out for quality assurance and to deal with emerging issues.

In findings consistent with the social learning theory, GOAL has found out that the effectiveness of the peer education programme lie in the fact that slum children and youth have established their own sub culture and referent group norms and behaviours, including in their language and styles of communication, which makes it hard for "outsiders" to penetrate and understand. Peer educators, recruited and trained from among the youth population, not only understand the dominant norms and phraseology of the youth, they are also able to find the best possible options for imparting skills and information to the youth around them. They therefore appeal effectively to the minds and hearts of the other young people.

Structurally, peer educators are recruited from among members of organised youth groups that expect feedback on what the individual has learnt, is doing and

planning to do. This places a level of responsibility on the peer educator who is expected to be accountable to his members. This way, GOAL is more assured of closer monitoring and supervision of peer education activities.

Among the notable impacts and achievements of the peer education programme since its implementation is the increased knowledge base around HIV/AIDS and improved psycho-social life skills to articulate sexual and reproductive health issues, including negotiating for and adopting safer sexual behaviours. The project has also observed a significant increase in the demand for HIV/AIDS prevention, care and support services including condoms and requests for VCT services, especially from the slum peer educators and other young people in the community.

# CHAPTER THREE

# METHODOLOGY

### 3.1.1 Site selection and site description

Mukuru Slums is located in Nairobi's industrial heartland to the South of the city. It's a sprawling informal settlement currently composed of seven main villages namely; Fuata Nyayo, Maruguini, Kisii/Hazina, Kayaaba, Reuben, Kwa Njenga and Lunga Lunga. Other smaller ones are Kabirira, Shimo, Commercial, Balozi, Kingstone and Sinai. It is bordered on the upper northern side by the Mater Hospital and on the far south by Outering road. The polluted Ngong' river runs right through it. It covers approximately 200 hectares and is home to an estimated 625000 people (1999 national census) with a density of 15753 per hectare, holding about 85,000 households. It is ranked the third largest slum in Kenya after Kibera and Mathare.

Family sizes are on the average about 6 per household living mostly iron sheet shacks built in plots of 8-10 households measuring 10×10 feet squared (without ventilation) that serves as cooking and sleeping area. Many adult men find casual employment in industrial area, while most women are involved in petty trades like hawking food, vegetables or domestic work in neighbouring middle class estates, such as South B, C and Hazina. The area is served by two clinics operated by welfare organizations. A number of these agencies also run primary education facilities in the slums. However, the area lacks a secondary school or vocational training centers.

Many young people lack post primary education and are thus unemployed. Idling is a favorite past time for most with the resultant use and abuse of drugs and alcohol. Use of local (illicit) brews like *"kumikumi"* and drugs like marijuana and inhalants are common among the young people. Crime rates are generally low but increasing.

Among the issues considered to be of concern to the young people in regard to HIV/AIDS are prevention, care and control , teenage pregnancy and teenage motherhood, disaster managements especially in regards to fires and floods, post primary education, lack of recreation facilities for young people, unemployment and community organization. It is estimated that there are over one hundred welfare agencies working to uplift the standards of life in Mukuru. The better known among these include Mukuru Promotion center, GOAL Kenya, DKA Support office, Feed the Children Centre, Hope International, Missionaries of Africa, Association of the Disabled People of Kenya, Children of Mukuru, Sisters of Mercy, White Fathers, Undugu Society and Salvation Army.

### *3.1.2 Sample design and sampling procedures*

The sampling frame for this study were young people of both genders aged 14-24 years residing within Mukuru slums and also participating in the GOAL Kenya peer education project. The sample size was determined in a way that ensured representation, and validity of data collected. Some of the criteria for sample

selection were gender, familiarity with and participation in the peer education project activities, age, and level of education. Eligible respondents were randomly selected using the lottery method.

### 3.1.3 Sources of data and data collection methods

#### 3.1.3. Sources of data

This study utilized both secondary and primary sources. Secondary pertinent data on peer education programmes in terms of magnitude of HIV/AIDS, theories and perceptions of young peoples in regard to HIV/AIDS prevention and control will be reviewed extensively from textbooks, periodicals, journals and other written materials. Other sources will include situation analysis reports and evaluations from the UN and other research and development agencies and related publications to ascertain consistency with international trends.

### 3.1.4 Data collection methods

Primary data was collected through actual field visits using structured interviews, observations and focus group discussions (FGDs). The field study was carried out between October 24th-30th , 2005. The questionnaire was administered to 60 young people living in and working around Mukuru and who are direct beneficiaries of GOAL Kenya 's peer education project. 53 questionnaires returned complete with 51%male and 49% female respondents. Three focus groups (of ten participants each) were also held to probe for more details and enable us gain more in-depth understanding of the situation. The recruitment was

done with the help of GOAL Kenya trained peer educators who were requested to identify at least five of their peers they have educated or who live near them, as set out in the sampling procedure. The researcher conducted the interviews with the help of three research assistants. Two GOAL Kenya staff and two local leaders were also interviewed for coherence, plausibility and correspondence with data received from young people.

Secondary data was obtained through desk literature review of relevant books, journals, research, evaluation and project reports from various organizations including agencies of the United Nations, GOAL Kenya and others.

### *3.1.5 Data processing and analysis*

Data collected from the survey respondents were coded and subjected to electronic analyses using the Statistical Package for the Social Sciences (SPSS). They were then tabulated into frequency and percentage tables that will allow for uni-variate and bi-variate descriptive and inferential analyses using the appropriate statistical procedures.

### *3.1.6 Problems and Limitations of the study*

A few constrains limited the comprehensiveness of this study, not least was the time factor. The researcher is currently resident out of the country. This has limited the time spent on conducting the research to interviews and focus group discussions. The researcher would have wished to spend more time observing

and verifying some of the information received. Similarly Mukuru, the area under study, is notoriously insecure. For this reason the study could only be undertaken during the day time and only in areas that were felt to be relatively safer. More time was thus spent on careful selection of respondents to ensure a representative sample was obtained.

The other critical limitation was the limited literature on perception studies on young people and HIV/AIDS, especially in Kenya. Most of the available literature has focused on impact and problems young people face, rather than how they perceive programmes designed for them.

# CHAPTER 4

# THE FINDINGS

## 4.1 Introduction

The findings were analyzed against the study's set objectives and categorized as follows:

## 4.1. Knowledge about peer education and HIV/AIDS

### *4.2.1 Preferred Sources of information about HIV/AIDS*

From the data elicited , it seems that HIV/AIDS has captured the attention of young people. All respondents (100%) said that they listen to or actively seek information about HIV/AIDS. However there information needs are met by various sources with the majority (46.3%) saying seminars and workshops are their favourite sources for HIV/AIDS information. In subsequent focus group discussions, it emerged the main reason for this was because seminars are often facilitated by professionals who were experts or knowledgeable and were able to respond to most of the tough questions more appropriately. This concurs with findings of Hughes-d'Aeth's evaluation study of peer education programmes in which it was found out that young people often sought "expert" opinion about what their peers tell them.

Other sources (including posters, videos and drama) accounted for 26.8% of favourite source. Significantly, only 17.1% said the mass media was their favorite source. NGO workers and friends accounted for only 7.3% and 2.4%

respectively as favourite sources of information. The reasons behind the low preference for NGO workers are particularly interesting.

**Table 4.1. Distribution of respondents by their favourite sources of information on HIV/AIDS**

| Favorite sources of information on HIV/AIDS | | Frequency | Valid Percent |
|---|---|---|---|
| | Radio/TV/Newspapers | 7 | 17.1 |
| | Seminars/workshops | 19 | 46.3 |
| | NGO workers | 3 | 7.3 |
| | Friends | 1 | 2.4 |
| | Others | 11 | 26.8 |
| | Total | 41 | 100.0 |
| Total | | 53 | |

Young people believe there is a disconnect between their real information needs and the content of what peer educators and NGO workers inform them about HIV/AIDS. Most of the respondents said NGO workers follow a preset curriculum with predetermined content and are not "flexible to get into other topics" outside of their set agenda but that could be of more interest and relevance to young people. NGO workers explained that they encourage their staff to follow a predetermined topic schedule in order to plan well for the specific sessions and to enable them monitor and track the issues covered much like "teachers follow a lesson plan". Whereas the NGOs and youth

peer educators may see this structured approach as good planning practice, the young people see it as a rigid and predictable method that does not always reflect their wishes. Young people prefer spontaneity in their quest for information but they felt that NGO workers and peer educators are hesitant to "dig deep" into issues such as "how to remove condoms" after sex. The young people also felt NGO workers become pedantic and repetitive over time, including staging the same drama and skits, "which is boring". These are potential areas for conflict that could impact negatively on peer education process.

However, it significant to note that from all the preferred sources of information, interpersonal communication is still the most popular form of receiving HIV/AIDS related information. Cumulatively, interpersonal communication (friends, NGO workers, seminars/workshops) accounted for over 60% of favorite sources of information. This confirms that young people are more comfortable receiving information in face to face interactions than in non interactive forms of communication like television and newspapers.

Another interesting finding was that while friends accounted for only 2.4% of favourite sources of information on HIV/AIDS, over 45% of young people preferred to discuss about HIV/AIDS and related issues with their friends, far

more than any other group. Peer educators come a close second at 37.5%. While this lends considerable credence to the long held belief and corroborates findings that majority of young people are more at ease discussing pertinent issues like HIV/AIDS with their peers, it does raise questions on the quality and reliability of information they receive and puts extra pressure and responsibility on peer educators to impart correct and relevant information to young people if they are going to make an impact.

Significantly, 78.6% of young people had "how to prevent HIV/AIDS infection" as their priority information need. The finding marks a radical departure from previous findings that young people do not always feel individually vulnerable and at risk of HIV infection. It may be a good indicator of a growing feeling of vulnerability to HIV/AIDS among young people reminiscent of the UNICEF study in Malawi that indicated young people were feeling hopeless in the face of HIV/AIDS, although it does not have the same sense of futility. Perhaps this is also a reflection of the high HIV/AIDS prevalence rates in Mukuru.

The fact that 19% of respondents also preferred information on "how to support family and relatives" cope with HIV/AIDS could be a pointer that young people are feeling increasingly under pressure of HIV/AIDS and being pushed into care giving roles and responsibilities for family and friends affected or infected by HIV/AIDS.

Curiously, only 2.4% had "where to get services" as a priority information need. There are several interpretations to this the most plausible being that young people feel once they know *how* to prevent HIV infections and *how* to help family and friends, they can always find out where to get services. Young people did mention in focus group discussions that they did not trust services close by, especially those that may reveal or expose their sexual activity such as voluntary counselling and testing and treatment for sexually transmitted infection. Their fear was that these services do not come with the requisite level of confidentiality.

Fear of being called upon "to give more details" on their questions or issues they want clarified is also partly responsible for why young people feel freer to seek and receive information in seminars and workshops since many of the speaker/ facilitators are likely to be people from elsewhere, who do not know them personally and therefore less likely to be interested in them as individuals. Seminars and workshops thus enables young people to retain their anonymity while at the same time getting crucial information.

Considering that 71.2% of respondents live with their families, it is instructive that only 5% feel comfortable discussing HIV/AIDS issues with family and relatives. This is evidence that most of the information young people have emanate from outside their home environment, yet the burden of HIV/AIDS is mostly felt at the household level where family members have to cope with

both the infected and the affected. The study did not delve further into the reasons why little discussions on HIV/AIDS takes place within families. It could be subject further research to determine the barriers to and how to improve HIV/AIDS communication within families and among relatives.

### 4.2.2. Young people's perception of peer education and peer educators.

For a number of young people in Mukuru, peer education is understood to mean "teaching and counselling among peers", "creating HIV/AIDS awareness in the community" and "sharing information with those who don't have it". These functional definitions capture the essence of peer education activities in the study site. Peer education activities are vibrant and no doubt plays an important role in HIV/AIDS interventions for young people in Mukuru. 100% of respondents knew about peer education with 86.3% having participated in a peer education activity in the last one month. 84.3% of respondents have sought help of a peer educator before while 97.6% knew of an organization promoting peer education in Mukuru. 92% of respondents think peer education meets their most important information needs about HIV/AIDS such as how to avoid infections, proper use of condoms etc, reproductive health etc. 78 % said they could access a peer educator any time they needed to. Most peer education activities take place in open spaces and school and community halls. Only 2.4% of peer education activities take place in private houses. This has several implications on the effectiveness of peer education.

Table 4.2: Distribution of responses on where most HIV/AIDS peer education activities take place

| Where do most peer education activities take place | | Frequency | Valid Percent |
|---|---|---|---|
| | Open spaces | 6 | 13.0 |
| | Community/schools | 39 | 84.8 |
| | Private houses | 1 | 2.2 |
| | Total | 46 | 100.0 |
| Total | | 53 | |

To begin with, the very public nature of peer education activities in Mukuru negates one of its objectives of providing confidential information and services to young people. It also implies that peer education activities in Mukuru is limited to the more generic form of public education or what the young people referred to as "awareness creation". Indeed 73.5% of the respondents said they liked group activities better than any other form of peer education activities. The fact that 43% of the respondents preferred peer education activities to take place "over the weekends " lend credence to the interpretation that many young people still view peer education as an organized group activity rather than as a spontaneous`process that should respond to their needs as is, where is. It also implies that young people may not trust the youth peer educators with what they consider more "personal" issues such as having a sexually transmitted infection for fear of breach of confidentiality. This was evident in the subsequent focus group discussions in which participants expressed concern at the tendency of some peer educators to "broadcast what you have discussed with them". On the other hand, it also raises the possibility that young people either do not see peer

educators as having the capacity or the mandate to extend their support to meeting individual youth needs. This is further reinforced by the fact that only a paltry14.3% preferred "one- on- one" discussions with peer educators.

**Table 4.3: Distribution of respondents by whether peer education meets their most important needs in regard to HIV/AIDS?**

| Do you think peer education meets your most important needs in regard to HIV/AIDS | Frequency | Valid Percent |
|---|---|---|
| Yes | 50 | 96.2 |
| No | 2 | 3.8 |
| Total | 52 | 100.0 |
| Total | 53 | |

### 4.2.3. Perceptions of young people on peer educators

Whereas 92.3% of respondents said they liked and admired peer educators for the work they do, most of this admiration was based on the fact that peer educators had "attended training and had the guts to speak about risky sexual behaviours". Training appeared to have elevated the social status of peer educators slightly above the rest of the peers and made others look upto them for guidance. The community was also shown to be supportive and "receptive to peer educators earning them extra respect among members of the community, but especially among their peers. Some peer educators were admired for volunteering to working in tough and insecure neighbourhoods" without pay.

However, respondents in focus group discussions expressed misgivings about the trustworthiness and honesty of some peer educators who base what they say on "hearsay" without verifying the facts themselves.

other peer educators teach people "about safe behaviours yet indulge in very risky behaviours (such as multiple sex partners) themselves. Other peer educators are "known drunkards who can not be trusted" while others "hold back information" from other young people, making them "unreliable and untrustworthy". Some peer educators "miss out on refresher courses thereby losing out on up to date information and new skills".

Table 4.4 : Distribution of respondents by their views on peer educators they know

| Do you think peer education meets your most important needs in regard to HIV/AIDS | Frequency | Valid Percent |
|---|---|---|
| Like/admire them | 48 | 92.3 |
| Do not like them | 1 | 1.9 |
| Not sure | 3 | 5.8 |
| Total | 52 | 100.0 |
| Total | 53 | |

In many cases, young people felt some peer educators are reactive rather proactive, by only waiting for the young people to go to them rather than making a deliberate effort to reach out to others. This makes some peer educators appear aloof and inaccessible to other young people "who may not be too free with them" but who could be in dire need of their assistance.

### 4.2.4. Perceptions on impact of GOAL Kenya's peer education programme on the lives of young people

Over 90% of young people felt that peer education responded well to their needs. These needs were identified as provision of information and promotion of safer behaviour against HIV/AIDS. GOAL Kenya's peer education project is therefore viewed as a positive intervention in Mukuru slums.

**Table 4.5: Distribution of respondents view on how peer education responds to the needs of young people**

| Do you think peer education respond to the needs of young people in your community | Frequency | Valid Percent |
|---|---|---|
| Yes | 48 | 92.3 |
| No | 4 | 7.7 |
| Total | 52 | 100.0 |
| Total | 53 | |

However, only 34% of respondents recognized GOAL Kenya as the organization implementing peer education activities in Mukuru, it would appear not many young people know the organizations behind the peer education project in Mukuru. 13.2% mentioned other agencies. Whereas this could be a good strategy for "creating local ownership of the project with a view to long term sustainability" it does call to question the issues of accountability in implementation, monitoring and evaluation of the project. Many young people did not know who to report to in case of a felt wrong (like breaching confidentiality,) or cases where peer educators were felt to "be

behaving badly". It also called to question how "peer educators are selected and trained". The implication for GOAL is that many young people do not feel completely involved and part of the peer education project, which could impact negatively on the project meeting its objectives. Indeed young people called for peer educators to "have supervisors who can monitor their conduct" to make them more accountable and responsible.

Despite the aforementioned, 98% of respondents agreed that peer education has made a difference and should be encouraged in their community. In follow up group discussions, young people cited the fact that they can obtain accurate information in a language they understand as one of the major impacts of peer education. Others felt that the peer education has resulted in good behaviour change among young people with many adopting safer sex practices like use of condoms, abstinence and being faithful. Others felt that peer education has encouraged open and more transparent discussions about HIV/AIDS in the community that could reverse and reduce the effects of HIV/AIDS. Peer educators themselves are said to have improved their communication skills with "others able to get jobs" as a result of their participation in peer education programmes.

However several constrain to the conduct of peer education was also noted. In all the focus group discussions "lack of motivation" was cited as a major draw back to the conduct of peer education in Mukuru. 68.4% of respondents

also cited "motivation" as a major way for improving peer education. Motivation was explained as "giving peer educators tokens of appreciation such as monetary allowance". Peer educators are volunteers who spend most of their time giving information to others, at the expense of other "gainful employment". This has led to considerable misunderstanding and misperception of peer educators with some regarding them as idlers, while others regard them as using them (young people) to get money from the NGOs running peer education programmes, such as GOAL. Some peer educators also volunteer with the expectation that this would open up the possibility of employment. Many peer educators drop out of the programme as a consequence of realizing there is no employment prospect. This is an area that needs careful consideration in future.

Lack of access to peer educators was also cited as a big constrain. Many peer educators do not have fixed abodes such as community youth resource centers where they can go and meet with other young people.

Another concern of young people was that many peer educators were only trained in HIV/AIDS yet young peoples needs went beyond HIV/AIDS to include among others, drug and alcohol abuse and career opportunities.
The singular focus on HIV/AIDS has to some extent led to some peer being stigmatized and labeled "AIDS people".

# CHAPTER 5

# SUMMARY CONCLUSIONS AND RECOMMENDATIONS

## 5.1 Summary

### 5.1.1 Knowledge of peer education and HIV/AIDS

Findings from the study indicate that peer education is well grounded and well received and accepted as an intervention strategy in Mukuru. The strategy provides an important source of information to young people on HIV/AIDS especially on preventing HIV infections and how to support relatives and friends cope with the pandemic. However, the depth, accuracy of content and diversity of information is cause for concern because young people believe that not all peer educators are equipped with right skills or have in-depth knowledge about HIV/AIDS. Consequently, young people do not always trust information they receive from peer educators, as indicated by their preference for seminars and workshops as the better source of receiving HIV/AIDS related information.

There is therefore need to improve the knowledge base of peer educators through more in-depth training and regular update on HIV/AIDS issues. Perhaps a review of the communication skills and focus on communication delivery skills of peer educators, could also be useful as part of the peer skills training and capacity building efforts.

### 5.1.2. Perception on peer educators

Peer educators are perceived as playing important role in the fight against HIV/AIDS. Their role elevates them to a higher social status in the eyes of their peers and the community. However not all peer educators live up to public expectations with some reported to be engaging in dubious activities and displaying conducts unbecoming, including engaging in risky behaviors such multiple sex partners , drunkenness. Some peer educators also withhold crucial information to the peers seeking them.

**Table 5.1: Respondents view on when peer education should be carried out**

| | | Frequency | Valid Percent |
|---|---|---|---|
| | During the day | 11 | 22.9 |
| | Working week days | 6 | 12.5 |
| | At night | 2 | 4.2 |
| | Over the weekends | 21 | 43.8 |
| | Any time | 8 | 16.7 |
| | Total | 48 | 100.0 |
| Total | | 53 | |

There is however, discernable misconception and misgivings among the young people, members of the community, sponsoring agencies and peer educators themselves on the exact roles and responsibilities of peer educators, including expectations on remunerations, training and duration of service of peer educators. The other issue is what young people can reasonable expect to receive from peer educators given that they work in a resource constrained environment, some imagine peer educators are well

paid for the work they do and therefore obliged to serve the young people as demanded.

### 5.1.3. Perception on impact of peer education project

Young people perceive peer education to be making a difference in their lives and encourage peer education in the community. They believe peer education has led to positive behaviour change among the young with regard to risky behaviours. Peer education has also improved discussions around HIV/AIDS among the youth and within the community. Most importantly, young people perceive peer educators to have developed better communication skills and built better social and professional networks that stand them better chances of getting employment.

## 5.2 Conclusions

The study has met its sets objectives of determining how young people perceive peer education and peer educators in the prevention and control of HIV/AIDS and their perception of GOAL Kenya's peer education programme. It has provided adequate insight into the factors that constrain effective peer education programming and the views that shape young peoples attitude on peer education. More specifically, the study provided good insights on how GOAL Kenya's peer education project should be modified and improved in order to respond better to the needs of young people in Mukuru.

## 5.3. Recommendations

The following are the recommendations of the study based on the findings:

1. **Criteria for selection and recruitment of peer educators**

It is recommended that GOAL Kenya, and any other agency working in peer education, develop and disseminate a minimum standard criteria for the selection, recruitment and training of peer educators. This should include issues of remunerations, expectations of both peer educators and the sponsoring agency, duration of service, etc. It is recommended that peer educators should not serve for more than three years to avoid fatigue and disillusionment. As much as possible, this criteria should be set and disseminated with the participation of the young people. GOAL policies regarding volunteerism should be well explained and set out in the minimum standards package.

On a broader level, the issue of volunteerism and support mechanisms for volunteers, especially those operating in insecure and resource constrained environments like Mukuru, should be reviewed and harmonized, at national level, or at least within agencies working with and for young people. As a minimum, a policy framework should be established that sets the standards for volunteers and their functions in HIV/AIDS intervention. This framework could include a system for grading and rewarding peer educators who have excelled in their work, helping them to move to the next level, while weeding out those who do not measure up. The rewards could be in form of certificates or further professional studies.

**2. Training of peer educators**

The training curriculum be revised and updated to include not only new and updated information about HIV/AIDS, but also emerging issues considered important to young people such as drugs and drug abuse, career options etc. Attendance of refresher and other subsequent training courses should be mandatory for all serving peer educators depending on satisfactory performance

**3. Conduct of peer education activities**

Accessing peer education and peer educators should not be left to the whims of peer educators themselves as this limits their effectiveness. Many respondents recommended that a community peer education room or resource center be set up where young people seeking information or other support can converge along with peer educators. Based on the discussions I would recommend that GOAL Kenya make such a move.

Peer educators should also be made accountable to both their peers and to their sponsoring agencies. GOAL Kenya should devise a system for monitoring and or supervising the work of peer educators to ensure errant ones are weeded out or restrained. This would restore greater confidence in the young people and the community about accountability and responsibility of peer educators

The youth peer educators should be equipped with more information, education and communication materials to ensure standardized approach and response to issues and questions raised by young people. Where possible these should include give-aways like leaflets on specific issues.

The monitoring system should include reporting on new and emerging issues of concern to the youth so as to enable more on target response to youth needs.

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**4. Improving GOAL Kenya's visibility and viability of peer education in Mukuru**

GOAL should strive to make itself more visible in its support to peer education activities in Mukuru. This will not only help in lending greater credence to peer education but also support accountability of peer educators. Some ways of doing this could include giving small identity badges, GOAL branded bags, t-shirts and caps.

**Table 5.2: Distribution of respondents views on how to improve peer education**

| | Frequency | Valid Percent |
|---|---|---|
| Accessible | 12 | 31.6 |
| Motivation | 26 | 68.4 |
| Total | 38 | 100.0 |
| Total | 53 | |

Other ways could include regular meetings between trained peer educators, their trainers, project sponsors and selected young people. This should ensure the project remains attuned to and responds adequately and efficiently to the needs of young people.

Another way would be for GOAL Kenya to support peer educators to organize community open days which could serve as away of introducing new peer educators to the community while at the same time providing a basis for engagement and dialogue with young people and other community members around HIV/AIDS and the conduct of peer education.

### 5. Further research

The study has raised important questions on the process of communication and information giving around HIV/AIDS in Mukuru. Among these include:

- .Why is there low preference among young people to discuss issues of HIV/AIDS with relatives and other family members, yet the burden of the disease is felt most at household level?
- What are the views and perceptions of peer educators on their role in combating HIV/AIDS and how effective do they think they are? How do they perceive their peers in the fight against HIV/AIDS?

Based on the above, the study recommends that more studies be undertaken to verify and ascertain these issues as they have direct relevance to the effectiveness of HIV/AIDS interventions.

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## ANNEXURES

### Annex 1: Questionnaire for young people

Please mark your response with an X where appropriate

Personal data

1. Are you currently in School? Yes ☐ No ☐

2. Sex: Male ☐ Female ☐

3. What is your age? __________years Don't Know: ☐

4. What is the highest level of education that you have achieved

   - Pre School ☐
   - Primary School ☐
   - Secondary School ☐
   - Post Secontadry ☐
   - Other – Explain ________________

5. Who do you currently live with?

Alone ☐ Friends ☐ Family/Relatives ☐ Other ☐

6. Marital Status

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Married more than 1 ☐

7 . What is your current employment: Employed Casual ☐ Employed Non

Casual    Self Employed. ☐    Un- employed ☐

**HIV/Information**

8 Do you often get to hear or listen to information about HIV and AIDS?

Yes ☐    No ☐

9. What are your favorite sources of information about HIV/AIDS?

Radio/TV/Newspaper ☐ Seminars and Workshops ☐ NGO Workers ☐

Friends ☐ Peer Educators ☐ Others_______________

10. How often do you discuss information related to HIV/AIDS?

Often ☐ Occasionally ☐ Rarely ☐ Not at all ☐

11. With whom do you normally discuss/talk with about HIV/AIDS?

Friends ☐ Family ☐ NGO Workers ☐ Peer Educators ☐

Other_____________

12. When was the last time you discussed about HIV/AIDS?

This week ☐ last 2weeks ☐ This month ☐ last 6 months ☐ Don't Know ☐

13. Can you remember the topic of your last discussion? Yes ☐ No ☐

14. What specific topic/issues do you like to discuss about HIV/AIDS?

- How to prevent infection ☐
- Where to get services ☐
- Supporting friend and Relatives ☐
- Other_____________________________

**Peer Education**

15. Have you ever heard of Peer Education for HIOV/AIDS education? Yes ☐ No ☐

16. Do you know of any organization promoting peer education in Mukuru ?

Yes ☐ No ☐

17. Please name them

- GOAL Kenya ☐

Others

- ________________________________________
- ________________________________________

18. Have you ever participated in any peer education activity on HIV/AIDS?

Yes ☐ No ☐

19. When was the last time you heard of this activity (ies)?

Last week ☐ Last one month ☐ Last 6 months ☐ Last One Year ☐

20. Where was this?

In Mukuru ☐ In Nairobi ☐ Elsewhere ☐

**Perception on effectiveness of Peer Education**

21. Have you ever sought the Help of a Peer Educator? Yes ☐ No ☐

22. In your experience, where do most HIV/AIDS peer education activities take place?

Open spaces ☐ Community/Schools ☐ Private Houses ☐

Others (*Please specify)*____________________

23. Which aspects of peer education activities do you like/enjoy most?

Group activities ☐ Special events ☐ One on one discussions ☐

Other(please specify)__________________________

24. When do you think peer education activities should be best carried out?

During the day ☐ Working week days ☐ At night ☐ Over Weekends ☐

Any time ☐ Other ______________________________

25. Do you think you can reach a peer educator any time you need to?

Yes ☐ No ☐

26. Would you go to peer educator for any HIV/AIDS related issues? Yes ☐ No ☐

**Impact of peer education**

27. Do you think Peer education provides your most important needs in regard to HIV/AIDS? Yes ☐ No ☐

28. Would you go to a peer educator for any HIV/AIDS related issues? Yes ☐ No ☐

**Perceptions on Peer Educators effectiveness**

29. What do you think of the peer educators that you know?

Like/admire them ☐ Do Not Like them ☐ Not sure ☐ Do not know any ☐

30. Are they good examples for others? Yes ☐ No ☐

31. Do you think Peer Education should be encouraged in your community?

Yes ☐ No ☐

32. Do you think that peer educators respond to the needs of young people in your community? Yes No

Please provide any other comment that you may wish to give on peer education in your community ( *optional*)

______________________________________________

______________________________________________

______________________________________________

***Thank you very much for your participation.***

Annex II.

## Topic Guide for Focus Group Discussions

(Young people)

My name is Justus Olielo. I am a student at the University of Nairobi. I am carrying out a research on HIV/AIDS and young people as part of my studies. I appreciate your coming to discuss with me this very important subject. Please feel free to discuss as much as possible. I assure you everything you say will be treated in strict confidence and will be used only for the purpose of this study.

Your views are important. There are no right or wrong answers, so do not be shy from saying what you think.

**Introduction:**

1. What comes to your mind when you hear the term "Peer education?" Is it a term you hear often? *(probe for why they think of peer education in the way they have said, where and from whom they hear the term?)*

2. Do you know of any peer education programmes? Can you describe them? *(probe for the location of the programmes, who is running them, cross check GOAL connection and for HIV/AIDS relevance)*

**Knowledge of peer education and HIV/AIDS**

3. Have you ever participated in any peer education programmes for HIV/AIDS prevention in your area?

4. What did you think of the experience?

5. What do you think of peer education as a way of preventing HIV/AIDS among young people? (probe for effectiveness)

**Perception on peer education**

6. Would you go to a peer educator for anything relating to HIV/AIDS? Why? Why not?
7. What do you think of peer educators?*(Probe for honesty, depth of knowledgeable, reliability,)*
8. What issues are you most likely to discuss with a peer educator? Why
9. What issues do you find difficult to discuss with a peer educator? Why?

**Perception of impact of GOAL Kenya peer education programme**

10. Do you think peer education has made a positive difference in the life of young people in Mukuru?
11. In what ways do you think it has changed life for young people
12. In your opinion, what changes would you recommend to make to peer education more effective to young people?
13. What special message would you send to GOAL and other agencies involved in peer education in your area?

***Thank you for your time. It has been most useful.***

## Annex III: Glossary of terms

### 1. *Youth/ young people*

For purposes of this study, the terms adolescents, young people and youth(s) have been used interchangeably in this document to refer to persons between 14-24 years. The World Health Organization defines adolescence as a period between the ages 10-24 years while the UN considers adolescents as persons aged between 15 – 24 years. While age has been used extensively to define youth or young persons, this study takes cognizance of the fact that young people are not a homogenous entity and that HIV and AIDS does not affect them in a similar manner. As the noted by the Population Council, the tendency to homogenize the experiences of young people "neglects the great diversity that exists across regions and in terms of school, work and marital status, social environment.

### 2. Peer

A similar other, peers are persons who share common characteristics on the basis of shared experiences, profession, age, gender, culture etc..

### 3. Education

Education is the process of imparting information to an individual or group in an effort to make them more knowledgeable about a specific issue or subject. In the HIV/AIDS context, youth peer education is the use of young persons to pass HIV/AIDS and related information to fellow youth in order to make them more knowledgeable about the subject.

### 4. Differences between Counseling and Education

Although Counseling and education provide vital components of HIV/AIDS management and control, the two terminologies are distinctively different and require specific skills. Generally, education is more knowledge based and factual, is less personal, structured and more public and the person giving the information often sets out as more knowledgeable than the person receiving it.

Counseling on the other hand, is more personal and intimate; less structured, is affective, value oriented and deals with perceptions and motivations. Counseling operates under the premise that the client knows the situation best and the counselor is not an expert

**5. Communication**

Communication is an interactive process characterized by the exchange of ideas, information, experiences and perceptions between persons and or groups through shared meaning. In program terms, communication implies a dialogue and interaction to understand one another better, give and share new ideas, transfer information and knowledge related to behaviour developments and change.

**6. Information**

Is a vertical, non interactive process in which facts, data etc is transmitted to passive receivers. No attempt at feedback is made.

**7. Psycho-social Life skills**

The WHO defines psycho social life skills as abilities for adaptive and positive behaviours that enable individuals to deal effectively with the demands and challenges of everyday life. These are individual skills such as self esteem, decision making, negotiation skills, conflict –resolution etc

**8. Advocacy:**

The assembling and deployment of strategies and activities designed to influence public perception and agenda on youth and HIV/AIDS including influencing public perception of their vulnerability, lobbying for the enactment and implementation of policies that would ensure their safety against HIV/AIDS, provision of youth friendly services, etc

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## Annexure V: SPSS analysis Tables (as per questionnaire)

**Are you currently in school?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 27 | 50.9 | 51.9 | 51.9 |
| | No | 25 | 47.2 | 48.1 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Gender**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Male | 26 | 49.1 | 51.0 | 51.0 |
| | Female | 25 | 47.2 | 49.0 | 100.0 |
| | Total | 51 | 96.2 | 100.0 | |
| Missing | System | 2 | 3.8 | | |
| Total | | 53 | 100.0 | | |

**Age**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 14-17 | 25 | 47.2 | 48.1 | 48.1 |
| | 18 and above | 27 | 50.9 | 51.9 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Highest formal school you completed?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Pre school education | 3 | 5.7 | 5.8 | 5.8 |
| | Primary school education | 26 | 49.1 | 50.0 | 55.8 |
| | Secondary school | 15 | 28.3 | 28.8 | 84.6 |
| | Post secondary school | 7 | 13.2 | 13.5 | 98.1 |
| | Other | 1 | 1.9 | 1.9 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Who do you live with currently?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Alone | 5 | 9.4 | 9.6 | 9.6 |
| | With friends | 7 | 13.2 | 13.5 | 23.1 |
| | With family/relative | 37 | 69.8 | 71.2 | 94.2 |
| | Others | 3 | 5.7 | 5.8 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Marital status**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Married | 4 | 7.5 | 8.7 | 8.7 |
| | Single | 41 | 77.4 | 89.1 | 97.8 |
| | Widowed | 1 | 1.9 | 2.2 | 100.0 |
| | Total | 46 | 86.8 | 100.0 | |
| Missing | System | 7 | 13.2 | | |
| Total | | 53 | 100.0 | | |

**Employment**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Employed casual | 3 | 5.7 | 7.3 | 7.3 |
| | Employed non-casual | 6 | 11.3 | 14.6 | 22.0 |
| | Self employed | 4 | 7.5 | 9.8 | 31.7 |
| | Unemployed | 28 | 52.8 | 68.3 | 100.0 |
| | Total | 41 | 77.4 | 100.0 | |
| Missing | System | 12 | 22.6 | | |
| Total | | 53 | 100.0 | | |

**Do you often listen to information about HIV and AIDS?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 52 | 98.1 | 100.0 | 100.0 |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Favourite sources of information about HIV/AIDS**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Radio/TV/Newspapers | 7 | 13.2 | 17.1 | 17.1 |
| | Seminars/workshops | 19 | 35.8 | 46.3 | 63.4 |
| | NGO workers | 3 | 5.7 | 7.3 | 70.7 |
| | Friends | 1 | 1.9 | 2.4 | 73.2 |
| | Others | 11 | 20.8 | 26.8 | 100.0 |
| | Total | 41 | 77.4 | 100.0 | |
| Missing | System | 12 | 22.6 | | |
| Total | | 53 | 100.0 | | |

**How often do you discuss information related to HIV/AIDS?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Regularly | 37 | 69.8 | 72.5 | 72.5 |
| | Occasionally | 7 | 13.2 | 13.7 | 86.3 |
| | Rarely | 5 | 9.4 | 9.8 | 96.1 |
| | Not at all | 2 | 3.8 | 3.9 | 100.0 |
| | Total | 51 | 96.2 | 100.0 | |
| Missing | System | 2 | 3.8 | | |
| Total | | 53 | 100.0 | | |

**With whom do you normally discuss HIV/AIDS issues?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Friends | 18 | 34.0 | 45.0 | 45.0 |
| | Family | 2 | 3.8 | 5.0 | 50.0 |
| | NGO workers | 4 | 7.5 | 10.0 | 60.0 |
| | Peer educators | 15 | 28.3 | 37.5 | 97.5 |
| | Others | 1 | 1.9 | 2.5 | 100.0 |
| | Total | 40 | 75.5 | 100.0 | |
| Missing | System | 13 | 24.5 | | |
| Total | | 53 | 100.0 | | |

**Last time you discussed about HIV/AIDS**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | This week | 27 | 50.9 | 54.0 | 54.0 |
| | Last two weeks | 9 | 17.0 | 18.0 | 72.0 |
| | This month | 12 | 22.6 | 24.0 | 96.0 |
| | Last six months | 2 | 3.8 | 4.0 | 100.0 |
| | Total | 50 | 94.3 | 100.0 | |
| Missing | System | 3 | 5.7 | | |
| Total | | 53 | 100.0 | | |

**Issues most aware of about HIV/AIDS**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | How to prevent infections | 33 | 62.3 | 78.6 | 78.6 |
| | Where to get services | 1 | 1.9 | 2.4 | 81.0 |
| | Supporting friends and relatives | 8 | 15.1 | 19.0 | 100.0 |
| | Total | 42 | 79.2 | 100.0 | |
| Missing | System | 11 | 20.8 | | |
| Total | | 53 | 100.0 | | |

**Ever heard of peer education for HIV/AIDS education?**

UNIVERSITY OF NAIROBI
EAST AFRICANA COLLECTION

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 52 | 98.1 | 100.0 | 100.0 |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Do you know of any organization promoting peer education in Mukuru?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 40 | 75.5 | 97.6 | 97.6 |
| | No | 1 | 1.9 | 2.4 | 100.0 |
| | Total | 41 | 77.4 | 100.0 | |
| Missing | System | 12 | 22.6 | | |
| Total | | 53 | 100.0 | | |

**Please name them**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | GOAL Kenya | 18 | 34.0 | 72.0 | 72 0 |
| | Other | 7 | 13.2 | 28.0 | 100.0 |
| | Total | 25 | 47.2 | 100.0 | |
| Missing | System | 28 | 52.8 | | |
| Total | | 53 | 100.0 | | |

**Ever participated in any peer education activity around HIV/AIDS?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 44 | 83.0 | 86.3 | 86.3 |
| | No | 7 | 13.2 | 13.7 | 100.0 |
| | Total | 51 | 96.2 | 100.0 | |
| Missing | System | 2 | 3.8 | | |
| Total | | 53 | 100.0 | | |

**When was this?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Last one week | 19 | 35.8 | 45.2 | 45.2 |
| | Last one month | 16 | 30.2 | 38.1 | 83.3 |
| | Last six months | 5 | 9.4 | 11.9 | 95.2 |
| | Last one year | 2 | 3.8 | 4.8 | 100.0 |
| | Total | 42 | 79.2 | 100.0 | |
| Missing | System | 11 | 20.8 | | |
| Total | | 53 | 100.0 | | |

**Where was this?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | In Mukuru | 26 | 49.1 | 57.8 | 57.8 |
| | In Nairobi | 19 | 35.8 | 42.2 | 100.0 |
| | Total | 45 | 84.9 | 100.0 | |
| Missing | System | 8 | 15.1 | | |
| Total | | 53 | 100.0 | | |

**Ever sought the help of a peer educator?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 43 | 81.1 | 84.3 | 84.3 |
| | No | 8 | 15.1 | 15.7 | 100.0 |
| | Total | 51 | 96.2 | 100.0 | |
| Missing | System | 2 | 3.8 | | |
| Total | | 53 | 100.0 | | |

**Where do most HIV/AIDS peer education activities take place?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Open spaces | 6 | 11.3 | 13.0 | 13.0 |
| | Community/schools | 39 | 73.6 | 84.8 | 97.8 |
| | Private houses | 1 | 1.9 | 2.2 | 100.0 |
| | Total | 46 | 86.8 | 100.0 | |
| Missing | System | 7 | 13.2 | | |
| Total | | 53 | 100.0 | | |

**Aspects of PE liked most**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Group activities | 36 | 67.9 | 73.5 | 73.5 |
| | Special events | 6 | 11.3 | 12.2 | 85.7 |
| | One on one discussions | 7 | 13.2 | 14.3 | 100.0 |
| | Total | 49 | 92.5 | 100.0 | |
| Missing | System | 4 | 7.5 | | |
| Total | | 53 | 100.0 | | |

**When do you think peer education should be carried out?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | During the day | 11 | 20.8 | 22.9 | 22.9 |
| | Working week days | 6 | 11.3 | 12.5 | 35.4 |
| | At night | 2 | 3.8 | 4.2 | 39.6 |
| | Over the weekends | 21 | 39.6 | 43.8 | 83.3 |
| | Any time | 8 | 15.1 | 16.7 | 100.0 |
| | Total | 48 | 90.6 | 100.0 | |
| Missing | System | 5 | 9.4 | | |
| Total | | 53 | 100.0 | | |

**Can you access a peer educator any time?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 41 | 77.4 | 78.8 | 78.8 |
| | No | 11 | 20.8 | 21.2 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Do you think peer education meets your most important needs in regard to HIV/AIDS?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 50 | 94.3 | 96.2 | 96.2 |
| | No | 2 | 3.8 | 3.8 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Would you go to a PE for any HIV/AIDS related issues?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 50 | 94.3 | 96.2 | 96.2 |
| | No | 2 | 3.8 | 3.8 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**What do you think of the PEs that you know?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Like/admire them | 48 | 90.6 | 92.3 | 92.3 |
| | Do not like them | 1 | 1.9 | 1.9 | 94.2 |
| | Not sure | 3 | 5.7 | 5.8 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Are they good examples for others?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 48 | 90.6 | 96.0 | 96.0 |
| | No | 2 | 3.8 | 4.0 | 100.0 |
| | Total | 50 | 94.3 | 100.0 | |
| Missing | System | 3 | 5.7 | | |
| Total | | 53 | 100.0 | | |

**Do you think peer education should be encouraged in your community?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 52 | 98.1 | 100.0 | 100.0 |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**do you think that PEs respond to the needs of young people in your community?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 48 | 90.6 | 92.3 | 92.3 |
| | No | 4 | 7.5 | 7.7 | 100.0 |
| | Total | 52 | 98.1 | 100.0 | |
| Missing | System | 1 | 1.9 | | |
| Total | | 53 | 100.0 | | |

**Any other comments?**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Accessible | 12 | 22.6 | 31.6 | 31.6 |
| | Motivation | 26 | 49.1 | 68.4 | 100.0 |
| | Total | 38 | 71.7 | 100.0 | |
| Missing | System | 15 | 28.3 | | |
| Total | | 53 | 100.0 | | |