

SOCIO-DEMOGRAPHIC AND PROGRAMMATIC CORRELATES OF
SUSTAINABLE HIV-PROTECTIVE BEHAVIOURS AMONG ADOLESCENT
GIRLS AND YOUNG WOMEN AGED 15-24 YEARS RESIDING IN MUKURU
SLUMS IN NAIROBI

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DECLARATION


This thesis is my original work and that it has not been submitted elsewhere for examination, award of degree or publication. Where other people's work or my work has been used, this has properly been acknowledged or referenced.

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DEDICATION

This work is dedicated to: my parents Mr. and Mrs. Evanson Nguku, my wife Margaret Njathi, my three wonderful children Pauline Wambui, Grace Wangari, Prince Nguku; and all the adolescent girls and young women of Mukuru Slums, Nairobi.

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ABBREVIATIONS AND ACRONYMS

- AIDS: Acquired Immune Deficiency Syndrome
- AGYW: Adolescent Girls and Young Women
- ANOVA: Analysis of Variance
- AYP: Adolescents and young people
- BCC: Behaviour change communication
- BIG: Bold idea for girls
- CDC: Centres for Disease Control and Prevention (USA)
- EBI: Evidence-Based (Informed) behavioural Intervention
- GFR7: Global Fund Round 7 Program
- HFG: Partnership for an HIV-Free Generation (HFG)
- HIV: Human immuno- deficiency virus
- HWK: HOPE worldwide Kenya
- IMB: Information-Motivation-Behavioural Model
- KAIS: Kenya Aids Indicator Survey
- KARPR: Kenya AIDS Response Progress Report
- KAPB: Knowledge, Attitude, Practice and Behaviours
- KASF: Kenya AIDS Strategic Framework
- KES: Kenya Shillings
- KII: Key informant interview
- KNASP: Kenya National AIDS Strategic Plan
- MARPS: Most at risk populations
- NACC: National AIDS Control Council

NASCOP: National AIDS and STI Control Programme

NGO: Non-Governmental Organization

OVC: Orphaned and Vulnerable Children

PEPFAR: President's Emergency Plan for AIDS Relief (USA)

STI: Sexually transmitted infection

SRHR: Sexual and Reproductive Health and Rights

UNFPA: United Nations Population Fund

WHO: World Health Organization?

OPERATIONAL DEFINITION OF TERMS

Behaviour Change Communication

In this study, the use of Behaviour Change Communication is as defined by the United Nations Population Fund (UNFPA). The three HIV prevention service delivery programmes under review in the study had Behaviour Change Communication aspects and aimed to elicit HIV protective behaviours among the beneficiaries. Behaviour Change Communication is defined as an interactive process of any intervention with individuals, communities and/or societies to develop communication strategies to promote positive behaviours which are appropriate to their settings. This in turn provides a supportive environment which will enable people to initiate and sustain positive and desirable behavioural outcomes (UNFPA, 2002).

HIV protective behaviours

Acquisition and transmission of HIV is attributable to a range of factors including behavioural, biological, demographic and socio-economic (Davey *et. al.*, 2017; Camlin *et. al.*, 2014; Johnson and Bundleder, 2002). The behavioural factors include the number of HIV-infected sexual partners that one has and consistent and correct use of condoms (Rodger *et. al.*, 2014; Kennedy *et. al.*, 2010). HIV protective behaviours are defined as the behaviours that make people less vulnerable to infection with HIV and other sexually transmitted illnesses. In this study, these factors include: fidelity in monogamous sexual relationship and correct and consistent use of condoms during sexual intercourse for the sexually active participants.

Gender Norms

Gender norms are defined as ideas about how women and men should be and act.

Internalised early in life, gender norms can establish a life cycle of gender socialisation and stereotyping (Moheyuddin,2005).

Health Promotion

In this study, health promotion is defined according to the Ottawa Charter of Health Promotion (1986). The Charter defined health promotion as the process of enabling people to increase control over their health and its determinants, and thereby improve their health. Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The charter described the fundamental conditions and resources needed for good health to include: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (Smith *et. al.*, 2006).

Combination Prevention

There have been several interventions showing promise in partially protecting against HIV transmission and acquisition. Applied singly, none of them is sufficient to control the HIV pandemic. Kurth *et. al.* (2011) opine that there is an unprecedented opportunity to develop “prevention packages” that combine various arrays of evidence-based strategies, tailored to the needs of diverse subgroups and targeted to achieve high coverage for a measurable reduction in population-level HIV transmission. These prevention packages are referred to as “Combination prevention” and is defined as a combination of mutually reinforcing evidence-informed and human rights-based

behavioural, biomedical, and structural interventions implemented for HIV/STI prevention (Hankins and de Zaldoondo, 2010). This study provides an opportunity to determine the efficacy of different combination prevention packages to elicit sustainable HIV protective behaviours among slum-dwelling adolescent girls and young women.

Evidence-based (Informed) Behavioural Interventions (EBIs)

The Centres for Disease Control and Prevention (CDC), based in the United States of America has developed a Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention. The interventions are evaluated against explicit *a priori* criteria which show sufficient evidence that the intervention works. The EBIs are usually integrated into HIV prevention programmes and not usually implemented singly. EBIs are contextualized and adapted for use in different countries including Kenya. In this study, EBIs are defined as interventions that have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy in behaviour change and are considered to be scientifically sound (NAS COP, 2015; CDC, 2015).

Sustainable HIV protective behaviours

In this study, sustainable HIV protective behaviours are considered to include fidelity to one sexual partner and consistent and correct condom use by sexually active adolescent girls and young women *one year* after benefiting from a HIV prevention programme. In the absence of literature or study on how long it takes for a required behaviour to be considered sustained after a HIV prevention programme, one year was adopted as the

endpoint in this study following the observation by Baldwin *et. al.* (2006) in a smoking cessation study. Health Promotion Sustainability is defined as the ongoing capacity of implementing organizations and resolve of communities and individuals to work together to establish, advance, and maintain effective strategies that continuously improve health and quality of life for all (CDC, 2009). In the conceptual framework of this study, sustainability of HIV protective behaviours is considered to be affected at organizational, community and individual levels.

ABSTRACT

The high incidence of HIV infections among slum-dwelling adolescent girls and young women (AGYW) has been attributed to the numerous and often layered vulnerabilities that they encounter, including unfavourable power relations that are worsened by age-disparate sexual relations, limited access to sexual and reproductive health information; and violence against women. Despite the large and immediate HIV prevention need of young women, there is a dearth of information on which factors are associated with practice of sustainable HIV protective behaviours; and the programme models that are most efficacious for eliciting the behaviours in the sub-population.

The purpose of the study was to determine social demographic and programmatic correlates of sustainable HIV-protective behaviours among adolescent girls and young women aged 15-24 years residing in Mukuru Slums in Nairobi. This was done by assessing HIV protective behaviours practiced by the participants who had benefited from three different HIV prevention programme models at least one year before. This research contributes to the realization of the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19 which guides Kenya's response to the HIV epidemic.

In this retrospective cohort study, purposive sampling was used to select the three programmes and probability proportionate to size sampling was used to select the young women from among previous beneficiaries of the programmes. A total of 423 respondents participated in the study, including 207 previously exposed and 216 previously unexposed

AGYW. The participants responded to a standard Knowledge, Attitudes, Perceptions of power; and Behaviour (KAPB) questionnaire. Chi-square tests with p-values, Odds ratios with 95% confidence intervals and Pearson's correlation coefficients were calculated to determine relationships between independent variables (participants program model of exposure, age, level of education, marital status, income status, village of residence and participants' living arrangements) and dependent variables (consistent condom use and prevalence of one sexual partner).

The results showed that significantly ($p < 0.05$) higher condom use was observed among previously exposed participants with all the socio-demographic factors considered. For the previously exposed participants, condom use was significantly associated with minimum of secondary school level of education ($\chi^2 = 14.851$, $p = 0.001$) and monthly income of more than KES 1,000. One sexual partner was associated with being 15-19 years old ($\chi^2 = 11.263$, $p = 0.001$), minimum of secondary school level of

education; and monthly income of more than KES 1,000. Chi-square tests results showed highly significant association between HIV prevention programmes of exposure and consistent condom use (AGYW ($\chi^2 = 114.330$, $p < 0.0001$)) and prevalence of one sexual partner ($\chi^2 = 18.134$, $p < .0001$) by the participants.

The findings show that previous exposure to an HIV prevention programme model integrating EBIs, gender, and economic empowerment aspects; a minimum of secondary school education; and monthly income of at least KES 1,000 are associated with sustainable practice of HIV protective behaviours by slum-dwelling adolescent girls and young women. This work would inform the development of national strategies for this sub-population who are highly susceptible to HIV infection. Extra qualitative research is recommended among Mukuru AGYW, community leaders and HIV prevention program

managers to provide their perceptions on challenges and solutions to ensuring sustainable practice of HIV protective behaviours by AGYW in the community.