In 2001 the Centre for British Teachers (CfBT) won a commission to design a pilot HIV prevention education program. The aim was to pilot the program in one district and then, if successful, to scale up to the rest of the country. Project developers faced a series of obstacles to meeting this goal, including teachers’ discomfort teaching about sex and condoms, the need to create a curriculum from scratch, and the challenge of designing a program that could be sustainable at a national level.

Situation faced by CfBT planners

HIV/AIDS epidemic in Kenya

At the time the project was being designed Kenya was facing a generalized HIV/AIDS epidemic, with all population groups susceptible to infection. This is still the case—in 2007 HIV prevalence for 15-49 year-olds was between 7.1% and 8.3% (UNAIDS & WHO, 2008). While sentinel surveillance figures appear to show declining rates of infection among pregnant women, infection rates remain at 5% or above for both rural and urban women. As has been seen elsewhere in sub-Saharan Africa, young women are far more vulnerable to HIV infection than young men (see Figure 1). For 15-24 year-olds, male prevalence was 0.6% to 2.1% while female prevalence was 4.6% to 8.1% (UNAIDS & WHO, 2008).

The HIV/AIDS epidemic has had long-term demographic impacts on the population of Kenya. Life expectancy at birth has fallen from 59 years in 1990 to 53 in 2006, largely due to the effects of HIV (World Bank, 2008). Shorter life expectancies may damage extended family support systems, which often rely on elder family members to care for children. There are signs of hope however; Improvements in the availability of antiretrovirals (ARVs) has quadrupled the number of people treated from 29,000 people in 2004 to over 125,000 in 2006 (UNAIDS, 2008). Though this is an impressive increase, this number represents only approximately 27% of Kenyans with advanced HIV.

While HIV is a critical issue nationwide, regional differences in prevalence rate exist. PSABH was piloted in Nyanza province because of high HIV prevalence there. Researchers have documented a number of high-risk behaviors in Nyanza. In a 2000 study of 15-24 year-olds, 61% of all men and 50% of married men had had concurrent partners in the past year. More than 60% did not use condoms with non-spousal partners and more than 80% did not use condoms with their spouses (Egesah, Voeten, Meester, & Habbema, 2000). According to the PSABH team, compared to other Kenyan provinces Nyanza has a low age of sexual debut and high levels of self-reported sexual activity.

---

1 The program developers include Mary Gichuru and Janet Wildish who were part of the PSABH design team and played central leadership roles in the program until 2006 and 2005 respectively. Mary Gichuru was PSABH Project Manager from its inception in 1999 until August 2006. Eleanor Maticka-Tyndale led the evaluation team from the University of Windsor.
Figure 1. HIV prevalence in Kenya by gender and age groups

![Bar chart showing HIV prevalence by age group and gender.]

Source: (Dupas, 2006)

Government response to HIV/AIDS

It was a key aim of PSABH to work with government from the beginning. However, the response of the Kenyan government to the HIV/AIDS crisis up to this point has been mixed. The government declared AIDS a national disaster in 1999, 15 years after Kenya’s first documented AIDS case. However, after this 15-year delay in action, the government moved quickly to develop a coherent response. In 2000 the government created the National AIDS Control Council (NACC), which then initiated a comprehensive five-year strategy that crossed all sectors of government—the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005.

As part of this five-year plan, HIV/AIDS became part of the national curriculum in 2000. Teachers were required to infuse HIV/AIDS messages into all subjects. However, lack of teacher training and the fact that HIV/AIDS was not an examination subject meant that implementation of the infusion requirement was uneven (Ndambuki, McCretton, Rider, Gichuru, & Wildish, 2006). In 2004 a revised national curriculum included HIV/AIDS messages in a more explicit and structured way. However, not all teachers got the in-service training that was supposed to accompany the new materials, and some topics were still intended to be covered by infusion.
Primary education in Kenya

In 2003 Kenya eliminated primary-level school fees. The overall result of the policy change was to drastically increase the number of children attending school. In 2004, Kenya’s gross enrollment ratio was 111% and its net enrollment ratio 76% (UNESCO, 2007). While the percentages entering school are increasing, children still drop out at a high rate. Only 73% of children who begin primary school in Kenya stay in school through the end of the primary cycle (UNESCO, 2007). It is likely that the influx of 1.2 million students reduced the quality of education in Kenya (Bentaouet Kattan & Burnett, 2004). In some areas teachers have been observed to have one hundred children or more in classrooms (UNESCO, 2007; Wax, 2003).

CfBT experiences in Kenya

From 1996 to 2000, DFID’s Department of Education funded a project, called the Kenyan Primary School Management Project (PRISM), designed to improve leadership and management of primary schools. During this project, the need for a primary-school based HIV education program became clear. A community survey was conducted at the end of the five-year period, and participants indicated that HIV was one of the most serious problems their communities faced.

Near the end of PRISM, a call for proposals for a DFID Department of Health-funded HIV initiative was issued. An umbrella of initiatives, called HIV/AIDS Prevention and Care (HAPAC) was managed by the Futures International Group. One of the elements of this initiative was behavior change, and the Department of Health required a program evaluation that would track measurable behavioral outcome indicators rather than process indicators like number of teachers trained. DFID’s Department of Education required that the proposed programs were designed to operate within the existing structures of the Kenyan education system, with the goal of long-term sustainability. Partially due to the earlier CfBT programs, PRISM and SPRED, the Kenyan MoE had a large and experienced cadre of teacher trainers who were based in provincial and strict headquarters.

1. If you were to design an HIV/AIDS control program for the whole region of Nyanza, who would be your target group and what would be your target behaviors?
2. What role would primary school prevention programs play in this overall strategy? What are the advantages of using primary schools? What are the disadvantages?

Program Design

The initial challenge set out by HAPAC was to protect the “window of hope,” young people under the age of 15, from becoming infected. PSABH therefore targeted children ages 12 to 16 who were attending primary school. Program designers acknowledged that their program would be unable to impact socioeconomic factors and familial problems such as abuse and the need to engage in high-risk activities for money or food. Therefore, according to the program

---

2 Gross enrollment ratio is defined by UNESCO as “total enrolment in a specific level of education, regardless of age, expressed as a percentage of the population in the official age group corresponding to this level of education” (UNESCO, 2007).
developers, they defined their target group as a “core group… who, with access to knowledge, skills, and some social support, stood a fair chance of avoiding HIV infection.”

As they began to conceptualize their program, developers were well-aware of the failure of previous school-based HIV/AIDS prevention programs on the continent. In 2004, research team leader Dr. Eleanor Maticka-Tyndale of the University of Windsor and colleague Melanie Gallant published a review of 11 studies evaluating school-based HIV prevention programs in Africa (Gallant & Maticka-Tyndale, 2004). The authors concluded that although many studies assessed the impact of prevention programs on knowledge, few had even measured the impact on sexual behavior. Clearly, PSABH aimed to address this problem, as its funder mandated that behavior change measures be included among the outcomes. Despite the lack of evidence, there was also widespread skepticism that such programs could change behavior. Some of the reasons for these difficulties were widely reported. They included the taboos of discussing sex with children, the difficulties of changing sexual behavior amidst the constraints of poverty, and transactional sex (Gallant & Maticka-Tyndale, 2004; World Bank, 2002).

Initially, program developers used a theoretical model emphasizing the role of knowledge in behavior change (knowledge, attitude, skills, motivation, practice). However, when Dr. Maticka-Tyndale joined the PSABH team, she urged the developers to think more systematically through the theory underlying the program. After considering the social context of HIV infection, the PSABH team decided that Bandura’s social learning theory (1977) was more appropriate to the project.

**PSABH Objectives**

1. To deliver an HIV education intervention to upper primary-school pupils that was integrated into regular classroom teaching and also used diverse co-curricular activities.
2. For pupils to:
   a) increase HIV-related knowledge,
   b) increase communication with parents and teachers about HIV, AIDS and sexuality,
   c) increase assistance to each other to avoid sexual activity,
   d) increase self-efficacy with respect to: (i) abstaining from sexual intercourse; (ii) using condoms,
   e) decrease potential exposure to HIV by: (i) delaying first sexual intercourse; (ii) decreasing sexual activity; (iii) increasing condom use.

Source: (Maticka-Tyndale, Wildish, & Gichuru, 2007)

Specific sexual behaviors were targeted by the program: “The primary outcome goal for pupils was to reduce risk of HIV infection by delaying first sexual intercourse, decreasing sexual activity, and, for those who were sexually active, increasing condom use” (Maticka-Tyndale et al., 2007). Program designers wanted to give students needed information and counteract misinformation, which was common. PSABH was also intended to build students’ skills, particularly adult-child communication about sensitive topics and critical thinking skills. From the beginning, the program was designed to be sustainable within the education system and continuous rather than limited-time. PSABH was not intended to be an add-on to the curriculum, but a means of infusing information and skill-building into the existing curriculum without requiring extra time from teachers.
1. Given these challenges how would you go about developing a successful behavior change program: What would be your first steps? Who would you talk to? What would you ask? How would you go about getting information?

2. How well does the program’s aims and methods fit with social learning theory? What are the advantages and disadvantages of using this theory?

Baseline data collection and results

In November 2001 quantitative and qualitative data were collected to assess the baseline status of risk behavior, knowledge, and attitudes among students, teachers, and community members. Questionnaires were used to gather information from students and teachers in 80 target and 80 control schools in Nyanza, while students and teachers in a subset of schools participated in in-depth interviews and focus groups. Researchers found that the majority of respondents knew about HIV and AIDS and saw it as a serious community concern. As one community member said, “It is a big problem now that we are having” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). However, this admission of the problem did not mean that the topic was discussed openly: “In this community there is AIDS. But if somebody dies people never say the truth. But from our observations, the symptoms are clear, there is AIDS” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). Participants said that those who revealed a positive HIV status could be isolated within the community or judged. In the survey, 34.5% agreed to some extent that “HIV is God’s punishment for wicked behavior” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004).

The baseline data collection also provided useful information on students’ sexual behavior. While some critics of the program may have argued that primary school students were too young for a program such as PSABH, researchers found that 53% of students in standards 6 and 7 had already had sex, with the median age of sexual initiation before age 12 (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). One third of boys and one quarter of girls reported that they had used condoms (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004).

One of the most informative early pieces of work from the research arm of PSABH came from qualitative interviews. They found that respondents, adults and children alike, identified patterns of dialogue and behavior that led to sex. The program developers explained, “The sexual scripts threw light onto issues of expectations during dating, the economic context around sex, the complicity of families in early sex and the inability of both genders to create alternative dialogues and outcomes around dating and sex.” Most children used dating and “playing sex” interchangeably, and only one child did not mention sex while discussing the activities that people who were dating might do together (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). Young people described the use of mediators to declare their interest in a sexual relationship:

“They write letters to each other and send it through a third party… [and] at times the third party breaks the news… like now if I have a boyfriend I will send him a
letter through Mary. Sometimes Mary visits me at home and... brings me money from the boy and I receive it.” (Maticka-Tyndale et al., 2005)

In many cases, gifts or money were exchanged. One boy said, “She knows what you mean when you buy her chips,” while another said, “If a boy has given a girl money then they can have sex and they will love each other very much” (Maticka-Tyndale et al., 2005). These scripts were an incredibly important feature to define at this stage of project development, because they were responsible for creating “a sense of inevitability and a lack of personal responsibility among young people for the sexual act that ultimately resulted” (Maticka-Tyndale et al., 2005). Once the first part of the script was enacted, the rest would surely follow. In order for students to accept condom use, abstinence, and other protective behaviors, these sexual scripts would need to be altered or become more flexible.

Boys believed that their sexual desires were not within their control: “When he is in puberty stage it forces him beyond control... He cannot be patient to wait or stop to play sex because when he has reached that age it forces him” (Maticka-Tyndale et al., 2005). Dr. Maticka-Tyndale and colleagues found that it was rare for a boy to mention alternatives to sexual activity when he felt strong sexual urges. One boy did suggest, “Just get hold of a jembe [a hoe] and dig hard. By the time you are through with digging the sex feelings will have disappeared” (Maticka-Tyndale et al., 2005). However, there was also some evidence that young people were willing to revise the sexual scripts predominant in their communities. In a focus group, girls asserted that “Boyfriends and sex are not like air. They are not necessary to life” (Maticka-Tyndale et al., 2005, p. 38).

1. How would you use the information on sexual scripts?
2. Given this information on sexual scripts, what program components would you add to the program in order to increase its effectiveness?

The information from the sexual scripts research was used in a number of ways. Role playing using the patterns described by youth allowed students to practice avoiding situations where a script might begin to play out, and also how to alter scripts (See Appendix A for a sample activity from the PSABH School Health Guide). The vocabulary that youth used were worked into songs and drama activities. Teachers also used the scripts when counseling students and working with school health clubs. The accuracy with which teachers and the program in general treated the local sexual scripts increased students’ respect for the program, according to the developers.

PSABH developers faced a number of obstacles as they began designing their program. HIV rates in Kenya were high, particularly in Nyanza province. As the sexual scripts research demonstrated, early and unprotected sexual behavior was the norm among young people. While schools offered an opportunity to reach large numbers of children, particularly after school fee abolition in 2003, many teachers were uncomfortable with addressing sex and condoms in the classroom. Despite these challenges, PSABH planners at CIBT had the benefit of having implemented two previous projects in Kenya and were hopeful that they could build on their successes. One strength that came out of the PRISM project was the development of training capacity in the education sector. PSABH planners would build upon this strength in the design and implementation of their project.
Components of PSABH

1. *Teacher training*[^3] conducted by the MoE and the Ministry of Health using materials designed for PSABH by CfBT. The two-week initial training session and the follow-up session focused on integrating HIV education into the curriculum, strategies for training other teachers on these subjects, and how to guide and communicate with students with HIV/AIDS-related concerns.[^4] For example, teachers watched a video modeling effective counseling and discussed the basic skills that were required, including communication, empathy, and listening. Teachers also learned how to support students through the use of question boxes, student health clubs, and other student activities. A skills-based component of the training focused on ways to help students increase their ability to resist pressure to engage in sexual activity, as in role plays where students can practice making assertive responses to someone pressuring them.

2. *Student-level components including student health clubs and question boxes.* The anonymous question box allowed students to ask questions about sensitive or embarrassing topics. In some schools, community members were also allowed to contribute questions to the box. Teachers responded to questions weekly. School health clubs, led by older students or a member of the teaching staff, were intended to promote healthy behaviors among members and the school community, arrange activities including school health days, and to provide information and support on health-related topics. The Health Club Activity kit[^5] suggested a series of activities for health clubs to participate in.

3. *Training of a community representative.* One community representative per school attended a two-week training session designed to sensitize the community to the need for PSABH, making the teachers’ role in the schools easier.

4. *Peer supporter training.* Four students per school were selected by their schools to participate in a one-week training session. Peer supporters ran health-related school activities and answered questions from peers in formal and informal contexts.


6. *Training of Deans of Curriculum and students from pre-service teacher training colleges* to ensure that new teachers would enter the profession with the skills provided by PSABH training.

In addition, a number of variations on the main design were experimented with, including models in which health workers, church leaders, and additional teachers were trained.

[^3]: In the initial formulation of PSABH, two teachers per school were trained. In later rounds, three and four teachers per school were trained.

[^4]: The complete training manual may be downloaded from www.psabh.info.

[^5]: The School Health Club Activity Kit was designed and compiled by Dr. Melanie Gallant.
Development of program curriculum and materials

The PSBH team developed the materials used in the program from scratch. The three main products created for the program were the training manual, a Q&A booklet, and the School Health Club Activity Kit. Collaborating with NGO representatives and members of the MoE curriculum development group, KIE, the team built training units focusing on the technical knowledge, attitudes, and skills that they believed were critical. At the time, the MoE curriculum response to HIV was a series of primary-level textbooks entitled “Let’s Talk About It.” Focusing on breaking the silence that existed at the time around HIV and AIDS, these books did not attempt to demystify the transmission of HIV in a scientific manner. However, the PSABH team decided to incorporate them into the program, buying sets for all participating schools. One of the program developers explained, “Although as program managers, we found the material limited in terms of the sexual transmission of HIV, we decided that it was more important to build the capacity of the Ministry and endorse their own efforts rather than to compete with them.” The program materials continued to be reviewed and improved during the course of the program, especially the sections regarding guidance and counseling and technical information about HIV and AIDS.

In addition to KIE, the Kenyan MoE and Ministry of Health were involved, particularly at the provincial level. A provincial officer from each department was involved in program development, trainer training, and teacher training. MoE staff also participated in the project as data collectors.

Process

Teacher and community member training

In the baseline report, teachers expressed the need for more training on how to address sex and HIV in the classroom. One teacher said, “We are so much willing to help these children. But we need to have proper training so that we are confident with what we are saying or doing, so that we get the proper approach and we know how to handle these problems we are meeting” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). Another said, “If you are not well prepared you cannot be very confident but if you know what you want to talk about very well there is no problem” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). Program developers found that teachers often discussed HIV transmission only in a non-sexual context, for example through blood transfusion, piercing, or razors. Therefore, it became clear to the program designers that training needed to be a central component of PSABH.

Classroom teachers, head teachers, and community members were trained together in groups run by Kenyan trainers from the Ministries of Health and Education. Many of these trainers were MoE Quality and Assurance Officers (QASO) and Teacher Advice Centres (TAC) tutors. CfBT Africa Director Dr. Harvey Smith⁶ reported a high degree of commitment among the teacher trainers: “The PSABH team was able to build up a very high degree of ownership, commitment and enthusiasm among these staff.” Training sessions followed the PSABH training

⁶ Dr. Harvey Smith, a longtime CfBT team member, joined the PSABH program in 2007 when he became Africa Director based in Nairobi.
manual closely, as several classes were being trained at once and a reliance on the manual was the only way to maintain consistency. However, PSABH managers acknowledged that with 450 trainers with different abilities and opinions, complete consistency was impossible. As the program developers explained, “the delivery of the material may have always followed the manual in practical terms but the quality of the delivery, the detail of the messages conveyed and emphasis most certainly varied.”

There were several different types of sessions in the training program. Ministry of Health trainers who had been trained by medical doctors delivered technical information on HIV and AIDS. These modules tended to be very consistent across cohorts, though the information presented changed over time in response to trainees’ questions and knowledge level. Other sessions were designed to allow participants to identify and discuss the issues they felt were most important. Therefore, the range of topics covered in depth may be different from group to group.

During training, the teachers and other community members faced their own attitudes toward HIV and assessed their own behaviors and risk level. This was a difficult and often fearful process for both participants and the program leaders. The program developers said, “This is a highly challenging element in a program when the people who are acting as change agents are struggling with the same behaviors that the program seeks to change.” Many of the training leaders themselves, who numbered 450 at one point, were living with HIV and some died of AIDS-related causes during the training phase, complicating the planning and training process. In the context of a high-HIV prevalence country, the knowledge, attitudes, and behaviors of the trainers need to be addressed before they can effectively influence others.

Implementation fidelity

PSABH was developed as a program that could be adapted and supported by the MoE in the long run. The reliance on teachers and MoE teacher trainers meant that implementation fidelity was less of an issue than it might have been if they had introduced a project that was less integrated. According to the program developers,

“PSABH was designed by people who knew how Kenyan schools ran. We intentionally designed the strategies to build on what was either already being done at school, or what the MoE had instructed should be happening in the delivery of the curriculum, so we made it very possible for people to respond to the implementation strategies of the training.”

It was made clear during training what was expected from the participating schools, and the three participating teachers7 and community member from each school were guided in planning for implementation. While there were required aspects of the program, including a question box, a school health club, and a weekly HIV lesson developed by MoE, teachers were also encouraged to work to their strengths. Teachers who were talented in music were encouraged to use that medium to reach students and spread messages. Those in fields other than health were encouraged to use their subject time in ways that promoted the goals of PSABH. Program developers believed that the flexibility of PSABH made implementation fidelity a less critical issues than if a rigid curriculum were used.

7 In the final PSABH model four teachers participated in training, as opposed to the two-teacher model initially evaluated. Having additional trained teachers in each school allowed the program to survive staff turnover.
Program results at 18 months

Headed by Dr. Maticka-Tyndale, PSABH researchers conducted both qualitative and quantitative evaluations of the program. Selected results at 18 months are shown in Tables 1-3.

Box 1. Understanding the results tables

Tables 1 and 2 below show adjusted odds ratios. Odds ratios express the ratio of the odds of the behavior or attitude occurring in the target group as compared to the control group. In these tables an odds ratio of less than one indicates that the PSABH students were less likely to report that behavior or attitude, while an odds ratio larger than one indicates that the PSABH students were more likely to report the behavior or attitude. These are all adjusted odds ratios because the analyses control for various background factors and pre-program differences between groups, as noted under each table.

Asterisks denote the statistical significance of the results. If p < .05 there is less than a 5% probability that group differences were found by chance and we can therefore attribute them to the effect of the intervention.

Also note that the methodologies of the tables differ, and thus are not directly comparable. Table 1 uses a quasi-experimental methodology with 40 matched pairs of schools. The schools were matched on school district and academic performance. The analysis in Table 2 uses a cluster randomized sample selection of 160 schools.

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Adjusted Odds Ratios</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPV^A</td>
<td>NVPP^B</td>
<td>PPV^A</td>
<td>NVPP^B</td>
<td></td>
</tr>
<tr>
<td>Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual debut during program</td>
<td>.71</td>
<td>----</td>
<td>.59***</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Condom used last sex</td>
<td>.98</td>
<td>.89</td>
<td>.86</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>Sexual intercourse in last three months</td>
<td>1.82</td>
<td>1.51</td>
<td>.55*</td>
<td>.84</td>
<td></td>
</tr>
<tr>
<td>Perceived self-efficacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can say no to sex</td>
<td>1.15</td>
<td>.87</td>
<td>1.36</td>
<td>1.84**</td>
<td></td>
</tr>
<tr>
<td>I can have a BF/GF and not play sex</td>
<td>1.10</td>
<td>.85</td>
<td>.97</td>
<td>1.59*</td>
<td></td>
</tr>
<tr>
<td>I can tell BF/GF about using condoms</td>
<td>.91</td>
<td>1.10</td>
<td>.87</td>
<td>.62*</td>
<td></td>
</tr>
<tr>
<td>If I play sex I can make sure we use a condom</td>
<td>1.15</td>
<td>1.17</td>
<td>.80</td>
<td>.76</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Odds ratios adjusted for age, standard, ethnic group, SES and religion.
* p ≤ .05, ** p ≤ .01, *** p ≤ .001.
^A Pre-program virgin
^B Non-virgin pre-program
Source: (Maticka-Tyndale et al., 2007)
Table 2. PSABH results in Nyanza Province at 18 months after baseline (160 intervention and control schools)

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual debut past year</td>
<td>.62***</td>
<td>.60***</td>
</tr>
<tr>
<td>Ever played sex</td>
<td>.80**</td>
<td>.86**</td>
</tr>
<tr>
<td>Never forced</td>
<td>1.11</td>
<td>.87*</td>
</tr>
<tr>
<td>Avoided a place to avoid sex</td>
<td>1.35**</td>
<td>1.07</td>
</tr>
<tr>
<td>Condom used last sex</td>
<td>1.07</td>
<td>1.53**</td>
</tr>
</tbody>
</table>

Perceived self-efficacy

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can say no to sex</td>
<td>1.07</td>
<td>1.30**</td>
</tr>
<tr>
<td>I can have a BF/GF and not play sex</td>
<td>1.20*</td>
<td>1.30**</td>
</tr>
<tr>
<td>I can tell BF/GF I will wait until marriage for sex</td>
<td>1.15*</td>
<td>1.25**</td>
</tr>
<tr>
<td>I believe ‘no’ means ‘no’</td>
<td>.90</td>
<td>1.20**</td>
</tr>
</tbody>
</table>

Notes: Odd ratios control for differences between control and intervention groups at baseline, student age and grade. * p ≤ .05, ** p ≤ .01, *** p ≤ .001.

Table 3. Percent of pupils in Nyanza responding yes to “You can prevent HIV by using a condom correctly when playing sex”

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>6 months</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>18 months</td>
<td>58%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Source: (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Metcalfe, 2004)

Qualitative research showed that teacher’s reluctance to discuss condoms with students remained a problem. As reported by PSABH management, teachers believed that condoms were effective protection against HIV, but strongly felt that if they taught students about condoms they would become sexually active earlier and have more frequent sex. Teachers were also afraid of recriminations from the larger community if they taught children about condoms. One teacher said, “People are having different views about condoms. To me there is no need talking about it, it will be very risky to talk about it, because once you talk about it, it means you are for it” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004). Another said, “Some of the churches don’t want that around here...especially these new churches. They say introducing or teaching sex to a child is teaching the child to do the very thing” (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland, & Sverdrup-Phillips, 2004).
1. *Given the information available to program developers at the time* what do you think were the strengths of their program design? What were the weaknesses?

Please refer to Tables 1-3 when answering these questions:

2. Was PSABH a success overall? For specific subgroups?

3. There are at least two results in the table of concern. What are they? How would the program have resulted in these outcomes? What changes would you make to avoid these concerns?

4. Do the results indicate that any possible adjustments to the program?

5. Would you expand PSABH to other regions of Kenya?
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CfBT</td>
<td>Centre for British Teachers</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
</tr>
<tr>
<td>HAPAC</td>
<td>HIV/AIDS Prevention and Care</td>
</tr>
<tr>
<td>KIE</td>
<td>Kenya Institute of Education</td>
</tr>
<tr>
<td>KNASP</td>
<td>Kenya National HIV/AIDS Strategic Plan</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
</tr>
<tr>
<td>PRISM</td>
<td>Primary School Management Project</td>
</tr>
<tr>
<td>PSABH</td>
<td>Primary School Action for Better Health</td>
</tr>
<tr>
<td>QASO</td>
<td>Quality and Assurance Officer</td>
</tr>
<tr>
<td>SPRED</td>
<td>Strengthening Primary Education Project</td>
</tr>
<tr>
<td>TAC</td>
<td>Teacher Advice Centres</td>
</tr>
</tbody>
</table>
Appendix A
Sample Health Club Activities

<table>
<thead>
<tr>
<th>ACTIVITY: PERSUASION</th>
</tr>
</thead>
</table>

**Purpose:**
- Having young people find ways to say if, when and how they want to play sex when someone is encouraging them to do so.

**Outcomes:**
- Young people experience what it is like to refuse to play sex with a partner and to be refused by a partner.

**Background Information:**
- **Persuasion** is the act of trying to advise another person to think or behave in a different manner or way.
- **Sexual persuasion** is a specific type of persuasion. It happens when someone tries to convince another person to play sex.
- **Sexual coercion** is a form of persuasion. This happens when someone tries to pressure or force another person to play sex against her/his will.
- **Refusal** is the act of denying or not complying. It is expressing a wish not to accept or do something.

**Procedure**
- Ask the group of pupils to split into small groups of 3 to 5.
- Get each group to come up with phrases and sentences that people use when trying to persuade a partner to play sex. Allow 10-15 minutes for this.
- Ask the group to break into pairs. Each pair needs to nominate ‘A’ and ‘B’ partners.
- ‘A’ partners should start off by being the person who wants to have sex, and should read the first of their ten statements. Partner ‘B’ should then reply giving a reason why they do not want sex.
- Partner ‘A’ continues until all the statements have been read, and partner ‘B’ has responded to them. This takes between 15-20 minutes.
- When all the statements have been read, the partners exchange roles.
- Have the group come back together and ask them how it felt when responding to the ‘persuading’ statements.
- Useful questions to pose might include:
  - Was it difficult to think of ways to refuse to play sex?
  - How did it feel to be refusing to play sex all the time?

**NOTE TO LEADER**
Some ‘pairs’ may be happy to act out their roles in front of the rest of the group, although no one should be forced to do so. This encourages further discussion.
**Activity Worksheet: Persuasion**

Things one partner may say to **PERSUADE** (get) the other partner to play sex.

"I'll be very careful."
"If you really loved me, you would."
"I haven't got AIDS, so you've no need to worry."
"I've got some condoms now, so there's no excuse not to."
"Everyone else is doing it."
"I'll buy you something nice if you let me do it."
"I'm really turned on now - if we don't go the whole way, I will be in agony!"
"There are names for people like you who lead others on."
"I gave you a gift so now it is time for you to pay me back."

Things a partner may say to **REFUSE** to play sex.

"I am too young to play sex."
"I am waiting until marriage to play sex."
"I am concentrating on my studies."
"I do not want to get pregnant."
"I would rather just be a friend that does not play sex."
"I don't want to play sex with you."
"You don’t have to play sex to show your love for a person."
"Playing sex is not proof of love."
"I have personal goals right now and playing sex is not one of them."
"People I trust agree that I do not have to play sex in order to succeed in life."
"Many young people are now abstaining from playing sex. I am one of them."
"There are many dangerous consequences of me playing sex at my age. I would rather abstain."

Source: (Republic of Kenya Ministry of Education, n.d.)
Acknowledgements

We would like to thank several key past and present members of the CfBT and PSABH teams, without whose generous assistance this case study could not have been written: Dr. Harvey Smith and Felista Kamiti at CfBT, Janet Wildish and Mary Gichuru formerly of CfBT, and Dr. Eleanor Maticka-Tyndale of the University of Windsor. Where we have quoted “program developers” in the case study, we are referring to the joint written responses of Wildish, Maticka-Tyndale, and Gichuru to our queries.

References


