

**Adapting and Piloting a Combined Gender, Livelihoods, and
HIV Prevention Intervention with
Street-connected Young People in Eldoret, Kenya**

by

Lonnie Elizabeth Embleton

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Institute of Medical Science
University of Toronto

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Abstract

Despite being highly vulnerable to acquiring human immunodeficiency virus (HIV), no effective evidence-based interventions exist for street-connected young people in low- and middle-income countries (LMICs). In Kenya, street-connected young people have a heightened HIV prevalence, engage in sexual practices that elevate their exposure to HIV, and experience structural drivers of HIV acquisition, such as gender inequities and economic marginalization. Therefore, the overall objective of this doctoral thesis was to adapt and pilot a combined gender, livelihoods, and HIV prevention with street-connected young people in Eldoret, Kenya using a multi-stage mixed methods study design. In the first stage, the Stepping Stones and Creating Futures interventions and a matched-savings programme were adapted using a modified ADAPT-ITT model. During adaptation, we used community-based research methods informed by a rights-based approach, with four Peer Facilitators and 24 street-connected young people aged 16 to 24 years. Numerous adaptations came forth to the programme content and delivery. This adaptation process resulted in producing a comprehensive intervention entitled

'Stepping Stones ya Mshefa na Kujijenga Kimaisha'. In the second stage, we piloted the adapted intervention with 80 street-connected young people using a pre- and post-intervention convergent mixed methods design. The primary outcomes of interest were HIV knowledge and gender equitable attitudes. Secondary outcomes included condom-use self-efficacy, sexual practices, economic resources, and livelihoods. Participants had significant increases in HIV knowledge and gender equitable attitudes from pre- to post-intervention. Attendance level at the intervention was a significant predictor of HIV knowledge and gender equitable attitudes change scores. Intervention participants reported encouraging changes in condom use knowledge, condom use self-efficacy, health-seeking practices, daily earnings, housing, livelihood activities, and street-involvement. Overall, this research demonstrated that it was feasible to adapt an evidence-based intervention with street-connected young people and provides a model for other researchers and organizations in LMICs to use, which may assist in addressing the knowledge gap in effective interventions for street-connected young people. The pilot findings support the potential for further testing with a rigorous study design to investigate how best to tailor the intervention, particularly accounting for gender differences, and increase the overall effectiveness of the programme.

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Contributions

Dr. Paula Braitstein provided guidance on the study design, interpretation of results, and manuscript preparation in Chapters 4, 5, and 6. Dr. Braitstein also provided funding support for the execution of this project.

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Dr. Adrienne K. Chan provided guidance on the study design and contributed to the manuscript preparation in Chapter 4, and thesis preparation.

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List of Abbreviations

AMPATH	Academic Model Providing Access to Healthcare
CAD	Canadian Dollar
CRC	Convention on the Rights of the Child
EBI	Evidence-based Intervention
FGDs	Focus Group Discussions
GISE Groups	Group Integrated Savings for Empowerment Groups
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
HSV-2	Herpes Simplex Virus-2
IGAs	Income Generating Activities
Ksh	Kenyan Shillings
LMICs	Low- and Middle-income Countries
MTRH	Moi Teaching and Referral Hospital
MU	Moi University
NASCOP	National AIDS and STI Control Program
OSCAR	Orphaned and Separated Children’s Assessment Related to their Health and Well-being
PI	Principal Investigator
PrEP	Pre-exposure Prophylaxis
SCY	Street-connected Young People
STIs	Sexually Transmitted Infections
UG	Uasin Gishu
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
UNOHCHR	Office of the United Nations High Commissioner for Human Rights
USD	United States Dollar
WHO	World Health Organization

Chapter 1 Background

Over the past nine years, first as a Masters level graduate student, then as a research consultant, and finally as a doctoral student, I have lived and worked in Kenya and built a programme of research with street-connected children and youth in collaboration with and under the supervision of Dr. Paula Braitstein through the Academic Model Providing Access to Healthcare (AMPATH). The purpose of this dissertation was to continue to build upon this body of work and to find evidence-based solutions to respond to the most pressing health issues we have uncovered through our research over the years. At the time of commencing my doctoral work, a potentially hidden epidemic of human immunodeficiency virus (HIV) among street-connected young people living in Eldoret, Kenya had been revealed. This discovery combined with other grave concerns identified in previous studies, namely extreme sexual and gender-based violence and gender inequities in the street subculture, and a lack of viable livelihood options for this group, led to the focus of this dissertation. This dissertation therefore sought to investigate how best to intervene in these key areas of need and produce new knowledge that can be used by stakeholders, researchers, and policymakers working with street-connected young people in low- and middle-income countries (LMICs) to ameliorate their health and well-being.

I begin this dissertation by reviewing the literature on street-connected children and youth in LMICs to provide a broad description of their social and economic circumstances and the health inequities they experience. I explore and situate their HIV vulnerabilities, and

demonstrate how street-connected young people living in HIV endemic settings in sub-Saharan Africa are a young key population who require multi-faceted interventions that use a combination of behavioural, biomedical, social, and structural interventions for HIV prevention. I then report on a scoping review of the literature to identify potentially suitable, feasible, and effective interventions to use with street-connected young people in Eldoret, Kenya. Through this literature review, I identified the combined Stepping Stones and Creating Futures interventions as potentially suitable, feasible, and effective evidence-based interventions that respond to the key identified needs, and could potentially be successfully adapted and used with street-connected young people in Eldoret. During the development and planning stage of this research project, a matched-savings programme was integrated into the intervention to further address structural drivers of HIV acquisition for this population. The overall objective of this dissertation then became to adapt and pilot these interventions using a multi-stage mixed methods study design with street-connected young people in Eldoret, Kenya. The findings of this dissertation present practical strategies for working with street-connected young people that can be used by stakeholders, researchers, and policymakers in LMICs to reduce social and health inequities and work towards reducing significant HIV vulnerabilities, which leave this marginalized population extremely susceptible to acquiring HIV.

1.1. Street-connected children and youth in low- and middle-income countries

1.1.1. Defining and characterizing street-connected children and youth

In LMICs, children and youth find themselves growing up with strong connections to public spaces and the streets, where they may play, work, live, and conduct their daily lives. The number of children and youth present on the streets in any given setting may fluctuate over time and according to changes in the environmental, social, economic, political, and cultural contexts (OHCHR, 2012). Consequently, due to complexities counting and defining this diverse population no accurate estimates exist of the specific numbers of children (persons below 18 years of age), adolescents (persons between the ages of 10 and 19), or youth (persons between the ages of 15 and 24) who spend a portion or majority of their time on the streets in LMICs (OHCHR, 2012; Panter-Brick, 2002).

Children and youth living and working on the streets in LMICs have been known by various terms and definitions, which have been used to convey their circumstances and connections to the streets and public spaces. In the 1980's global organizations adopted the term 'street child' to refer to *'any girl or boy who has not reached adulthood, for whom the street in the widest sense of the word, including unoccupied dwellings, wasteland, and so on, has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, directed, and supervised by responsible adults'* (OHCHR, 2012; Panter-Brick, 2002).

The United Nations International Children's Emergency Fund (UNICEF) developed a typology of children and youth with street connections to separate them into three categories based on

their degree of familial contact and where they slept at night: *'children of the street'* were those who spent both days and nights on the street with limited or no family contact and were considered *'street-based'*; *'children on the street'* were those who spent a portion or majority of their time on the street while returning home to a family/guardian at night and were considered *'home-based'*; and *'children from street families'* were children from families living on the streets (OHCHR, 2012). The use of the term *'street child'* and these categories has since been heavily criticised for a number of reasons. First, the term *'street child'* fails to capture the diversity of children and youth working and living on the streets and refers to them as a homogenous group (Panter-Brick, 2002). Yet, children and youth connected to the streets are a heterogeneous group in terms of age, sex, ethnicity, nationality, disability, sexual orientation, gender identities, and other factors (OHCHR, 2017). Second, the term and the discrete categories do not adequately account for children and youths' diverse life experiences, relationships, and the fluidity of their movement on and off the streets during different periods of time (Panter-Brick, 2002). Children and youth may spend variable amounts of time on the street from day-to-day and during different periods of their lives. They may be engaging in work and informal labour, substance use, socializing with peers, or performing daily living activities such as cooking, sleeping, and washing on the streets or in public spaces. This may be out of necessity due to the lack of options, or by force, or children and youth may have voluntarily chosen to conduct a portion or majority of these activities publicly on the streets. Moreover, the nature of their relationship and the amount of time children and youth connected to the streets spend with their families may vary significantly (OHCHR, 2017). Lastly the term *'street child'* has been criticized for its negative connotations and may be a stigmatizing label, yet in

some cases children use it themselves with pride to define their social identity (OHCHR, 2012; Panter-Brick, 2002). Most recently in response to these criticisms, the terminology ‘street-connected’ has become adopted by the Office of the United Nations High Commissioner for Human Rights (UNOHCHR) to encompass all children and youth for whom the streets play a central role in their everyday lives and social identities (OHCHR, 2012, 2017). This broad definition attempts to capture the fluid relationship children and youth have with the street environment, their choice in developing a relationship to the streets, and the role the street may play in their survival, coping strategies, and resiliency (OHCHR, 2012).

1.1.2. Why do children and youth live and work on the streets?

In LMICs, street-connected children and youth report that poverty is the primary factor driving their street-connections, followed by abuse, family conflict, psychosocial, other reasons, and lastly delinquency (Embleton, Lee, Gunn, Ayuku, & Braitstein, 2016). While poverty is the most frequently reported reason for street-involvement, these reported reasons likely interact synergistically to contribute to unfavourable family or household circumstances, which result in children and youth turning to the streets for survival (Embleton, Lee, et al., 2016; OHCHR, 2012). Despite delinquency rarely being a reason for street-involvement (Embleton, Lee, et al., 2016), street-connected children and youth are frequently characterized as juvenile delinquents (OHCHR, 2012). This misconception commonly results in the criminalization of street-involvement, repressive policies, and street-connected children and youth experiencing substantial stigmatization and discrimination, all of which may have long-lasting consequences for street-connected children and youths’ health and well-being (OHCHR, 2012, 2017).

Alternatively, street-connected children and youth are seen as ‘victims’ of their social circumstances who lack agency and need to be rescued from the street environment using welfare-based approaches, which generally fail to take into account the child or youth’s own views or involve them in any decision-making process regarding their lives (OHCHR, 2017; Panter-Brick, 2002). Instead of labelling and stereotyping street-connected children and youth as ‘delinquents’ or ‘victims’, it is critical to understand that street-connected children and youth are rights holders, according to the United Nations Convention on the Rights of the Child (CRC) (OHCHR, 2017; UN, 1990).

1.1.3. Street-connected children and youth as rights holders

In 2017, General Comment No. 21 on Children and Street Situations was released by the Committee on the Rights of the Child to provide authoritative guidance to all States to respond to injustices frequently experienced by street-connected children and youth and to improve their circumstances using a child-rights approach (OHCHR, 2017). Child-rights strategies include approaches whereby the child is consulted or participates in decisions affecting their health and well-being and is respected as a rights holder (OHCHR, 2017). Specifically, street-connected children and youth have a right to be heard (Article 12), which includes a right to participate in the process to inform policies, and design, implement, coordinate, monitor, and review programmes and interventions targeting the population. The General Comment No. 21 on Children and Street Situations states that interventions are most beneficial when street-

connected children and youth themselves are actively involved in designing, shaping, and implementing programmes to improve their circumstances (OHCHR, 2017).

However, child-rights strategies are often disregarded, and welfare-based and repressive approaches are predominantly used with street-connected children and youth in LMICs. Welfare strategies include those whereby the child is considered a victim to be rescued from the street environment, and repressive approaches consider street-connected children and youth delinquents (OHCHR, 2017). It has been demonstrated that through the use of repressive policies and interventions, street-connected children and youth frequently experience numerous human rights violations, social exclusion, and structural discrimination (Consortium for Street Children, 2017; Embleton, Gayapersad, et al., 2019; Embleton, Shah, et al., 2019; Human Rights Watch, 1997, 2006b, 2006a, 2014; OHCHR, 2017; Ray, Davey, & Nolan, 2011; Save the Children, 2012). The use of child-rights, welfare-based, and repressive approaches are shaped by the social, economic, political, cultural, and environmental contexts in which interventions are designed and implemented, and these contextual factors also shape and influence the lives, health, and well-being of street-connected children and youth. These contextual conditions in which people live and work comprise the social determinants of health (Solar & Irwin, 2010). The social determinants of health include structural level determinants such as the social and political mechanisms which influence and shape social hierarchies and configure the labour market, educational system, and other social and public policies as well as social and cultural values. These structural determinants of health shape an individual's socioeconomic position and influence intermediary determinants of health, including material and psychosocial circumstances and behavioural and biological factors (Solar & Irwin, 2010).

Together, these social determinants of health are likely responsible for the substantial social, economic, and health inequities street-connected children and youth experience in LMICs.

1.1.4. Health equity impacts and the health status of street-connected children and youth in LMICs

Health inequities are defined by the World Health Organization (WHO) as *'health differences that are socially produced, systematic in their distribution across the population, and unfair'* (Solar & Irwin, 2010). Thus, health inequities arise when individuals in a society have unequal rights and inadequate access to key social determinants of health, including but not limited to freedom from discrimination, food, clothing, housing, education, and medical care (Solar & Irwin, 2010). Street-connected children and youth in LMICs likely experience health inequities that are socially produced and unjust as a result of structural discrimination and human rights violations endured by this marginalized population (Consortium for Street Children, 2017; Embleton, Gayapersad, et al., 2019; Embleton, Shah, et al., 2019; Human Rights Watch, 1997, 2006b, 2006a, 2014; OHCHR, 2017; Ray et al., 2011; Save the Children, 2012). The social and structural factors affecting street-connected children and youths' health in LMICs are vast including but not limited to: the factors precipitating their street-involvement namely abject poverty, family conflict, changes in family structure, abandonment and abuse; a lack of safe and adequate housing; exposure to hazardous working conditions through engaging in informal labour and precarious work; a lack of sound social and public policies to support this population; involvement in the criminal-legal system, and being out of school (Embleton, Lee, et al., 2016; Ray et al., 2011; Woan, Lin, & Auerswald, 2013).

In LMICs, street-connected children and youth have disproportionate morbidities in the areas of mental health, infectious diseases, sexual and reproductive health, HIV, nutrition, and growth and development (Noreña-Herrera, Rojas, & Cruz-Jiménez, 2016; Woan et al., 2013). Moreover, they experience substantial physical and sexual violence, exploitation, and unintentional injuries, have a high prevalence of substance use and misuse, and face significant barriers to accessing healthcare (Embleton, Mwangi, Vreeman, Ayuku, & Braitstein, 2013; Woan et al., 2013). While the disproportionate morbidities street-connected children and youth in LMICs experience have been documented (Woan et al., 2013), there has been little reported on their mortality or causes of death, despite having significant morbidities and other risk factors for mortality. However, a small quantitative study in Kenya uncovered that the majority of street-connected children and youths' deaths in a small geographic region in western Kenya were attributed to HIV and acquired immune deficiency syndrome (AIDS), assault, and accidents. The study found that the documented underlying cause of death for 60% of street-connected girls and young women and 26% of street-connected boys and young men was HIV and AIDS (Embleton, Ayuku, Makori, Kamanda, & Braitstein, 2018). Furthermore, mortality and HIV vulnerability among street-connected children and youth in eastern Africa was explored in a qualitative ethnographic study in Tanzania recounting the death of a street-connected young man. This exploration suggested that a convergence of structural factors including the political and economic context, the HIV/AIDS epidemic, and experiences of physical and sexual violence at home and on the streets, increases and contributes to street-connected children and youths' HIV vulnerability and mortality (Lockhart, 2008). Despite these findings, very little has been documented and reported on street-connected children and youths' HIV prevalence in sub-

Saharan Africa. A 2016 systematic review failed to identify and include any HIV prevalence studies focused on street-connected children and youth in sub-Saharan Africa (Noreña-Herrera et al., 2016), despite the region being the most heavily affected by HIV and AIDS globally (UNAIDS, 2018a). Most recently, studies in Kenya have found that street-connected children and youth have an overall HIV sero-prevalence between 4.1%-8.1% (Braitstein et al., 2019; Goldblatt et al., 2015; Shah et al., 2018; Winston et al., 2015), which exceeds that of other young people aged 15-24 in the country, which is estimated to be 2.1% (National AIDS Control Council, 2014). Taken together, these findings suggest that HIV is possibly an important and overlooked morbidity for street-connected children and youth living in HIV endemic settings in sub-Saharan Africa.

1.2. HIV among young people in sub-Saharan Africa

Despite a steady decline in the number of new cases of HIV in sub-Saharan Africa from 2010 to 2017, including a sharp reduction in eastern and southern Africa (30%), the region remains most affected by the HIV epidemic. Over half (53%) of the world's 36.9 million people living with HIV reside in eastern and southern Africa, and the region accounted for 45% of the world's HIV infections in 2017 (UNAIDS, 2018a). In sub-Saharan Africa, children and youth now comprise a large proportion of the overall population and represent a 'youth bulge', which may be impacting the ability of countries on the continent to reduce the number of new HIV infections among young people. It has been suggested that young people are being left behind in the HIV response in some countries. In 2017, 290 000 [160 000 – 390 000] new cases of HIV among young people aged 15-24 occurred in eastern and southern Africa (UNAIDS, 2018b).

Furthermore, 90% of the world's AIDS-related deaths among adolescents aged 10-19 occurred in sub-Saharan Africa (UNAIDS, 2018a). Adolescent girls and young women residing in sub-Saharan Africa accounted for 80% of all new HIV infections among young women aged 15-24 globally, and this group continues to be disproportionately acquiring HIV in eastern and southern Africa (Govender et al., 2018; UNAIDS, 2018a, 2018b). Driven by substantial gender inequities, including gender-based violence, harmful masculinities, and physiological factors in the female genital tract (Abbai, Wand, & Ramjee, 2016; UNAIDS, 2018a), young women in this region accounted for two out of every three newly acquired HIV infections (UNAIDS, 2018b). Despite living in HIV endemic settings, young people in sub-Saharan Africa have low levels of basic knowledge of HIV prevention measures, with only 34% of young men and 28% of young women knowing how to protect themselves from acquiring HIV (UNAIDS, 2018b). Moreover, young people in sub-Saharan Africa face additional issues in relation to HIV prevention, testing, and treatment including: stigma and discrimination, disclosure issues, restrictive laws and policies requiring parental/guardian consent to access HIV services, and poor quality adolescent care (UNAIDS, 2018a).

1.2.1. Young key populations: where are street-connected young people?

Young key populations have been identified that are the most vulnerable to acquiring HIV (Bekker, Johnson, Wallace, & Hosek, 2015; Pettifor, Stoner, Pike, & Bekker, 2018). Young key populations are classified as young men who have sex with men, transgender youth, young people who inject drugs, young people who sell sex, young women in eastern and southern Africa, and young people involved in the criminal-justice system (Bekker et al., 2015; Govender

et al., 2018; Pettifor et al., 2015, 2018). The WHO also recognizes that young people may be particularly vulnerable to acquiring HIV in the context of abject poverty, social marginalization, and discrimination (WHO, 2013). Street-connected children and youth may be a specific young key population that is frequently overlooked. Street-connected children and youth are an extremely hard-to-reach group for researchers and practitioners, they may or may not fit into or identify with any of the existing young key population categories, and they have a distinct and stigmatized identity due to their street-connections (OHCHR, 2012), all of which may separate them from other young key populations and leave them behind in HIV prevention efforts. Yet, street-connected children and youth living in sub-Saharan Africa have numerous HIV vulnerabilities and should be considered a distinct young key population. To better comprehend these HIV vulnerabilities, we can situate various factors that influence and shape an individual's susceptibility to acquiring HIV within the social-ecological model.

1.2.2. The social-ecological model: a framework for understanding HIV vulnerability across multiple levels

The social-ecological model (Figure 1) developed by Bronfenbrenner (Bronfenbrenner, 1993) is a framework for understanding multiple levels of influence on an individual's behaviour. There are five nested hierarchical levels, which are highly interactive and involve mutually reinforcing processes between the levels to maintain them (Kaufman, Cornish, Zimmerman, & Johnson, 2014). The social-ecological model is a helpful framework to comprehend the relationships between social and structural factors that influence individual practices and health (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013). In the context of HIV, the framework can be used as a tool to describe and understand the multiple levels of influence on an individual's behaviours

that leave them vulnerable to acquiring HIV, and also to situate complex, multi-level or multi-faceted HIV prevention interventions that include structural, social, behavioural, and

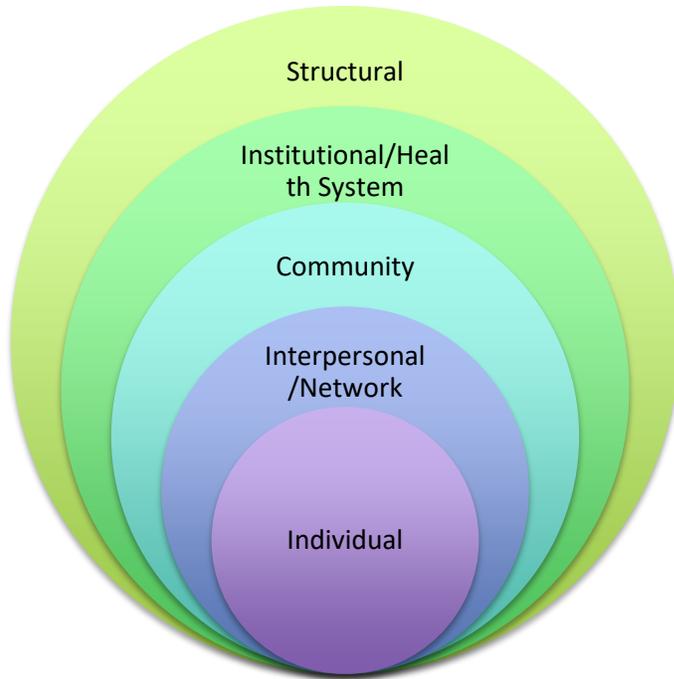


Figure 1 The social-ecological model

model Kaufman et al (2014) outlined factors at the individual, interpersonal/network, community, institutional/health system, and the structural environment that influence HIV-related behaviours or behaviour change. Individual level factors at the micro-level are behavioural or biological characteristics, such as risk perception or physical health, which are associated with vulnerability to acquire HIV (Baral et al., 2013; Kaufman et al., 2014). The interpersonal/network level factors are comprised of relationships, including family, sexual partners, and friends, who may influence health and health behaviours through social support or social influence. Social and sexual networks can influence HIV risk due to factors such as HIV infection rates within a network, or the perpetration of sexual and gender-based violence in intimate partner relationships. Networks can also provide healthy social support, trust, and

biomedical components (Baral et al., 2013; Baxter & Abdool Karim, 2016; Kaufman et al., 2014; Pettifor et al., 2018; UNAIDS, 2010). Kaufman et al (2014) proposed a multi-level approach for situating HIV prevention and AIDS care approaches using the social-ecological model. In this version of the social-ecological

foster good communication, which can act as protective factors to reduce HIV transmission (Baral et al., 2013; Kaufman et al., 2014). Community factors operate at a larger group level, and can reinforce social and cultural norms or stigma, which may increase HIV risk or promote health. For example, social and cultural norms within a specific context may promote multiple concurrent partners and harmful gender roles, which may augment vulnerability to acquiring HIV (Kaufman et al., 2014). These social-cultural norms are shaped by the larger or macro-level structural and contextual forces, and influence interpersonal/network and individual level practices (Baral et al., 2013). Institutional/health system factors focus on the health system and include issues such as confidentiality, quality of service providers, adequacy of resources, and culturally competent and sensitive care environment (Kaufman et al., 2014). Lastly, macro-level or structural factors include political and economic factors, policies, laws, environmental and infrastructure influences, and the broader social cultural context, which shapes factors such as gender equity (Kaufman et al., 2014). The social-ecological model therefore provides a conceptual framework for comprehending street-connected children and youths' HIV vulnerabilities. Moreover, it can be used to then situate a multi-faceted HIV prevention intervention targeting specific aspects of this marginalized group's HIV vulnerability at different levels (individual, interpersonal/network, community, institutional, structural).

1.2.3. Situating street-connected children and youths' HIV vulnerability in social ecological Model

Figure 2 presents key factors influencing street-connected children and youths' HIV vulnerabilities at each level of the social-ecological model adapted from Kaufman et al (2014). Structural drivers of HIV acquisition refer to the social, cultural, community, economic, legal,

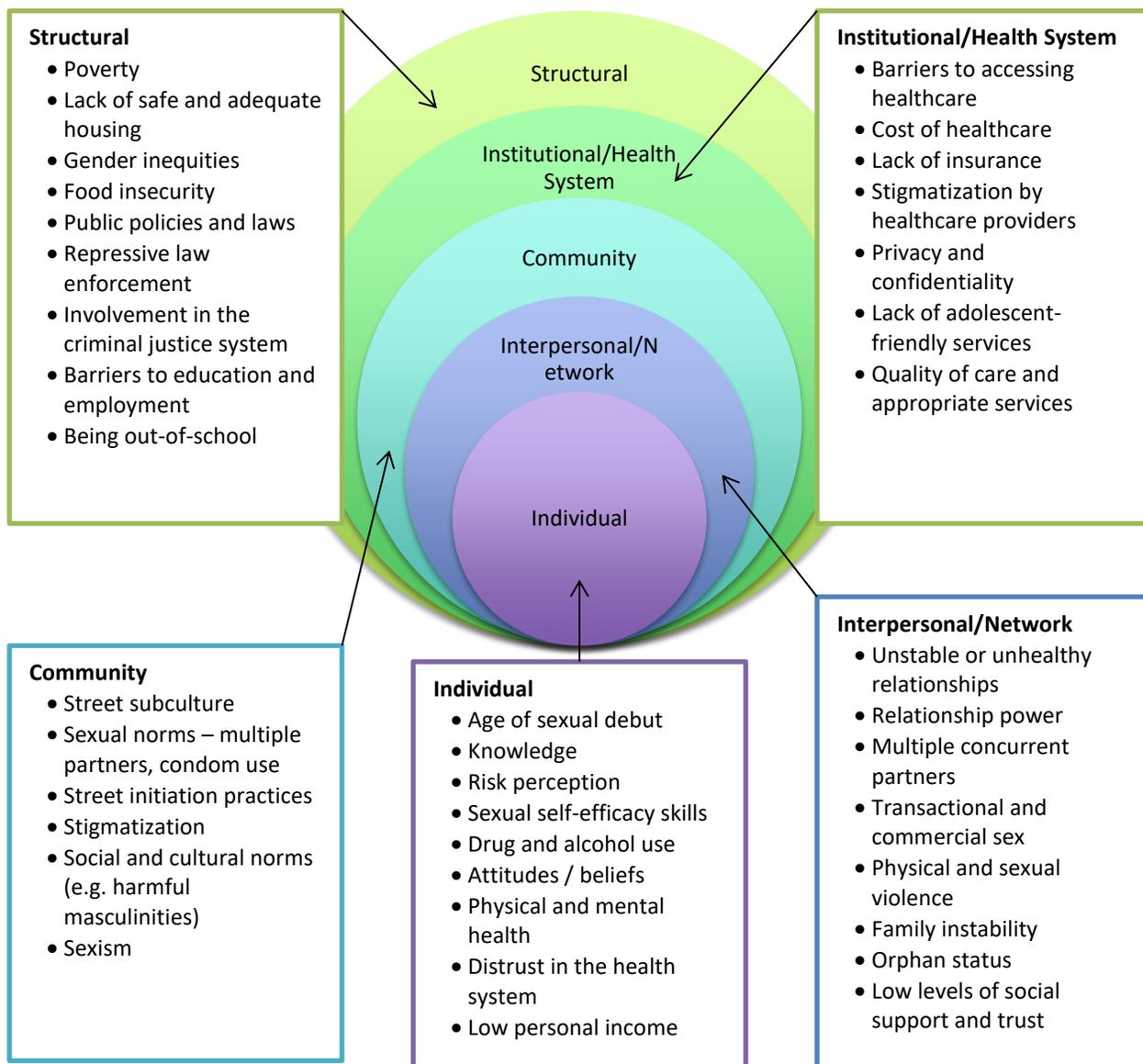


Figure 2 Factors influencing street-connected children and youths’ HIV vulnerabilities at each level of the socio-ecological model adapted from Kaufman et al (2014).

and political factors in a context that facilitate or constrain an individuals’ ability to avoid acquiring HIV (Sumartojo, 2000; Sumartojo, Doll, Holtgrave, Gayle, & Merson, 2000). These macro-level factors directly or indirectly affect an individual’s ability to avoid acquiring HIV (Sumartojo, 2000), and are often beyond the control of an individual (Kaufman et al., 2014). Associations between structural factors and HIV risk have been established, as well as some

causal mechanisms that link structural factors to HIV acquisition; however, the relationship between HIV acquisition and structural factors can be complex and variable between contexts and over time (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). Several structural factors have been associated with vulnerability of acquiring HIV including but not limited to: poverty and economic marginalization, informal housing, food insecurity, the failure to remain in school, low levels of educational attainment, public policy and laws, criminalization of at-risk groups, gender equity, and access to health and social services (Cluver, Orkin, Meinck, Boyes, & Sherr, 2016; Gupta et al., 2008; Kaufman et al., 2014; MacPherson, Richards, Namakhoma, & Theobald, 2015; Pettifor et al., 2018).

Several studies have identified that street-connected children and youth in sub-Saharan Africa experience numerous structural drivers of HIV acquisition including: extreme poverty (Abebe, 2009; Beyene & Berhane, 1997; Chireshe, Jadezweni, Cekiso, & Maphosa, 2010; Evans, 2002; Lockhart, 2008; Oduro, 2012; Tadele, 2000; Young, 2004); a lack safe and adequate housing (Abebe, 2009; Anarfi, 1997; Anarfi & Antwi, 1995; Beyene & Berhane, 1997; Lugalla & Mbwambo, 1999; Sorsa, Kidanemariam, & Erosie, 2002); social marginalization, stigmatization, and structural discrimination (Embleton, Shah, et al., 2019; Gayapersad et al., 2019; Young, 2003); food insecurity (Braitstein et al., 2013; Strobbe, Olivetti, & Jacobson, 2013); gender inequities (Embleton, Wachira, et al., 2018; Sorber et al., 2014; Wachira et al., 2015); barriers to education and employment (Evans, 2002); being out-of-school (Aderinto, 2000; Aidan, 1997; Beyene & Berhane, 1997; Lockhart, 2008; Strobbe et al., 2013); criminalization of street-connections and involvement in the criminal justice system (Human Rights Watch, 1997; Lockhart, 2008; Moolla, Myburgh, & Poggenpoel, 2008; Sorber et al., 2014); and an absence of

sound policies and programmes for this population (Berckmans, Velasco, Tapia, & Loots, 2012; Coren et al., 2016; Embleton, Gayapersad, et al., 2019; Sorber et al., 2014). Poverty, being out-of-school, gender inequities, and a lack of safe and adequate housing may be particularly important structural drivers of HIV vulnerability for street-connected children and youth in sub-Saharan Africa. For adolescent girls and young women in eastern and southern Africa, it has been shown that poverty and economic marginalization contribute to young women engaging in age-disparate relationships and transactional sex to secure social, economic and material provisions (Gibbs, Willan, Misselhorn, & Mangoma, 2012; Pettifor et al., 2018; Wamoyi et al., 2014). Gender norms and gender power dynamics intersect with poverty where young women are often economically dependent on men, and therefore this dependence allows men to control sexual decision-making, which may leave young women unable to negotiate condom use and prone to physical and sexual violence (Appiah, Tenkorang, & Maticka-Tyndale, 2017; Closson et al., 2018; Kim, Pronyk, Barnett, & Watts, 2008; MacPherson et al., 2015; Tenkorang & Maticka-Tyndale, 2014; UNAIDS, 2018a). Additionally, being out-of-school and young women's low levels of education have been associated with HIV vulnerability (Kim et al., 2008; Pettifor et al., 2016, 2018). Lastly, unstable housing has been associated with high-risk sexual practices in high-income settings (Aidala et al., 2016; Grieb, Davey-Rothwell, & Latkin, 2013). In contrast, stable housing has been associated with a decrease in sexual risk practices (Dickson-Gomez, McAuliffe, Convey, Weeks, & Owczarzak, 2011), and the provision of housing has been associated with undetectable viral loads among homeless people living with HIV (Hawk & Davis, 2012). Therefore, precarious housing or sleeping on the streets may strongly influence street-connected children and youths' sexual risk practices and vulnerability to acquiring HIV in sub-

Saharan Africa.

The health system at the institutional-level influences HIV vulnerability when there are barriers to accessing healthcare, a lack of appropriate services or providers, resource constraints, breaches in confidentiality or privacy, or negative attitudes of healthcare providers (Kaufman et al., 2014). Moreover, young people face additional barriers to accessing healthcare and sexual and reproductive health services due to a lack of adolescent-friendly spaces, policies restricting access to sexual and reproductive healthcare for adolescents, adolescents needs in relation to privacy and confidentiality, and stigmatizing or negative attitudes from healthcare providers regarding adolescent sexuality (Morris & Rushwan, 2015; WHO, 2012). Street-connected children and youth experience barriers to accessing healthcare, including due to the cost and a lack of health insurance, stigmatization by healthcare providers, issues in relation to privacy and confidentiality, and a lack of access to adolescent-friendly services (Kaime-Atterhög, Lindmark, Persson, & Ahlberg, 2007; Kudrati, Plummer, & Yousif, 2008; Lockhart, 2008), thereby influencing their HIV vulnerability at the institutional-level.

At the community-level, the well-being of a community, community-level stigma, social cohesion, and cultural norms are factors related to HIV vulnerability (Kaufman et al., 2014; Pettifor et al., 2018). Community-level factors in the street subculture support sexism and construct harmful gender norms which may strongly influence street-connected children and youths' HIV vulnerability (Aptekar & Ciano-Federoff, 1999; Embleton, Wachira, et al., 2018; Lockhart, 2002; Wachira et al., 2015). Street initiation practices often involve physical, sexual, psychological, and economic violence for both street-connected young women and young men in order to be accepted into the street subculture, and these initiation practices vary between

different street contexts (Embleton, Wachira, et al., 2018; Lockhart, 2002, 2008; Munene & Nambi, 1996; Wachira et al., 2015). Given the established links between violence and HIV acquisition risk (Jewkes, Dunkle, Nduna, & Shai, 2010; UNAIDS, 2018a), the use of physical and sexual violence in street initiation processes leaves both young men and women connected to the streets vulnerable to acquiring HIV. Moreover social, cultural, and sexual norms in the street subculture promote substance use, hegemonic masculinities, and normalize harmful sexual practices (Aptekar & Ciano-Federoff, 1999; Cottrell-Boyce, 2010; Embleton, Wachira, et al., 2015, 2018; Kaime-Atterhög et al., 2007; Kudrati et al., 2008; Lockhart, 2002; Wachira et al., 2015).

Interpersonal-level factors such as the nature and health of relationships, communication, intimate partner violence, social support, peer influence, and trust, may all impact HIV vulnerability (Kaufman et al., 2014; Pettifor et al., 2018). Street-connected children and youth are often involved in unstable or unhealthy relationships, which include having multiple concurrent partners (Anarfi, 1997; Embleton, Wachira, et al., 2015), and engaging in transactional and commercial sex (Embleton, Wachira, et al., 2016, 2015; Kayembe et al., 2008; Kudrati et al., 2008; Olley, 2006; Winston et al., 2015). For adolescents, transactional sex has been consistently associated with HIV infection, and for girls and young women, age-disparate relationships have been linked with HIV acquisition (Pettifor et al., 2018). Moreover, street-connected children and youth, especially girls and young women, experience physical and sexual violence (Aidan, 1997; Chireshe et al., 2010; Embleton, Wachira, et al., 2015; Hills, Meyer-Weitz, & Asante, 2016; Ikechebelu, Udigwe, Ezechukwu, Ndinechi, & Joe-Ikechebelu, 2008; Kudrati et al., 2008; Lalor, 1999; Lockhart, 2002, 2008; Lugalla & Mbwambo, 1999;

Mandalazi, Banda, & Umar, 2013; McAlpine, Henley, Mueller, & Vetter, 2010; Molla, Ismail, Kumie, & Kebede, 2002; Munene & Nambi, 1996; Oduro, 2012; Suda, 1997; Wachira et al., 2015; Wutoh, Kumoji, Xue, Campusano, & Wutoh, 2006), which may be perpetrated by peers, parents and relatives, police or other authorities, and other adults in the community.

Experiencing physical and sexual violence has been strongly associated with HIV acquisition (UNAIDS, 2018a), particularly sexual and gender-based violence (Jewkes, Dunkle, et al., 2010; Pettifor et al., 2018; UNAIDS, 2018a). Lastly, street-connected children and youth frequently experience family instability, an absence of one or both parents, and may be orphans (Abebe, 2009; Anarfi, 1997; Ballet, Bhukuth, & Radja, 2013; Evans, 2004; Lalor, 1999; Munene & Nambi, 1996; Oduro, 2012; Sorber et al., 2014; Strobbe et al., 2013; Suda, 1997), which may also influence their interpersonal-level HIV vulnerability as found in other adolescents (Pettifor et al., 2018).

Individual-level factors may include perceptions, beliefs, emotions, health status, skills, and sexual practices (Kaufman et al., 2014). As a result of the need to survive on the streets, street-connected children and youth engage in numerous sexual risk practices. In sub-Saharan Africa, the majority of street-connected children and youth are sexually active (Anarfi, 1997; Anarfi & Antwi, 1995; Kayembe et al., 2008; Mudingayi, Lutala, & Mupenda, 2011; Sorsa et al., 2002; Strobbe et al., 2013; Tadesse, Awoke Ayele, Birhanu Mengesha, & Addis Alene, 2013; Winston et al., 2015; Wutoh et al., 2006), have an early age of sexual debut (median age of 13 and 14.5 years) (Anarfi, 1997; Winston et al., 2015), have a low level of HIV knowledge and believe several myths and misconceptions in relation to HIV and other sexually transmitted infections (STIs) (Embleton, Wachira, et al., 2016; Kayembe et al., 2008; Mandalazi et al., 2013;

Mthembu & Ndateba, 2012; Sorsa et al., 2002; Swart-Kruger & Richter, 1997; Tadele, 2000; Tadesse et al., 2013; Wutoh et al., 2006), engage in sex under the influence of drugs and alcohol (Embleton, Ayuku, Atwoli, Vreeman, & Braitstein, 2012; Tadele, 2000), have reported inconsistent condom use (Kayembe et al., 2008; Mudingayi et al., 2011; Tadele, 2000; Tadesse et al., 2013; Winston et al., 2015), and have poor physical and mental health outcomes (Atwoli et al., 2014; Ayaya & Esamai, 2001).

Finally, the literature suggests that street-connected children and youth are contracting STIs (Kaime-Atterhög et al., 2007; Kayembe et al., 2008; Mandalazi et al., 2013; Olley, 2007; Tadele, 2000; Winston et al., 2015), and some studies have found an elevated HIV prevalence in this population in Kenya (Braitstein et al., 2019; Goldblatt et al., 2015; Shah et al., 2018; Winston et al., 2015). Taken together, this evidence demonstrates that street-connected children and youth living in HIV endemic settings in sub-Saharan Africa are a population who is extremely vulnerable to acquiring HIV and should be considered a young key population in HIV prevention efforts.

1.3. Street-connected children and youth in Kenya

1.3.1. The phenomenon of children and youth taking to the streets in Kenya: what precipitated it?

Street-connected children and youth are prevalent in Kenya (Braitstein et al., 2019; Save the Children, 2012). It has been estimated that 250,000 to 300,000 children and youth in the country are connected to the streets, however no national census has occurred and the exact number is unknown given the fluidity and transience of young people's street-involvement

(Ayuku, Kaplan, Baars, & de Vries, 2004; IRIN, 2007). Gender differences exist in the composition of the street-connected children and youth population in Kenya, with a higher proportion of boys and young men than girls and young women being street-connected (Aptekar & Ciano-Federoff, 1999; Braitstein et al., 2019; Save the Children, 2012). It has been hypothesized that this difference is due to gender norms in child upbringing, where boys are encouraged to become economically independent from a young age and therefore turn to the streets, whereas girls are often protected by families and expected to remain in the home performing domestic labour (Aptekar & Ciano-Federoff, 1999).

A convergence of changes and crises in Kenya's political, economic, and cultural systems over the last 50 years have led to the emergence of and an increase in children and youth on the streets in Kenya (Lugalla & Kibassa, 2002). Children and youth connected to the streets in Kenya first appeared during British colonialism with the development of new towns, rural-urban migration, and colonial policies (Ayuku, Kaplan, et al., 2004; Lugalla & Kibassa, 2002). In the mid-1980s structural adjustment policies ordered by the World Bank and the International Monetary Fund sought to improve the economies of sub-Saharan Africa through a variety of measures including but not limited to: trade liberalization, privatization of state owned institutions, devaluation of local currencies, cost-sharing policies for health and education, and adoption of multi-party democratic systems of governance. These policies exacerbated poverty for families, which fuelled the number of children migrating to the streets (Lugalla & Kibassa, 2002). The implementation of structural adjustment programs has been implicated in the rise of rural-to-urban migration due to agricultural subsidies, which impacted subsistence farming families. These families subsequently sought out alternative income generation in urban

informal settlements, leading to an influx of children and youth on the streets in urban settings (Lugalla & Kibassa, 2002). Concurrently, the emergence of the HIV and AIDS epidemic exacerbated poverty for families and left many children orphaned. The growing orphan crisis overwhelmed many communities and weakened the ability of extended families to meet traditional care-taking expectations (Lugalla & Kibassa, 2002; Nyambedha, Wandibba, & Aagaard-Hansen, 2003; Suda, 1997). The dissolution of the traditional cultural social safety net, left many children without care environments to meet their needs, leaving them in some circumstances to turn to the streets for survival (Embleton et al., 2014; Lugalla & Kibassa, 2002; Nyambedha et al., 2003; Suda, 1997).

In 1991, the political shift to multiparty democracy in Kenya led to civil conflict. In Uasin Gishu County, of the former Rift Valley Province, the number of street-connected children and youth first peaked during the 1991-1993 ethnic clashes. During this volatile period, ethnic violence, forced migration, and redistribution of illegally obtained land, left rural subsistence families destitute and displaced. As a result, more families migrated into urban informal settlements, propelling children and youth into the streets in Eldoret town, the administrative capital of Uasin Gishu County (Ayuku, Kaplan, et al., 2004). Similarly, the 2007 post-election violence contributed to a rise in street-connected children and youth in towns that were impacted by the conflict (Save the Children, 2012). Overall, the phenomenon of street-connected children and youth in Kenya has been primarily attributed to poverty (Aptekar & Ciano-Federoff, 1999; Save the Children, 2012; Seidel et al., 2018; Sorber et al., 2014; Suda, 1997; Von Acker, Oosrrom, Rorh, & De Kemp, 1999), family dysfunction and abuse (Aptekar & Ciano-Federoff, 1999; Auerswald, Kwena, Ochieng, & Bukusi, 2012; Save the Children, 2012;

Seidel et al., 2018; Sorber et al., 2014; Suda, 1997; Von Acker et al., 1999), being orphaned and abandoned (Sorber et al., 2014; Suda, 1997), living in a household affected by HIV (Goodman, Mutambudzi, Gitari, Keiser, & Seidel, 2016), dissolution of traditional kinship structures (Lugalla & Kibassa, 2002; Nyambedha et al., 2003; Suda, 1997), and political instability resulting in post-election violence (Save the Children, 2012). Very few children and youth report coming to the streets out of peer pressure, boredom, or due to delinquency (Save the Children, 2012; Sorber et al., 2014); yet this is a commonly held perception among government officials, healthcare providers, and the community, which leads to stigmatization and discrimination of street-connected children and youth in Kenya.

1.3.2. Stigmatization and structural discrimination: a source of street connected children and youths' health inequities and HIV vulnerability in the context of Kenya

Street-connected children and youth in Kenya are largely neglected, feared and stigmatized by the public (Auerswald et al., 2012; Barsulai, 2014; Gayapersad et al., 2019; Save the Children, 2012). In Kenya, street-connected children and youth are known by the public as *chokoraa* (garbage pickers) (Davies, 2008; Embleton, Wachira, et al., 2018; Gayapersad et al., 2019; Lugalla & Kibassa, 2002), a term socially constructed in the 1970's to reflect their actions and appearances, as they are often seen picking and eating from public dustbins (D. Ayuku, personal communication, March 2018). Qualitative research has uncovered that the *chokoraa* identity intersects with street-connected children and youth's gender and further amplifies gender inequities in the street subculture. For girls and young women connected to the street, the *chokoraa* identity results in an inability to report crimes and seek justice in cases of rape and

sexual and gender-based violence. While for young men, the *chokoraa* identity allows them to freely perpetrate sexual and gender-based violence without persecution (Embleton, Wachira, et al., 2018). These gender inequities and structural discrimination by law enforcement authorities leave girls and young women connected to the streets extremely vulnerable to acquiring HIV. Furthermore, the identity of *chokoraa* is associated with various negative stereotypes including that street-connected children and youth are delinquents, violent, thieves, dirty, and dangerous (Gayapersad et al., 2019; Muiruri, 2016; Nyassi, 2016; Odenyo, 2017; Ombati, 2018). The social process of stigmatizing street-connected children and youth through labelling them *chokoraa* and attaching negative stereotypes to the population, leads to substantial structural discrimination (Gayapersad et al., 2019). Stigmatization and discrimination have been linked to health inequities for marginalized populations (Hatzenbuehler, Phelan, & Link, 2013; Link & Phelan, 2002), including people living with HIV (UNAIDS, 2018a), and likely contribute to street-connected children and youths' vast social and health inequities in Kenya, and their vulnerability to acquiring HIV.

Street-connected children and youth in Kenya experience several avoidable morbidities including post-traumatic stress disorder and other psychosocial health problems (Atwoli et al., 2014; Seidel, Chang, Mwongera, Gitari, & Goodman, 2017), substance use and misuse (Cottrell-Boyce, 2010; Embleton, Atwoli, Ayuku, & Braitstein, 2013; Embleton et al., 2012; Othieno, Obondo, Kathuku, & Ndeti, 2000), malnutrition (Braitstein et al., 2013), negative sexual and reproductive health outcomes (Embleton, Wachira, et al., 2016, 2015; Kaime-Atterhög et al., 2007; Wachira et al., 2016; Winston et al., 2015), tuberculosis (Szkwarko et al., 2016), and other illnesses (Ayaya & Esamai, 2001; Suda, 1997). Moreover, children and youth connected to the

streets in Kenya succumb to death prematurely through preventable causes of mortality, including HIV and AIDS, assault, and injury (Embleton, Ayuku, et al., 2018). As assault and accidental injuries in this study attributed to almost half of all deaths, it is indicative of the tremendous violence experienced by street-connected children and youth, and a lack of adequate policies to protect children and youth connected to the streets (Embleton, Gayapersad, et al., 2019; Embleton, Shah, et al., 2019; Human Rights Watch, 1997; Save the Children, 2012).

Street-connected children and youth in Kenya are discriminated against on the basis of their connections to the street and 'other' identities (Embleton, Shah, et al., 2019; Save the Children, 2012). This contravenes the Convention on the Rights of the Child General Comment No. 21 which outlines that States are required to respect and ensure the rights of the child are upheld without discrimination on the basis of their connections with the street, that is, on the grounds of their social origin, property, birth or other status, resulting in lifelong negative consequences (Embleton, Shah, et al., 2019; OHCHR, 2017). Discrimination may be direct or indirect. Indirect discrimination includes policies that result in exclusion from basic services. Direct discrimination includes repressive policies to prevent begging, loitering, or other survival behaviours used by street-connected children and youth with the use of criminalization of offences, street sweeps or targeted violence (OHCHR, 2017). Direct discrimination including conflict with law enforcement, criminalization of street-connections, and involvement with the criminal justice system are all structural factors, which likely influence street-connected children and youths' HIV vulnerability in this context.

In Kenya, street-connected children and youth are frequently involved in the criminal-justice system. Many report experiencing conflict with the police, arrest and incarceration, and harassment, violence, and beatings from authorities (Aptekar & Ciano-Federoff, 1999; Auerswald et al., 2012; Cottrell-Boyce, 2010; Human Rights Watch, 1997; Kaime-Atterhög & Ahlberg, 2008; Sorber et al., 2014; Suda, 1997). The prevailing paradigm in Kenya assumes that children on the street are predominantly juvenile delinquents, and the government response is often characterized by social exclusion, criminalization, and oppression by police and civic authorities (Blomfield, 2016; Cherono, 2017; Embleton, Gayapersad, et al., 2019; Embleton, Shah, et al., 2019; Human Rights Watch, 1997; Ollinga, 2017; Ombati, 2018; Omulo, 2017; Save the Children, 2012). Strategies involving direct discrimination frequently include the use of violent street sweeps, forced migration, criminalization of street-involvement, children being placed in juvenile detention, and targeted violence conducted by police and other authorities (Blomfield, 2016; Cherono, 2017; Daily Nation, 2015; Embleton, Gayapersad, et al., 2019; Human Rights Watch, 1997; Magut, 2015; Ndanyi, 2017; Nyassi, 2016; Odenyo, 2017; Ollinga, 2017; Omulo, 2017; Save the Children, 2012). It has been suggested that these strategies are used to uphold political power, prestige, and social order (Embleton, Shah, et al., 2019). It is likely that the socioeconomic, cultural, and political context in Kenya produces structural discrimination and unequal socioeconomic positions for street-connected children and youth through the system of governance, social and public policies, which results in their social and health inequities (Embleton, Gayapersad, et al., 2019; Embleton, Shah, et al., 2019), and thus impacts their vulnerability to acquiring HIV. In response to this process of stigmatization and

structural discrimination, street-connected children and youth in Kenya have formed a unique subculture in the streets.

1.3.3. The street subculture and socioeconomic characteristics of street-connected children and youth in Kenya

The *chokoraa* label is rejected by street-connected children and youth and is considered an offensive term in the street subculture (Davies, 2008; Embleton, Wachira, et al., 2018; Gayapersad et al., 2019). In response to the stigmatizing label of *chokoraa*, street-connected children and youth create their own distinct identities, which have positive connotations. Street-connected children and youth in Eldoret, Kenya self-identify as *Mshefa* and in other cities and towns across the country may use other terms. *Mshefa* is a Swahili slang word meaning hustler or someone who works hard to survive (Wachira et al., 2015). The *Mshefa* identity may be a reflection of their resiliency characteristics (Ayuku, Devries, Mengech, & Kaplan, 2004). Street-connected children and youths' gender leads to different expressions of the *Mshefa* identity (Embleton, Wachira, et al., 2018), and gender differences in adjustment to the street subculture and psychosocial well-being have been found (Aptekar & Ciano-Federoff, 1999). Street-connected young women's *Mshefa* identity is tied to traditional expressions of womanhood in Kenya, to aspire to marriage, pregnancy, and childbearing, while being subservient and sexually responsible to men. Whereas street-connected young men's *Mshefa* identity is a reflection of hegemonic masculinity and is largely conveyed through the ability to demonstrate ones' capacity to provide, to sustain ones' livelihood through hustling in the informal economy, hypersexuality, and through their power, control, dominance, and aggression in the street subculture (Embleton, Wachira, et al., 2018).

Street-connected children and youth socially construct a street subculture that has its own social hierarchy and laws and rules (Auerswald et al., 2012; Embleton, Wachira, et al., 2018; Wachira et al., 2015). Generally, street-connected children and youth congregate in and belong to specific 'bases' or 'barracks' which are distinct venues or territories within a city (Auerswald et al., 2012; Cottrell-Boyce, 2010; Sorber et al., 2014; Wachira et al., 2015). At night they may sleep in the 'base' or on verandas, at bus stops, on the streets, in shared rented rooms in informal settlements, or return to their family home (Braitstein et al., 2019; Davies, 2008; Kaime-Atterhög & Ahlberg, 2008; Suda, 1997). Each 'base' or 'barrack' may have a set of geographic boundaries, which defines areas for street-based economic activities (Kaime-Atterhög & Ahlberg, 2008; Wachira et al., 2015). Within each barrack a social hierarchy exists (Auerswald et al., 2012; Wachira et al., 2015). In urban settings, the social hierarchy in the street subculture is patriarchal, leadership is predominantly held by young men and is either attained by force or democratically (Embleton, Wachira, et al., 2018; Wachira et al., 2015). The laws and rules of the street subculture are shaped by social-cultural values and norms of Kenyan society, including gender inequities, and are enforced by male barrack leaders and other members of the street community. The use of physical violence and beatings are used to uphold the laws and rules in the street subculture (Wachira et al., 2015), which is a likeness to the use of mob justice in Kenya, which has been attributed to deficiencies in the legal system (Embleton, Wachira, et al., 2018; Helbling, Kalin, & Nobirabo, 2015). To belong to a 'base' or 'barrack' children and youth new to the streets undergo an initiation process (Auerswald et al., 2012; Cottrell-Boyce, 2010; Embleton, Wachira, et al., 2018; Wachira et al., 2015). Initiation practices common to both street-connected boys and young men and girls and young women

include interrogation, payment of taxes, and smearing of a black soot (Wachira et al., 2015). Initiation practices unique to street-connected boys and young men are physical abuse, theft of personal possessions, volatile solvent use (i.e. glue sniffing), being forced to eat garbage, and anal rape of those who are perceived to be physically weak (Auerswald et al., 2012; Cottrell-Boyce, 2010; Wachira et al., 2015). Rituals unique to street-connected girls and young women are to be forced to 'become a wife or sexual partner', and rape, including gang rape (Aptekar & Ciano-Federoff, 1999; Auerswald et al., 2012; Wachira et al., 2015). Once a child or youth is initiated and belongs to a group on the street they create a tight-knit social network, which provides support and belonging (Ayuku, Odero, Kaplan, De Bruyn, & De Vries, 2003; Kaime-Atterhög & Ahlberg, 2008). The use of volatile solvents, particularly industrial glue from shoemakers, but in some cases petrol (Cottrell-Boyce, 2010; Davies, 2008; Embleton et al., 2012; Kaime-Atterhög & Ahlberg, 2008; Othieno et al., 2000), is said to provide a sense of belonging and shared identity within the street subculture (Cottrell-Boyce, 2010; Embleton, Atwoli, et al., 2013). It has been reported by children and youth that glue dulls their senses, reduces hunger, assists with loneliness and sleeping outdoors, provides warmth, and helps them deal with negative feelings and harsh experiences on the streets (Auerswald et al., 2012; Cottrell-Boyce, 2010; Embleton, Atwoli, et al., 2013; Kaime-Atterhög & Ahlberg, 2008).

Street-connected children and youth participate in a street-based or informal labour economy. Typically children and youth connected to the streets in Kenya survive through begging, selling plastic bags, other casual labour and running errands, carrying luggage, watching and parking cars, transactional and commercial sex, collecting recycling and scrap metals, and garbage picking (Aptekar & Ciano-Federoff, 1999; Auerswald et al., 2012; Davies,

2008; Embleton, Wachira, et al., 2015; Kaime-Atterhög & Ahlberg, 2008; Sorber et al., 2014; Suda, 1997; Wachira et al., 2015). Two studies have found that street-connected children and youth earn on average between 50-100 Kenyan shillings (Ksh) per day (~ 0.51 – 1.33 CAD), but have reported earning up to 500 Ksh (~ 6.70 CAD) per day in a few cases (Kaime-Atterhög & Ahlberg, 2008; Sorber et al., 2014). Street-connected children and youth report that they primarily use their earnings to buy food (Sorber et al., 2014). Boys and young men connected to the street report on average higher daily earnings in comparison to girls and young women connected to the streets (Sorber et al., 2014; Suda, 1997).

Several gender inequities have been identified in the street subculture in Kenya including: physical, sexual and gender-based violence, rape, including gang rape, inequitable forms of work and daily earnings, a lack of women's leadership roles as 'barracks leaders', young women's limited sexual agency on the streets, boys and young men's hypersexuality, and girls and young women's subservience to boys and young men in the street subculture (Aptekar & Ciano-Federoff, 1999; Embleton, Wachira, et al., 2018; Sorber et al., 2014; Suda, 1997; Wachira et al., 2016, 2015). It has been hypothesized that these gender inequities result from social and structural forces intersecting with the street subculture. Consequently, girls and young women connected to the streets experience sexual and gender-based violence and poor sexual and reproductive health outcomes, all of which impact their vulnerability to acquiring HIV and overall health and well-being (Embleton, Wachira, et al., 2018; Wachira et al., 2016, 2015).

1.4. Building a body of research with street-connected children and youth in Eldoret, Kenya

Eldoret is the capital of Uasin Gishu County, formerly located in Rift Valley Province; it is one of Kenya's 47 counties (Figure 3). Eldoret is located roughly 375 kilometers northwest of Kenya's

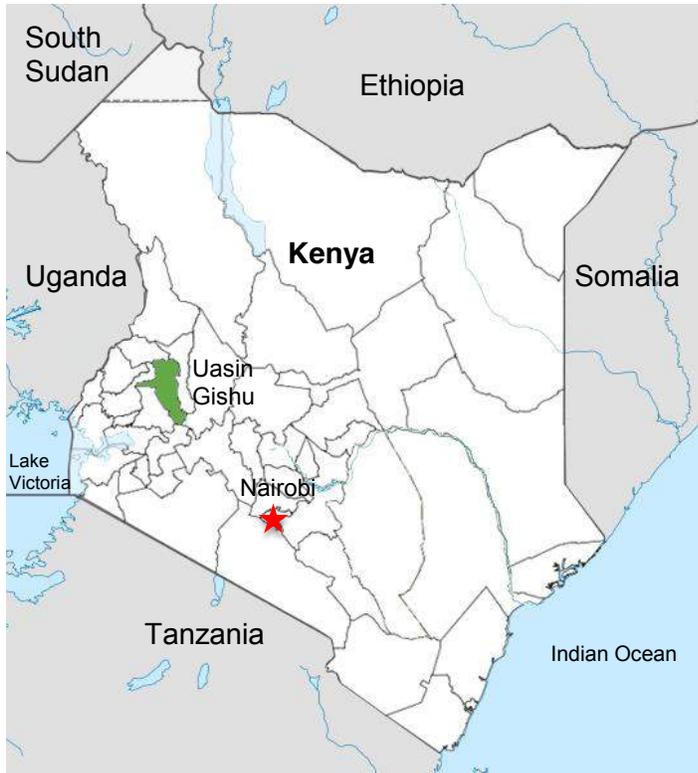


Figure 3 Uasin Gishu County location in Kenya

capital Nairobi. Uasin Gishu County has a population of approximately 894,179 individuals, of which 289,389 live in the capital city of Eldoret - the 5th largest city in Kenya (CRA, 2013). Over half (485,307 persons) of the population of Uasin Gishu County is below the age of 18 years, and it was predicted to be home to approximately 114,907 youth aged 15-19 and 126,007 young people aged

20-24 by 2014 (Kenya National Bureau

of Statistics, 2015). Uasin Gishu has a poverty rate of 49.6%, and about 277,684 people live below the Kenyan poverty line, defined as having 1,562 Ksh (~ \$21.00 CAD) per month per person in rural areas and 2,913 Ksh (~ \$39.00 CAD) in urban areas per month per person.

Approximately 62% of the county has a primary education and 13% has a secondary education (CRA, 2013). Uasin Gishu has an HIV prevalence of 4.7%, slightly below the national average of 5.9%. Consistent with countrywide distribution, the HIV prevalence among women in Uasin

Gishu County is higher (6.7%) than that of men (4.0%). In 2015, a total of 26,771 people were living with HIV in Uasin Gishu County, of which 15% were young people aged 15-24 (National AIDS Control Council, 2016).

In 2016, a point-in-time count identified there were 1419 individuals under the age of 29 connected to the streets in Eldoret (Braitstein et al., 2019). Of those, 497 were less than 15 years of age, 653 were 15 to 24 years of age and 269 were aged 25 to 29. Approximately 74% of individuals counted were young men. Of those 15 to 24 years of age this rose to 78%. Among street-connected children less than 15 years of age, more girls were street-connected (35%), and fewer boys were street-connected (65%) in comparison to older age groups. The majority of those counted below the age of 15 slept at home with their parent(s) or legal guardian(s) (48%), followed by another location (17%) or on the streets (16%), in the barracks (6.6%), with siblings or relatives (6.6%), or in a rental with friends (6.6%). Those aged 15 to 24 years primarily reported sleeping in other locations (25%), followed by on the streets (24%), in a rental with friends (21%), or in the 'base' or 'barracks' (14.1%) (Braitstein et al., 2019). It is believed there are between 1000-3000 street-connected young people in and around Eldoret at any time and that this number varies with seasonal changes and migration patterns in this highly mobile population.

The city of Eldoret is home to Moi University, Moi Teaching and Referral Hospital (MTRH), and the Academic Model Providing Access to Healthcare (AMPATH) (Einterz et al., 2007). AMPATH is a long-standing partnership between Moi University, MTRH, and a consortium of universities led by Indiana University, of which the University of Toronto is a partner. AMPATH commenced in 2001 to respond to the HIV and AIDS pandemic (Einterz et al.,

2007). AMPATH delivers HIV treatment and other primary healthcare, provides education, and undertakes research in networks of urban and rural Ministry of Health hospitals, health centers, and dispensaries across 8 counties in western Kenya (Rachlis et al., 2016). The programme has enrolled over 150,000 people living with HIV and provides HIV care and treatment to greater than 85,000 patients in 143 Ministry of Health facilities (Ndege et al., 2016).

Our research team has developed a community- and rights-based programme of research with street-connected children and youth working through Moi University and AMPATH (Embleton, Ott, et al., 2015; Kamanda et al., 2013). Over the past 9 years I have been conducting research in Eldoret, Kenya and have built a broad portfolio of research focused on and with street-connected children and youth (Embleton, Atwoli, et al., 2013; Embleton et al., 2012, 2014; Embleton, Ayuku, et al., 2018; Embleton, Lee, et al., 2016; Embleton, Mwangi, et al., 2013; Embleton, Ott, et al., 2015; Embleton, Wachira, et al., 2016, 2015). I am committed to improving the lives and circumstances of street-connected children and youth through conducting research with this population. Work to date conducted by myself and the broader research team identified a potentially hidden epidemic of HIV among street-connected children and youth and uncovered structural and social factors contributing to their HIV vulnerability in Eldoret, Kenya.

1.4.1. Street-connected young people's HIV vulnerability in Eldoret, Kenya: a convergence of sexual risk practices, gender inequities, and economic marginalization

Qualitative research undertaken to date in Eldoret, Kenya has explored sexual risk practices and the underlying social and structural factors driving street-connected children and youths' HIV

vulnerability, while quantitative research has described their sexual risk practices and quantified their STI and HIV morbidity.

Quantitative research conducted by Winston et al. from 2011 to 2012 initially uncovered a disproportionate burden of STIs and HIV among girls and young women connected to the streets in comparison to young men (Winston et al., 2015). This study found that 28% of participants tested positive for at least one STI, and this rose to 56% among young women. Out of 200 participants, 12 young women tested positive for HIV (15% of females) and no young men. Most commonly participants were infected with herpes simplex virus (HSV) HSV-2, chlamydia, gonorrhoea, and HIV. The study also identified numerous sexual risk practices among street-connected young people including low levels of condom use, transactional sex, and forced sex. Participants who reported engaging in transactional sex, drug use, or alcohol use were significantly more likely to be HIV positive (Winston et al., 2015). This study found that street-connected young people in Eldoret, Kenya had an STI and HIV prevalence that was higher than the national and regional prevalence for young people of similar age groups (Hawken et al., 2002; National AIDS Control Council, 2016; Wachira et al., 2014). The high STI and HIV prevalence among young women connected to the streets in Eldoret suggests they have a heightened vulnerability to acquiring HIV in comparison to young men and suggests potential gender differences in sexual risk practices. Overall, these quantitative findings began to identify concerning rates of STIs and HIV among this population and started to characterize the individual-level sexual risk practices and gender differences in the distribution of STIs and HIV among street-connected young people in Eldoret, Kenya (Winston et al., 2015).

Subsequently in 2013 our team conducted a qualitative study that sought to explore the

language used for sex, sexual practices, and their function unique to the street subculture among street-connected young people aged 11-24 in Eldoret, Kenya, which resulted in four publications (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2016, 2015). This work described the street subculture, social hierarchies, initiation practices and identities of street-connected young people in Eldoret. This research began to uncover substantial gender inequities and how street-connected girls and young women are sexually objectified and exploited in the Eldoret street subculture (Embleton, Wachira, et al., 2015; Wachira et al., 2015), but highlighted how street-connected young men also experience physical abuse and sexual violence (Wachira et al., 2015). Alarming street-connected young people in this study recounted severe intimate partner violence in the context of their relationships, including sexual violence (Embleton, Wachira, et al., 2015; Wachira et al., 2015). Given the association between sexual and gender-based violence, intimate partner violence, and HIV acquisition, these findings are particularly concerning (Jewkes, Dunkle, et al., 2010; Li et al., 2014; Mitchell, Wight, Van Heerden, & RoCHAT, 2016; UNAIDS, 2018a). Moreover, gender inequitable norms have been associated with sexual risk practices that elevate exposure to HIV in sub-Saharan Africa (MacPherson et al., 2015; Shannon et al., 2012), and therefore gender inequitable sexual practices in the street subculture likely elevate street-connected girls and young women's HIV vulnerability. In conjunction with these gender inequities and sexual and gender-based violence, street-connected young people live in impoverished circumstances. The intersection of poverty, gender inequities, sexual and gender-based violence and HIV acquisition for young women has been well established (Kim et al., 2008; MacPherson et al., 2015).

This qualitative work also explored the sexual practices in the street subculture. It was

suggested that abstaining from sex on the streets was impossible, and that acceptable sex acts include vaginal intercourse and oral sex performed on a man by a woman. Unacceptable sexual acts included masturbation, anal intercourse, sex between men, and sex between women; yet, these sex acts occur on the streets. These unacceptable sexual practices were deemed punishable within the street subculture with acts of physical violence (Embleton, Wachira, et al., 2015). Street-connected young people reported that they engaged in sex for pleasure, procreation, and to secure safety, economic, and material provisions. Participants described engaging in numerous sexual risk practices including multiple concurrent partnerships, commercial sex, and condomless sex (Embleton, Wachira, et al., 2015). Both street-connected young women and street-connected young men reported engaging in transactional sex with individuals outside of the street subculture, but it was discussed that street-connected young men who engage in transactional anal sex earn more than young women for vaginal sex (Embleton, Wachira, et al., 2015). However street-connected young men's reported engagement in transactional sex is very limited in comparison to street-connected young women's (Sorber et al., 2014; Winston et al., 2015). Young women connected to streets generally described the nature of their relationships as transactional to guarantee their security and provisions (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2016). Young women's engagement in transactional sex for securing social, economic, and material provisions and age-disparate relationships have been associated with HIV acquisition (Pettifor et al., 2018; Wamoyi, Stobeanau, Bobrova, Abramsky, & Watts, 2016). It has been demonstrated that young women's engagement in transactional and age-disparate relationships to secure social, economic, and material resources leads to unequal power dynamics in sexual relationships and

may increase young women's vulnerability to acquiring HIV through undermining condom use, multiple concurrent partnerships, and increasing exposure to intimate partner violence (Kim et al., 2008; Pettifor et al., 2018; Wamoyi et al., 2016).

Next, this qualitative study uncovered that street-connected young people believe several myths and misconceptions in relation to condom use, STIs and HIV, including blaming street-connected girls and young women for the transmission of STIs and HIV (Embleton, Wachira, et al., 2016). Having incorrect knowledge of HIV transmission and prevention methods may impair ones' recognition of their vulnerability to acquiring HIV and engaging in preventive practices. Yet, according to the health belief model, an individuals' perceived susceptibility of acquiring HIV is one of the necessary, but not sufficient, conditions for behaviour change (Rosenstock, 1974). Correct knowledge is also essential for an individual's self-efficacy to perform skills, such as condom use (Closson et al., 2018). Studies have demonstrated that higher levels of correct HIV knowledge significantly increases an individual's perceived HIV risk (Bernardi, 2002), and greater perception of risk has been linked to higher levels of sexual self-efficacy (Tenkorang & Maticka-Tyndale, 2014). The lack of accurate knowledge among street-connected young people in Eldoret regarding condom use, STIs, and HIV (Embleton, Wachira, et al., 2016) represents a troubling finding that requires remediation given the high prevalence of STIs and HIV uncovered by Winston et al (2015). Lastly, this qualitative work explored street-connected young women's experiences of pregnancy and highlighted their vulnerability acquiring HIV given their lack of agency in relation to sexual and reproductive health (Wachira et al., 2016).

As a follow-up to this work, alarmed by the gender inequities and differences in acquisition of STIs and HIV among street-connected young people in Eldoret, our team sought to conduct a secondary data analysis using intersectionality as a framework to explore and understand the social and structural drivers of these inequities (Embleton, Wachira, et al., 2018). This work revealed how macro-level structural factors shape and intersect with the street subculture to produce substantial gender inequities and harmful sexual and reproductive health outcomes for street-connected young people. Specifically it revealed the strong role that the patriarchy, sexism, political and economic context, and social-cultural forces play in shaping the Eldoret street subculture, resulting in hegemonic masculinities and detrimental gender roles and norms for young men and women; thereby influencing HIV vulnerability (Embleton, Wachira, et al., 2018). Street-connected boys and young men in Eldoret with very little education or vocational skills (Sorber et al., 2014), face the insurmountable task of trying to embody traditional social-cultural masculinities, which expect men to be the breadwinner and provider (Izugbara, 2015; Jewkes, Flood, & Lang, 2015). In Kenya and other sub-Saharan African contexts, it has been posited that young men who are unable to secure traditional masculinities construct violent and hypersexual masculinities as a result of feeling powerless and emasculated. As a result, young men perpetrate sexual and gender-based violence and engage in multiple sexual partnerships to assert their masculinity and regain their power and dominant social position (Gibbs, Sikweyiya, & Jewkes, 2015; Izugbara, 2015; Silberschmidt, 2001). Within the street subculture it is therefore likely that street-connected boys and young men attempt to affirm their masculinity through the use of sexual and gender-based violence, multiple sexual

partnerships, and through power, dominance, and control over girls and young women's bodies and social and economic resources in the street subculture (Embleton, Wachira, et al., 2018).

Girls and young women connected to the street are therefore mostly reliant on street-connected boys and young men for security, economic, and material provisioning. Moreover, division of labour and informal work in the street subculture may be gendered as girls and young women may be seen as 'unable to work' and are subjugated to relying on their bodies to engage in transactional sex survival (Embleton, Wachira, et al., 2016, 2015, 2018; Sorber et al., 2014; Wachira et al., 2015). Young women connected to the streets stated that sex was rarely engaged in for pleasure. Transactional sex with or without agency frequently resulted in girls and young women experiencing physical and sexual violence, and their bodies being controlled by men in exchange for men's economic and material provisioning. Street-connected girls and young women's reliance on transactional sex for survival can be understood in relation to the patriarchal street subculture, sexism, and Kenya's political-economy, where boys and young men hold power and control over informal jobs in the street subculture, and girls are forced rely on transactional sex for survival (Embleton, Wachira, et al., 2015, 2018; Sorber et al., 2014; Wachira et al., 2015). These findings underscore the role that structural factors such as poverty and stark gender inequities in the street subculture play in influencing street-connected young people's vulnerability to acquiring HIV. Additionally, they point to the need for interventions to support street-connected young people's engagement in productive and sustainable livelihoods that do not result in detrimental health outcomes. Moreover, findings from this analysis reveal that dialogue about healthy masculinities and femininities and what it means to be a man and woman need to occur for street-connected young people. Interventions aimed at preventing

sexual and gender-based violence, shifting gender norms, and improving gender equity in the street subculture, need to include both street-connected boys and young men and women and girls and target issues from the macro-structural level to the micro-individual level (Embleton, Wachira, et al., 2018; Jewkes et al., 2015).

Work by Sorber et al (2014) further identified potential social and structural drivers of street connected young people's HIV acquisition in Eldoret Kenya. Poverty was the primary reasons street-connected children and youth reported migrating to the streets in Eldoret. Street-connected boys and young men in Eldoret frequently experience arrest, conflict with authorities, and spend time in juvenile detention and jail. Street-connected boys and young men's persecution and detainment in juvenile detention or jail (Sorber et al., 2014), impacts their ability to hustle in the informal economy and maintain relationships where they are expected to provide economic and material provisions to uphold traditional masculine ideals. Their detention may result in their relationships deteriorating and young women's engagement in multiple concurrent partnerships to secure provisions (Embleton, Wachira, et al., 2018). As a result of their frequent detainment in jail and the resulting deterioration in their relationships, street-connected young men are further marginalized and oppressed and this likely contributes to the construction of unhealthy and harmful masculinities in the street subculture, which has implications for HIV acquisition and violence against women and girls (Embleton, Wachira, et al., 2018; Gibbs, Sikweyiya, et al., 2015).

Street-connected young people are economically marginalized. Over half (53%) of street-connected young people in Eldoret reported earning less than 100 Ksh (~ 1.33 CAD) per day, with boys and young men reporting earning significantly more than girls and young

women. Both young men and women reported relying on begging as their primary source of income demonstrating their economic marginalization. Street-connected young men reported engaging in a wider range of income generating activities in comparison to young women including recycling, watching cars, carrying luggage, and casual labour. In contrast, street-connected young women reported primarily relying on begging, casual labour, commercial sex, and donations (Sorber et al., 2014). The results of this study further support the need for interventions to ameliorate livelihoods for both street-connected young women and men in this setting to address complex structural drivers of HIV acquisition.

Building on Winston et al's (2015) quantitative study characterizing HIV prevalence our research team retrospectively and prospectively collected mortality data to document cause of death among street-connected children and youth in Eldoret from October 2009 to December 2016 (Embleton, Ayuku, et al., 2018). We recorded 100 deaths among street-connected children and youth in Eldoret. Approximately 37% of these deaths occurred among youth less than 18 years of age. Street-connected boys and young men accounted for 66% of recorded deaths. This study found that 37% of deaths were attributed to HIV and AIDS; 59% among deceased street-connected girls and young women and approximately 26% among street-connected boys and young men in Eldoret. These results broadened the evidence suggesting that street-connected young people in Eldoret may be particularly vulnerable to acquiring HIV, that HIV was a priority health concern that needed to be addressed in the street subculture, and that street-connected young people are likely not accessing healthcare and not seeking treatment after testing HIV-positive (Embleton, Ayuku, et al., 2018).

1.4.2. Launching a Peer Navigator Program at AMPATH

In response to these findings, in 2015 we launched a Peer Navigator program through AMPATH to engage street-connected young people in the HIV prevention-care continuum (Shah et al., 2018). The Peer Navigators (one male and one female) were between the ages of 18 to 24, of mixed sero-status, and had experience being street-connected in Eldoret. The aim of the Peer Navigator program was to conduct outreach with street-connected children and youth in Eldoret to increase linkage to HIV testing and treatment, and to offer education and support related to HIV. Over the course of almost 3 years the Peer Navigators engaged 817 individuals from the street community in Eldoret aged 1 to 29 years (including infants of street-connected young mothers). At their initial encounter with the Peer Navigators, 89% of street-connected young people consented to HIV testing and 6.7% knew their HIV-positive status at the initial visit (16% of young women and 4% of young men). Through this outreach and linkage to HIV testing, 12 street-connected young people newly tested positive for HIV. In total the Peer Navigator program identified 67 street-connected young people living with HIV (27 young men and 36 young women). The overall HIV prevalence was 8.1%, with young women being four times more likely to be living with HIV than young men (18.4% vs. 4.6%). This indicated that street-connected young people in Eldoret have an HIV prevalence that exceeds adults and adolescents nationally and regionally (NAS COP, 2014; National AIDS Control Council, 2014, 2016). Lastly, this study supported the power that peers have in engaging street-connected young people in Eldoret in the HIV prevention-care continuum (Shah et al., 2018).

1.4.3. Establishing the HIV Prevalence among street-connected young people in Eldoret, Kenya

Finally, in 2016 the research team conducted a point-in-time count to estimate the number of street-connected young people below 30 years of age in Eldoret, and to establish an HIV prevalence in this population (Braitstein et al., 2019). Through the point-in-time count HIV testing and counselling was offered to establish HIV prevalence in this population. Overall the study found an HIV prevalence of 4.4%. When stratified by sex the HIV prevalence was 8.9% among street-connected girls and young women and 2.7% among street-connected boys and young men. When stratified by specific age groups and sex, the HIV sero-prevalence for street-connected young men aged 15-24 years was 2.8% and 5.6% for those aged 25-29 years, while the HIV sero-prevalence among street-connected young women aged 15-24 years was 10.8% and 26.8% for those aged 25-29 years (Braitstein et al., 2019).

Figure 4 shows the HIV prevalence among street-connected children aged less than 15 years, youth aged 15-24 years, and young people aged 25-29 years documented through the point-in-time count and Peer Navigator program in comparison to the national HIV prevalence among these age groups from the 2012 Kenya AIDS Indicator Survey (KAIS) (NASCOP, 2014; National AIDS Control Council, 2014). It is evident that street-connected young women aged 15-24 years have an HIV prevalence that exceeds other young women nationally, and are disproportionately acquiring HIV in comparison to street-connected young men. These prevalence findings demonstrate a clear need to implement interventions specifically targeting street-connected young people and linking them to the HIV prevention-care continuum.

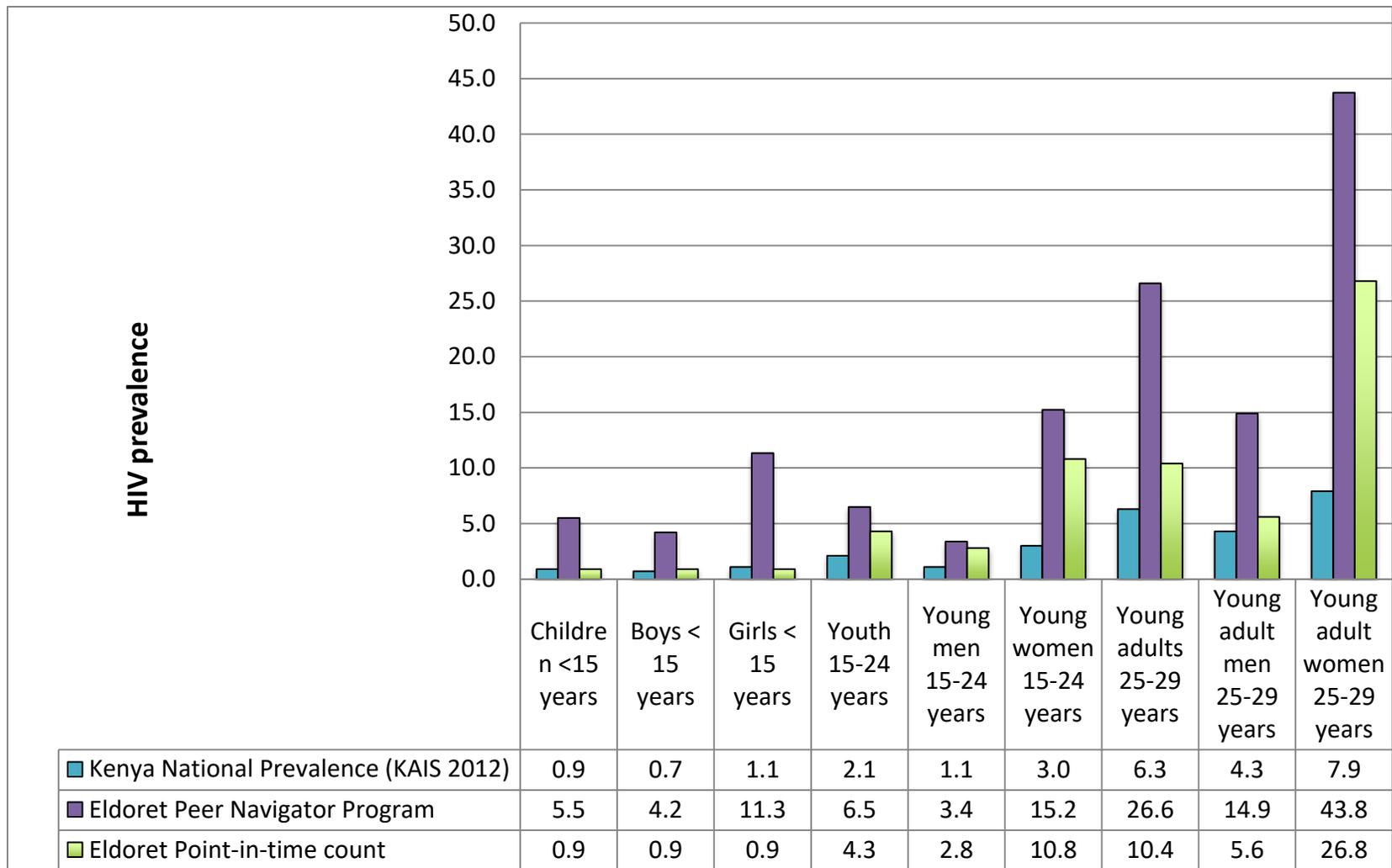


Figure 4 Kenya national HIV prevalence compared to street-connected young people's HIV prevalence identified through the Peer Navigator program and point-in-time count in Eldoret, Kenya stratified by age and gender groups

1.4.4. Summarizing the evidence and identifying key areas for intervention

In summary, the work to date conducted by our research team uncovered key individual, social, and structural aspects of street-connected young people's vulnerability to acquiring HIV in Eldoret, Kenya, which requires attention. First, street-connected young people have many myths and misconceptions in relation to condom use, STIs, and HIV, which points to the need to increase knowledge in these domains to improve risk perception and sexual self-efficacy. Second, the street subculture in the context of Kenya contributes to constructing harmful masculinities and femininities for street-connected young people and there is a need to shift gender norms and improve gender equity for both street-connected young women and young men. Given that gender inequitable norms have been associated with sexual risk practices that elevate exposure to HIV in sub-Saharan Africa (MacPherson et al., 2015; Shannon et al., 2012), it has been proposed that the inclusion of both men and women in interventions to reduce sexual and gender-based violence and shift gender norms is vital (Dworkin, Treves-Kagan, & Lippman, 2013; Gibbs, Jacobson, & Wilson, 2017; Gibbs et al., 2012; Jewkes et al., 2015). Third, both young men and women connected to the streets are economically marginalized typically earning less than 100 Ksh (~\$1.33 CAD) per day and engaging in precarious livelihood activities, demonstrating the need to intervene to secure livelihoods. The intersection of poverty and HIV acquisition risk for young people in sub-Saharan Africa has been established (Pettifor et al., 2018; Wamoyi et al., 2014). Therefore, this is likely a salient avenue to intervene at a structural level for street-connected young people, as street-connected young men's economic marginalization may contribute to the construction of the harmful masculinities in the street

subculture, and street-connected young women's economic marginalization intersects with gender inequities that result in young women relying on transactional sex for survival. Finally, it is evident that street-connected young people in Eldoret, Kenya are engaging in sexual practices that elevate exposure to HIV and have an HIV prevalence that exceeds other young people nationally, and therefore require interventions to address sexual and reproductive health.

Despite street-connected young people's clear vulnerability to acquiring HIV, the National AIDS and STI Control Programme (NAS COP) in Kenya, the organization that leads the Ministry of Health's interventions for HIV and AIDS, largely fails to adequately reach street-connected young people with HIV prevention efforts, as adolescent HIV prevention programmes are primarily school-based (Pitorak, Bergmann, Fullem, & Duffy, 2013). Additionally, the Adolescent Reproductive Health and Development Policy and Action Plan (2005-2015) (NCPD, 2005) which sought to expand adolescent reproductive health services, had limited implementation due to social, cultural and political challenges, including but not limited to, low political will and youth involvement, a lack of resources and poverty, and contentious attitudes about adolescent sexual health in some communities (Godia et al., 2013; NCPD, 2013). To address this gap in HIV programming, innovative multi-faceted interventions for street-connected young people should be designed, implemented, and evaluated for their effectiveness in Kenya. Overall, these findings from Eldoret suggest that this population requires multi-faceted interventions that address gender norms and inequities, sexual and gender-based violence, and sexual risk practices, while providing comprehensive sexual and reproductive health education, as well as a means to reduce street-connected young people's economic marginalization and support livelihood opportunities.

Chapter 2 Reviewing the literature to identify potentially suitable, feasible, and effective interventions to use with street-connected young people in Eldoret, Kenya

2.1. Interventions for street-connected children and youth in LMICs

To date, there is a dearth of evidence on effective interventions for street-connected children and youth in LMICs to reduce the harms associated with living and working on the streets (Berckmans et al., 2012; Coren et al., 2016; Dybicz, 2005; Naranbhai, Abdool Karim, & Meyer-Weitz, 2011; Watters & O’Callaghan, 2016). Nor have any effective interventions been specifically identified to reduce street-connected young people’s sexual risk practices (Coren et al., 2016; Naranbhai et al., 2011). In general, reviews conducted to identify effective interventions for street-connected children and youth in LMICs point to insignificant evidence and the need for more research on potentially effective interventions (Berckmans et al., 2012; Coren et al., 2016; Dybicz, 2005; Naranbhai et al., 2011; Watters & O’Callaghan, 2016). However, these reviews do identify some key components of interventions that should be considered integral to designing programmes for this population.

It has been widely suggested that an important component of designing, implementing, evaluating interventions for street-connected children and youth is to actively involve them in identifying health priorities and to ensure they participate in the design, planning, and management of any programme (Berckmans et al., 2012; Coren et al., 2016; Naranbhai et al., 2011; OHCHR, 2017). Coren et al. (2016) in their systematic review discuss the importance of

considering both individual-level and contextual factors in the design of interventions for street-connected children and youth, and the use of logic models to understand the relationship between contextual factors, interventions, and outcomes (Coren et al., 2013, 2016). Berckmans et al (2012) highlighted the importance of establishing trusting relationships with street-connected children and youth and that peer educators may play an invaluable role as they share lived experience, language, and may be able to discuss sensitive topics with street-connected children and youth in a manner that is more comfortable than with adults (Berckmans et al., 2012). Moreover, it was suggested that interventions for street-connected children and youth focused on livelihoods are an approach that have not received significant attention in academic literature, and the provision of financial assistance was identified as a clear gap. Given the structural factors, specifically poverty, social and economic inequity, and social exclusion experienced by street-connected children and youth, Berckmans et al (2012) suggests, a sustainable livelihoods approach may be a viable and important avenue for interventions with this population aimed at reducing the harms associated with street-involvement (Berckmans et al., 2012). A sustainable livelihoods approach also aligns with what Dybicz (2005) terms 'secondary prevention', aimed at ensuring street-connected young people can safely transition into adulthood off the streets and increase their ability to secure income (Dybicz, 2005).

What is clear from these reviews is that no one specific intervention will meet all of the needs of street-connected children and youth, and that interventions must be multi-faceted and address factors across multiple levels of the social-ecological model given their various intersecting vulnerabilities. As no effective interventions have been identified in the literature

addressing sexual risk practices, gender inequities, livelihoods, and other social and structural factors for street-connected children and youth in LMICs (Berckmans et al., 2012; Coren et al., 2013, 2016; Dybicz, 2005; Naranbhai et al., 2011; Watters & O’Callaghan, 2016), adapting an existing evidenced-based intervention with and for street-connected young people may be a viable approach to fill this gap.

2.2. Adapting evidence-based interventions for new contexts and populations

Adaptation is defined as the process of modifying or changing an evidence-based intervention for a new context to reduce mismatches, without conflicting with or negating its core elements, thereby maintaining intervention fidelity (Card, Solomon, & Cunningham, 2011; Gordon, Welbourn, & Trust., 2017; Wingood & DiClemente, 2008). Taking into account the new context is essential to ensure that the intervention’s content and delivery is culturally appropriate. The term context broadly encompasses multiple features (e.g. geographical, political, social, or cultural) that may interact with the intervention to produce variation in implementation processes or outcomes (Craig et al., 2018). Context is also a vital component of HIV implementation research. Numerous effective HIV interventions are rarely replicated in other contexts, as they need to be adapted to a new environment. Addressing context in the implementation or adaptation of an intervention may include considering language, ethnicity, cultural practices and gender norms, socioeconomic status, urban versus rural context, the healthcare facility, staff cultural competence, community readiness, sources of funding, and

socio-political influences that may impact intervention delivery (Castro, Barrera, & Martinez, 2004; Edwards & Barker, 2014).

Adaptations may involve modifying programme content or the method of programme delivery. Modifying content may occur as a result of needs or wants of a group that are not offered in the original intervention. While altering delivery may involve changing the characteristics of the delivery person, the mode of delivery (e.g. class-based, internet-based), and the location of delivery (Castro et al., 2004). Few models and theoretical frameworks exist for adapting existing evidence-based interventions (Card et al., 2011; Castro et al., 2004; John et al., 2014; Solomon, Card, & Malow, 2006; Wainberg et al., 2007; Wingood & DiClemente, 2008). One framework that has been used to successfully adapt HIV interventions with adolescents (Latham et al., 2010) and with other populations in sub-Saharan Africa (Audet, Salato, Vermund, & Amico, 2017; Wechsberg et al., 2015) is the ADAPT-ITT model (Wingood & DiClemente, 2008).

The ADAPT-ITT model provides a prescriptive method for adapting evidence-based interventions over 8 sequential steps: 1) assessment; 2) decision; 3) adaptation; 4) production; 5) topical experts; 6) integration; 7) training; 8) testing. The steps and methodologies used in the ADAPT-ITT model are outlined in Table 1 adapted from Wingood and DiClemente (2008). Each step of the ADAPT-ITT model poses a specific question that the adaptation team is required to answer and associated methodologies that can be used to answer it.

Step 1, Assessment, involves identifying the needs of the new target population, including HIV-associated risks and vulnerabilities. Step 2, Decision, involves reviewing the existing interventions, selecting one for the new target population, and deciding if it should be

adopted or adapted. Step 3, Administration, involves deciding what needs to be adapted in the original intervention and how to do so. This step involves the use of 'theatre testing' whereby a demonstration of the intervention is given to participants to elicit feedback. Step 4, Integration, involves producing a first draft of the intervention based on feedback, while balancing maintaining its core elements and fidelity. In Step 5, topical experts are engaged and consulted to provide expertise in relation to the interventions content and delivery. Step 6, Production, requires integrating adaptations arising from the topical experts into a second draft of the adapted intervention. In Step 7, personnel are trained in relation to all aspects of the adapted intervention and study. Lastly in Step 8, the adapted evidence-based intervention is pilot tested with the new target population and a third draft is produced (Wingood & DiClemente, 2008).

Using the ADAPT-ITT model with street-connected young people in Eldoret, Kenya to adapt an existing evidence-based intervention that responds to their needs in relation to gender inequities, livelihoods, sexual and reproductive health education, and HIV prevention, may be a feasible method of identifying a potentially feasible and suitable intervention for use with this marginalized population. Adapting a multi-faceted HIV prevention intervention that has been tested for its effectiveness and used with other vulnerable young people in sub-Saharan Africa may be suitable and increase the intervention's contextual relevance.

Table 1 Steps and methodology used in the ADAPT-ITT model developed by Wingood and DiClemente (2008)

Step	Questions	Methodology
1. Assessment	Who is the new target population and why are they at risk of HIV?	<ul style="list-style-type: none"> • Conduct a needs assessment and focus groups with the new target population • Conduct focus groups and interviews with the key stakeholders • Analyse results of formative research
2. Decision	What intervention is going to be selected and is it going to be adopted or adapted?	<ul style="list-style-type: none"> • Review HIV interventions defined as evidence-based interventions (EBI) • Decide on the intervention to be selected • Decide on whether to adopt as is or adapt the intervention
3. Administration	What in the original intervention needs to be adapted, and how should it be adapted?	<ul style="list-style-type: none"> • Administer theatre test with members of the new target population and involve key stakeholders as observers • Elicit participants' and stakeholders' reactions to the theatre test through a questionnaire
4. Production	How do you produce draft 1 and document adaptations to the intervention?	<ul style="list-style-type: none"> • Produce draft 1 of the adapted evidence-based intervention • Balance priorities while maintaining fidelity to the core elements and underlying theoretic framework of the original intervention • Develop an adaptation plan • Develop quality assurance and process measures
5. Topical Experts	Who can help adapt the intervention?	<ul style="list-style-type: none"> • Identify topical experts • Actively involve topical experts in adapting the evidence-based intervention
6. Integration	What is going to be included in the adapted intervention that is to be piloted?	<ul style="list-style-type: none"> • Integrate content from topical experts based on the capacity of the institution, and create draft 2 of the adapted EBI • Integrate scales that assess new intervention content in study survey
7. Training	Who needs to be trained?	<ul style="list-style-type: none"> • Train staff to implement the adapted EBI, including recruiters, facilitators, and assessment and data management staff
8. Testing	Was the adaptation successful, and did it enhance short-term outcomes?	<ul style="list-style-type: none"> • Test the adapted EBI as part of a pilot study • Analyse results of the pilot study and use results in phase 2 study • Analyse results of the phase 2b study to determine efficacy

In the context of this dissertation research, Step 1 Assessment, of the ADAPT-ITT model occurred from 2013 to 2015, where the research team identified needs in relation to HIV prevention and care, gender equity, and livelihoods among street-connected young people in Eldoret, Kenya (Braitstein et al., 2019; Embleton, Ayuku, et al., 2018; Embleton, Wachira, et al., 2016, 2015, 2018; Shah et al., 2018; Sorber et al., 2014; Wachira et al., 2016, 2015; Winston et al., 2015). Subsequently, in 2016 the doctoral candidate and two other research team members conducted a scoping review using Arksey and O'Malley's five-stage framework (Arksey & O'Malley, 2005) for Step 2 'Decision' of the ADAPT-ITT model. The scoping review sought to identify effective evidence-based interventions on the HIV prevention-care continuum for high-risk youth that may be suitable and could be adapted for and with street-connected young people in Eldoret, Kenya.

The results of the scoping review were presented to the full research team. Interventions were assessed in relation to their potential impact and position on the HIV prevention-care continuum; its type (behavioural, biomedical, social, structural, or a combination); and feasibility, applicability, and suitability in our setting. Through a series of meetings the research team came to a consensus on three interventions that were suitable for adapting and piloting with street-connected young people in the context of Eldoret, one of which I chose to use for this dissertation. The literature supporting the selection of the gender, livelihoods, and HIV prevention intervention, which was used in this thesis will now be reviewed.

2.3. HIV prevention for young people in sub-Saharan Africa: what works?

UNAIDS recommends combination HIV prevention programmes that are rights-based, evidence-informed and community-owned with a mix of biomedical, behavioural, and structural interventions (UNAIDS, 2010). For adolescents and young people The Global HIV Prevention Coalition highlights five prevention pillars to strengthen national adolescent and youth HIV prevention programmes including: 1) increasing access to combination prevention; 2) ensure that combination prevention for all young key populations is evidence-informed, human rights-based and is community-led and tailored to needs of key populations; 3) strengthen condom and behaviour change programmes; 4) increase the availability and uptake of voluntary male medical circumcision; 5) offer pre-exposure prophylaxis (PrEP) to groups of young people who are highly vulnerable to acquiring HIV (UNAIDS, 2018b). A number of reviews and systematic reviews have been conducted to identify and assess effective HIV prevention interventions for young people ages 10-24, with many identified interventions occurring in sub-Saharan Africa (Arrivillaga & Salcedo, 2014; Baxter & Abdool Karim, 2016; Gibbs et al., 2012; Hardee, Gay, Croce-Galis, & Afari-Dwamena, 2014; Harrison, Colvin, Kuo, Swartz, & Lurie, 2015; Harrison, Newell, Imrie, & Hoddinott, 2010; Kalamar, Bayer, & Hindin, 2016; Kirby, Laris, & Rolleri, 2007; Maticka-Tyndale & Brouillard-Coylea, 2006; Michielsen, Chersich, Temmerman, Dooms, & Van Rossem, 2012; Michielsen et al., 2010; Mwale & Muula, 2017; Napierala Mavedzenge, Doyle, & Ross, 2011; Napierala Mavedzenge, Luecke, & Ross, 2014; Wamoyi et al., 2014; Yankah & Aggleton, 2008).

These reviews demonstrate that the majority of interventions tested to date with adolescents have relied on cognitive behavioural theories of change, primarily focused on individual-level risk practices delivered through school-based interventions, failing to capture out-of-school youth (Michielsen et al., 2010, 2012; Napierala Mavedzenge et al., 2011, 2014; Yankah & Aggleton, 2008). These behavioural interventions have been effective at improving HIV knowledge and attitudes (Michielsen et al., 2010; Napierala Mavedzenge et al., 2011, 2014; Yankah & Aggleton, 2008), but have demonstrated mixed effectiveness on young people's self-reported sexual practices that elevate HIV exposure (Maticka-Tyndale & Brouillard-Coylea, 2006; Michielsen et al., 2010; Mwale & Muula, 2017), and they have had minimal impact on biological outcomes (Harrison et al., 2010; Michielsen et al., 2010; Napierala Mavedzenge et al., 2011, 2014; Yankah & Aggleton, 2008).

A notable exception among identified behavioural interventions was the community-based 'Stepping Stones' cluster randomized controlled trial from South Africa (Jewkes et al., 2006, 2008; Jewkes, Wood, & Duvvury, 2010). The Stepping Stones intervention consists of 13 participatory sessions focused on gender, communication, sexual health and HIV prevention. The trial did not reduce HIV incidence; however, programme participants experienced a 33% reduction in incident Herpes Simplex Virus-2 (HSV-2). Participation in Stepping Stones improved sexual risk practices among young men, with a lower proportion of young men reporting perpetration of physical or sexual intimate partner violence at 24 months follow-up, and less transactional sex, problem drinking, and drug use at 12 months. The study did find a small increase in the number of young women from the intervention engaging in transactional sex at

12 months, but this disappeared by 24 months (Jewkes et al., 2008; Jewkes, Wood, et al., 2010; Skevington, Sovetkina, & Gillison, 2013).

Key gaps identified in these reviews include the reliance on self-reported sexual practices, the lack of biological outcomes measured (Kalamar et al., 2016; Napierala Mavedzenge et al., 2014), and the absence of investigating the use of biomedical and structural interventions combined with behavioural approaches with adolescent populations (Harrison et al., 2010; Michielsen et al., 2012; Napierala Mavedzenge et al., 2014). The numerous reviews suggest that behaviour focused interventions alone are not enough to alter risk-taking behaviour among young people (Gibbs et al., 2012; Harrison et al., 2010), and that a focus on individual-level risk behaviours fails to take into account the numerous social and structural factors that limit young people's agency and ability to make behavioural changes (Gibbs et al., 2012; Harrison et al., 2010; Michielsen et al., 2012; Mwale & Muula, 2017; Yankah & Aggleton, 2008).

2.3.1. Structural interventions: economic and livelihood approaches to HIV prevention

Most recently, it has been recognized that social protection, economic, and livelihood approaches may be fundamental components of HIV prevention to address structural drivers of HIV acquisition (Arrivillaga & Salcedo, 2014; Cluver et al., 2015, 2016; Cluver & Sherr, 2016; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012; Kennedy, Fonner, O'Reilly, & Sweat, 2014; Kim et al., 2008; Pettifor, MacPhail, Nguyen, & Rosenberg, 2012; Toska et al., 2016; UNDP, 2014; Wamoyi et al., 2014). Economic and financial-based programmes aim to alleviate poverty and economically empower participants to make choices which they can transform into desired

actions and outcomes (Arrivillaga & Salcedo, 2014; Kim et al., 2008; Pettifor et al., 2012).

Economic-based approaches include: microfinance, conditional economic incentives, unconditional cash-transfers, vocational training and livelihood-strengthening programmes. In some cases these economic strengthening approaches have been combined with HIV education, gender transformative programmes, and other services (Cluver, Orkin, Boyes, & Sherr, 2014; Dunbar et al., 2014; Gibbs et al., 2012; Jewkes et al., 2014; Pronyk et al., 2006; Rotheram-Borus, Lightfoot, Kasirye, & Desmond, 2012).

Microfinance programmes include the use of small loans, savings, insurance, and the provision of other financial products and services to economically vulnerable individuals who are often unable to access formal financial institutions (Arrivillaga & Salcedo, 2014; Kennedy et al., 2014). Microfinance, vocational training, and livelihood strengthening approaches seek to support participants to develop their economic assets, secure livelihoods and commence income generating activities to address structural drivers of HIV vulnerability (Gibbs, Jacobson, et al., 2017; Kennedy et al., 2014). It has been hypothesized that for young women these economic and livelihood interventions work by allowing them to meet their own basic needs, thereby resulting in a reduction in their economic dependence on men and a reliance on transactional sex for securing social, economic, and material provisions. In turn, young women may enhance their ability to negotiate condom use, leave abusive relationships, have fewer partners, and avoid age-disparate relationships driven by economic marginalization (Gibbs et al., 2012; Kennedy et al., 2014; Wamoyi et al., 2014). For young men however, it remains unclear how these economic strengthening interventions alone may impact their sexual risk

practices and HIV vulnerability as very few studies have included young men to date (Gibbs et al., 2012; Kennedy et al., 2014).

Conditional economic incentives or conditional cash-transfers for participants in an intervention are contingent on achievement of a behavioural goal, such as remaining in school or STI free, and allow the individual to realize the immediate benefits of a behaviour change rather than imagining its positive future outcome (Harrison et al., 2015; Operario, Kuo, Sosa-Rubí, & Gálarraga, 2013). Conditional economic incentives for HIV prevention may provide the added nudge to elicit behaviour change and operate on the basis of behavioural economics (Gibbs, Jacobson, et al., 2017; Heise, Lutz, Ranganathan, & Watts, 2013; Medlin & de Walque, 2008). In contrast, unconditional cash-transfers are typically government social protection programmes that are paid monthly to eligible poor households not contingent on any behaviour (Pettifor et al., 2012).

A number of studies have found that receipt of conditional economic incentives, unconditional cash-transfers, microfinance, livelihood training, and combined economic strengthening and HIV prevention programmes have resulted in changes to structural drivers of HIV acquisition and sexual risk practices among young people in sub-Saharan Africa (Appendix I). Specifically, studies have found reductions in school drop-out (Cho et al., 2011; Hallfors et al., 2011), food insecurity (Dunbar et al., 2014), early marriage (Duflo, Dupas, Kremer, & Sinei, 2007; Hallfors et al., 2011), sexual debut (Cho et al., 2011; Handa, Halpern, Pettifor, & Thirumurthy, 2014), HIV risk practices (Cluver et al., 2014), transactional sex (Cluver et al., 2013), early childbearing and pregnancy (Duflo et al., 2007; Handa et al., 2015), HIV-prevalence (Baird, Garfein, McIntosh, & Özler, 2012), HSV-2 prevalence and incidence (Baird et al., 2012;

Karim et al., 2015), physical and/or sexual violence (Dunbar et al., 2014; Jewkes et al., 2014; Pettifor et al., 2016), unprotected sex (Pettifor et al., 2016; Pronyk et al., 2008), unwilling sex (Bandiera et al., 2012) and sexual risk taking intentions (Ssewamala, Han, Neilands, Ismayilova, & Sperber, 2010b). Additionally studies have demonstrated improved employment levels (Rotheram-Borus et al., 2012), gender equitable attitudes (Erulkar & Chong, 2005; Hallfors et al., 2011; Jewkes et al., 2014), HIV knowledge (Austrian & Muthengi, 2014; Bandiera et al., 2012; Dunbar et al., 2010), condom use (Bandiera et al., 2012), entrepreneurial skills (Bandiera et al., 2012), engagement in income-generating activities (Bandiera et al., 2012), savings, income, and earnings (Austrian & Muthengi, 2013, 2014; Bandiera et al., 2012; Dunbar et al., 2014, 2010; Erulkar & Chong, 2005; Jennings, Ssewamala, & Nabunya, 2016; Jewkes et al., 2014), HIV communication (Pronyk et al., 2008), HIV testing and counselling (Pronyk et al., 2008), sexual and reproductive health knowledge (Austrian & Muthengi, 2013), and HIV prevention attitudes (Jennings et al., 2016).

Overall these studies demonstrate that unconditional and conditional cash-transfers may be effective at reducing sexual risk practices that increase exposure to HIV among young people in sub-Saharan Africa. However, there remains a lack of evidence of their impact on reducing HIV incidence. It has been suggested that the mechanisms of action of unconditional and conditional cash-transfer programmes on reducing HIV risk practices is complex given numerous contextual factors, and that cash transfers combined with other programmes or services might have a greater effect on HIV prevention than cash alone (Cluver et al., 2014; Pettifor et al., 2016).

Similarly, utilizing other economic-strengthening approaches such as microfinance, vocational training or livelihood approaches combined with HIV and life skills education may improve structural factors such as daily earnings, savings, and gender equitable attitudes, and may reduce some sexual risk practices (Appendix I), however no studies have demonstrated a reduction in HIV incidence. Reviews have highlighted key gaps in the use of these structural and economic interventions for young people and other populations (Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012; Kennedy et al., 2014; Kim et al., 2008; Wamoyi et al., 2014).

First, the use of economic strengthening approaches alone may be inadequate. It has been suggested that economic strengthening approaches need to be combined with health education, life skills, or gender transformative programmes to address salient issues increasing HIV vulnerability, such as gender inequities and violence, in order to be effective (Arrivillaga & Salcedo, 2014; Gibbs, Jacobson, et al., 2017; Kennedy et al., 2014; Kim et al., 2008).

Second, a number of these studies have focused solely on adolescent girls and young women and have failed to include young men and therefore the effectiveness and outcomes associated with the use of some of these programmes with young men is unknown (Arrivillaga & Salcedo, 2014; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012; Kennedy et al., 2014). While young men have largely been excluded from economic strengthening approaches, the literature has explored how young men's economic marginalization and oppression may result in the social construction of harmful masculinities in some sub-Saharan African contexts, giving rise to sexual and gender-based violence and multiple sexual partnerships, which increase HIV vulnerabilities for young women and young men. Therefore, it has been suggested that research needs to occur to understand what building young men's livelihoods would look like,

and how this would influence HIV risk practices (Gibbs, Sikweyiya, et al., 2015). Next, the use of economic strengthening interventions only with young women has raised concerns regarding the potential for young men's negative reactions, such as increased intimate partner violence or harassment, given the shift in young women's economic power in relationships and challenging gender norms (Gibbs, Jacobson, et al., 2017; Kennedy et al., 2014). Consequently, it has been suggested that the inclusion of young men in combined gender transformative and economic strengthening interventions may be an important strategy to address these concerns (Dworkin et al., 2013; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012). Gender transformative interventions are those that seek to shift socially constructed gender roles and norms towards more gender equitable within relationships, with the goal of reducing violence, unsafe sex, and improving gender relations. It has been shown that gender transformative interventions can increase protective sexual practices, prevent intimate partner violence, modify inequitable attitudes, and reduce STI and HIV acquisition (Dworkin et al., 2013; Fleming, Gruskin, Rojo, & Dworkin, 2015). Young men are an important component of changing gender inequality, gender norms, and reducing sexual and gender-based violence, and thus reducing young people's risk of acquiring HIV. The inclusion of both young men and young women in gender transformative interventions has been limited and requires more research (Dworkin et al., 2013). However it has been suggested, when viewing issues of gender equity, violence, and HIV as interpersonal and across genders, it is evident that both young men and women need to embrace changes to achieve gender equality and reduce HIV vulnerabilities (Gibbs et al., 2012).

Third, it has been suggested that interventions using microcredit with young women may induce sexual risk practices due to the need to make loan repayments and thereby

increase HIV vulnerability (Dunbar et al., 2014; Gibbs et al., 2012; Wamoyi et al., 2014). It has been proposed that loans may not be suitable for young people whom are extremely vulnerable, and that mentorship, social support, and physical safety, may be essential foundational components for vulnerable adolescent girls and young women before increasing savings and commencing other livelihood activities (Kim et al., 2008; Wamoyi et al., 2014). Finally, it has been suggested that there is a need to continue to rigorously test and evaluate structural HIV interventions for young people in sub-Saharan Africa given the limited number of studies conducted to date (Wamoyi et al., 2014). When the efficacy and effectiveness of these multi-level interventions is firmly established, it will be important to test these structural interventions within different contexts to see if they are scalable (Edwards & Barker, 2014). Overall, more research is needed to address the overall effectiveness of these interventions at reducing adolescent sexual risk practices, assess their sustainability, and uncover their mechanisms of action on preventing HIV acquisition over time (Arrivillaga & Salcedo, 2014; Wamoyi et al., 2014).

2.3.2. Selecting an evidence-based intervention

Reviewing the interventions in Appendix I with respect to identifying potentially suitable and feasible multi-faceted interventions for street-connected young people in Kenya, it is evident that the use of school-based and household-based cash-transfer programmes may fail to reach this population once they have left home and are no longer in school. However, these are critically important programmes that may prevent child and youth street-involvement by addressing household poverty and drivers of school dropout, such as lack of school uniforms

and fees. For children and youth already connected to the streets, community-based and participatory multi-faceted interventions that have been tested with out-of-school young people may be feasible and suitable.

During Step 2 'Decision' of the ADAPT-ITT model process, the combined Stepping Stones and Creating Futures intervention was identified as one of three potentially effective interventions the research team sought to adapt and pilot to determine if they would be suitable, feasible, acceptable and potentially effective, with street-connected young people in the context of Kenya. The combined Stepping Stones and Creating Futures intervention was selected for numerous reasons: 1) its existing use with out-of-school young people living in informal settlements (Jewkes et al., 2014); 2) Stepping Stones and Creating Futures has demonstrated effectiveness at changing behavioural outcomes, improving gender equitable attitudes, and reducing sexual and gender-based violence and HSV-2 incidence (Jewkes et al., 2008; Jewkes, Wood, et al., 2010; Misselhorn, Mushinga, Jama Shai, & Washington, 2014; Skevington et al., 2013); 3) it has been used with both young men and women (Jewkes et al., 2014); 4) it has the ability to address social and structural drivers of HIV acquisition (Gibbs, Jewkes, Sikweyiya, & Willan, 2014; Gibbs, Washington, et al., 2017; Misselhorn, Jama Shai, Mushinga, Washington, & Mbathe, 2013); and 5) its focus on gender, livelihoods, and HIV which were key identified needs during Step 1 'Assessment'.

2.4. Stepping Stones and Creating Futures: a combined gender, livelihoods, and HIV prevention intervention

2.4.1. The Stepping Stones programme

Stepping Stones is a gender transformative, HIV, communication, and relationship skills intervention, which was developed by Alice Welbourn in 1995 from work in Uganda and has since been implemented in over 40 countries, adapted in 17 settings, and translated into 16 languages (Dworkin et al., 2013; Gordon et al., 2017; Jewkes et al., 2006, 2008; Skevington et al., 2013; Welbourn, 1995). Stepping Stones has been shown to reduce transactional sex, intimate partner violence, multiple concurrent partnerships, alcohol consumption before sex, and stigma against people living with HIV and AIDS, increase condom use, HIV knowledge, testing, and awareness, change attitudes, improve gender equity, and communication skills (Skevington et al., 2013). Only one study conducted in South Africa has measured the impact of the intervention on biological outcomes, and demonstrated a 33% reduction in incident HSV-2 (Jewkes et al., 2006, 2008); however, no study has proven its effectiveness in reducing HIV incidence (Alvarado et al., 2017; Paine et al., 2010; Skevington et al., 2013). The original curriculum consists of 13 participatory sessions that aim to improve sexual health and promote greater gender equity in relationships among men and women. Topics covered over the 13 three-hour sessions include: reflecting on love, sexual health joys, body mapping, menstruation, contraception and conception, sexual problems, unwanted pregnancy, HIV, STIs, safe sex, gender-based violence, motivations for sexual behaviour, dealing with grief and loss, and communication skills (Welbourn, 1995). The programme is delivered in single gender groups,

with 20 participants per group, with a same gender facilitator to create a safe and supportive environment. The single gender group format allows for open discussion where participants can candidly explore barriers and facilitators to behaviour change (Jewkes et al., 2006). Young men and women slightly older than study participants typically deliver the programme and receive extensive training over the course of 3-4 weeks (Jewkes et al., 2006). In addition, the programme includes three sessions where young men and women come together, and an opportunity for the participants to work together to disseminate their new knowledge to their broader community (Jewkes et al., 2006; Jewkes, Wood, et al., 2010). Peer group meetings bring together the young men and women who are participating in the single gender and age stratified sessions. The principle behind the peer group sessions is to give participants an opportunity to communicate openly together about their feelings and perspectives on the topics that have been explored through the curriculum. The first peer group meeting occurs between the third and the fourth session and focuses on gender norms and pressures and how these influence participants' sexual experiences. The second peer group meeting occurs between the seventh and eighth session and focuses on gender power inequity and experiences of violence (Jewkes et al., 2006; Welbourn, 1995). The final peer group meeting aims to have participants work together to summarize lessons learnt in the curriculum and have the opportunity to disseminate this to their wider community (Jewkes, Nduna, & Jama, 2010a).

The Stepping Stones programme is designed to be participatory and uses critical reflection, role-playing scenarios, and drama, which draw on the everyday reality of participants' lives (Gordon et al., 2017; Jewkes et al., 2006; Welbourn, 1995). The programme draws on Freirean critical pedagogy, encouraging participants to recognize their existing

knowledge from their lived experience, while fostering dialogue in a safe space between participants and facilitators (Gibbs, Jewkes, Mbatha, Washington, & Willan, 2014; Gibbs, Willan, Jama-Shai, Washington, & Jewkes, 2015; Jewkes et al., 2006; Skevington et al., 2013). Freire's philosophy stresses the importance of working *with* the oppressed, instead of *for* the oppressed. Educational projects that are carried out *with* the oppressed begin to bring about a critical consciousness among the participants, whom then can begin the journey to reach their full human potential (Freire, 2005). Freire views the traditional education system as a 'banking' concept of education, whereby the teacher fills the student with information in a didactic process, leaving the oppressed under the power of the oppressors. Traditionally, the educator's role is to regulate knowledge, promote rote memorization, and control what constitutes true knowledge, which precludes critical thinking and any transformation among students (Freire, 2005). Freire proposes an alternative 'problem-posing' model of education that re-conceptualizes the teacher-student relationship, to one that is co-intentional and dialogical, allowing both the student and the teacher to think critically through a co-investigational process of reflection and action (Freire, 2005).

Stepping Stones promotes an approach to education that is 'problem-posing' and moves away from the didactic teacher-student system and fosters one that is dialogical between participants and a facilitator (Gordon et al., 2017; Welbourn, 1995). Generating authentic dialogue requires a safe environment where power dynamics within relationships are equalized, which encourages participants to share their stories and thoughts openly (Poland, Cavalcante Jr., & Wong, 2012). Stepping Stones promotes dialogue through establishing a safe space at the outset of the programme and reducing power relations by equalizing participants

and facilitators through sitting in a circle to conduct sessions (Welbourn, 1995). Through this process of facilitation and dialogue in a safe space, the Stepping Stones programme aims to bring about a critical consciousness among participations through prompting participants to question their reality and to recognize the factors that shape their behaviours, which leave them vulnerable to HIV acquisition (Gibbs, Willan, et al., 2015).

2.4.2. The Creating Futures programme

In its third adaptation in South Africa (Jewkes, Nduna, et al., 2010a), Stepping Stones was combined with a structural intervention named Creating Futures (Misselhorn et al., 2013). Recognizing the role that poverty, gender inequity, and livelihood insecurities have on HIV vulnerability for young people in South Africa, the South African Medical Research Council in cooperation with KwaZulu Natal University and an eThekweni non-governmental organization collaborated to design an intervention responsive to these factors impacting HIV vulnerability for young people living in informal settlements (Misselhorn et al., 2014). Creating Futures was designed to build sequentially on Stepping Stones and uses similar participatory approaches to learning as Stepping Stones (Jewkes et al., 2014). The livelihood-strengthening curriculum consists of 11 peer facilitated single gender sessions in groups of 20. The programme was developed based on sustainable livelihoods framework, which states that people build and maintain their livelihoods drawing on a variety of resources. These resources are categorized into five 'capitals': financial, natural, human, physical, and social. These capitals can facilitate or constrain an individual's ability to build and sustain their livelihoods (Misselhorn et al., 2014). The Creating Futures sessions cover: securing and keeping jobs, budgeting, saving, debt, social

resources for livelihood, coping with crises, incoming generating activities, setting goals and building basic business principles. The goal of the programme is to empower young people to find pathways out of poverty and vulnerability (Jewkes et al., 2014; Misselhorn et al., 2014).

2.4.3. Outcomes of testing the combined programme in South Africa

The combined Stepping Stones and Creating Futures intervention was piloted in two urban informal settlements with out-of-school young people aged 18-34 in Durban, South Africa using an interrupted time series design (Jewkes et al., 2014). The combined programme comprised of 21 sessions was delivered sequentially over 12 weeks, in twice weekly 3-hour sessions delivered by trained facilitators of a similar age but different socioeconomic status. The intervention had a positive impact on participants' reported earnings across time points for both men and women. Young men's mean earnings increased by 247% from R411 (~\$ 40) to R 1015 (~\$102) and young women's increased 278% from R 174 (~ \$17) to R 484 (~\$48). For young women, there was a significant reduction in experiencing physical and/or sexual intimate partner violence in the prior three months from 30.3% to 18.9%. Both men and women reported improved gender equitable attitudes at 12 months, and young men significantly reduced controlling practices in their relationships (Jewkes et al., 2014). The combined intervention had an impact on young men's psychosocial health. Young men in the intervention experienced a substantial reduction in the symptoms of severe or moderate depression and reported a reduction in suicidal ideation. The intervention did not result in changes in transactional sex or condom use, however there was a trend towards young women increasing condom use (Jewkes et al., 2014). A qualitative evaluation of the programme with young men revealed that

participation in the programme created safe social spaces for dialogue and critical thinking, increased participation in the formal and informal economy, improved incomes and skills in relation to saving and budgeting (Gibbs, Jewkes, Sikweyiya, et al., 2014). The evaluation revealed that some young men experienced a shift in gender norms and relationships, and suggested some change in the perpetration of intimate partner violence. However, this shift may have been minimal as participants still discussed having control over their partners, the continuation of engaging in multiple concurrent partnerships, and the use of violence in relationships. Rather than a drastic shift to gender equitable masculinity, the intervention shifted gender norms from extremely harmful masculinities, which are characterized by hypersexuality and violence, to 'traditional' forms of masculinity characterized by economic provisioning and sustaining the household (Gibbs, Jewkes, Sikweyiya, et al., 2014). As young men in the intervention reported improved livelihoods (Jewkes et al., 2014), it was posited that this supported the shift towards more traditional masculinity with the ability to provide in relationships (Gibbs, Jewkes, & Sikweyiya, 2018; Gibbs, Jewkes, Sikweyiya, et al., 2014). However, it was found that the political and economic context limited the magnitude of young men's ability to establish stronger livelihoods. High rates of unemployment and crime, low levels of education, and a lack of capital to commence small businesses limited changes (Gibbs et al., 2018). Additionally the interpersonal contexts of young men's lives influenced change. Young men's romantic partners and families were supportive of their attempts to change, but in contrast peers made it challenging to implement positive changes to their lives through discouraging and ridiculing them. Lastly, it was found that there were primarily two forms of socially constructed masculinities in informal settlements, which limited participants' ability to

realize any radically new gender equitable identities. These findings suggested that different aspects of context facilitated or constrained changes for young men participants (Gibbs et al., 2018).

Finally, a process and implementation evaluation of the intervention found that poverty limited young people's participation, as informal work and short-term survival took precedence over attending the intervention. Moreover, transportation became a challenge for participants, as they did not have the money to cover the cost upfront despite receiving reimbursement. Young women's participation was further constrained due to their economic dependence on their partners, social obligations, and caring for children (Gibbs, Jewkes, Mbatha, et al., 2014). In addition, challenges and limitations in facilitation led facilitators to use a more didactic approach at times to delivering the intervention away from participatory methods. It was posited that this might have reduced critical thinking among participants and undermined the Freirian approaches to transformation (Gibbs et al., 2018; Gibbs, Willan, et al., 2015). Most recently, Stepping Stones and Creating Futures have been evaluated in a two-arm cluster randomized control trial in South Africa. However, the final results of the trial have yet to be released (Gibbs, Washington, et al., 2017).

Figure 5 situates the combined Stepping Stones and Creating Futures intervention within the social-ecological model. The model shows its potential impact on street-connected young people's HIV vulnerabilities in Eldoret, Kenya from the micro- to macro-level based on previous findings from studies using Stepping Stones and the combined Stepping Stones and Creating Futures programmes (Gibbs, Jewkes, Mbatha, et al., 2014; Gibbs, Jewkes, Sikweyiya, et al., 2014; Jewkes et al., 2014, 2008; Jewkes, Wood, et al., 2010; Skevington et al., 2013).

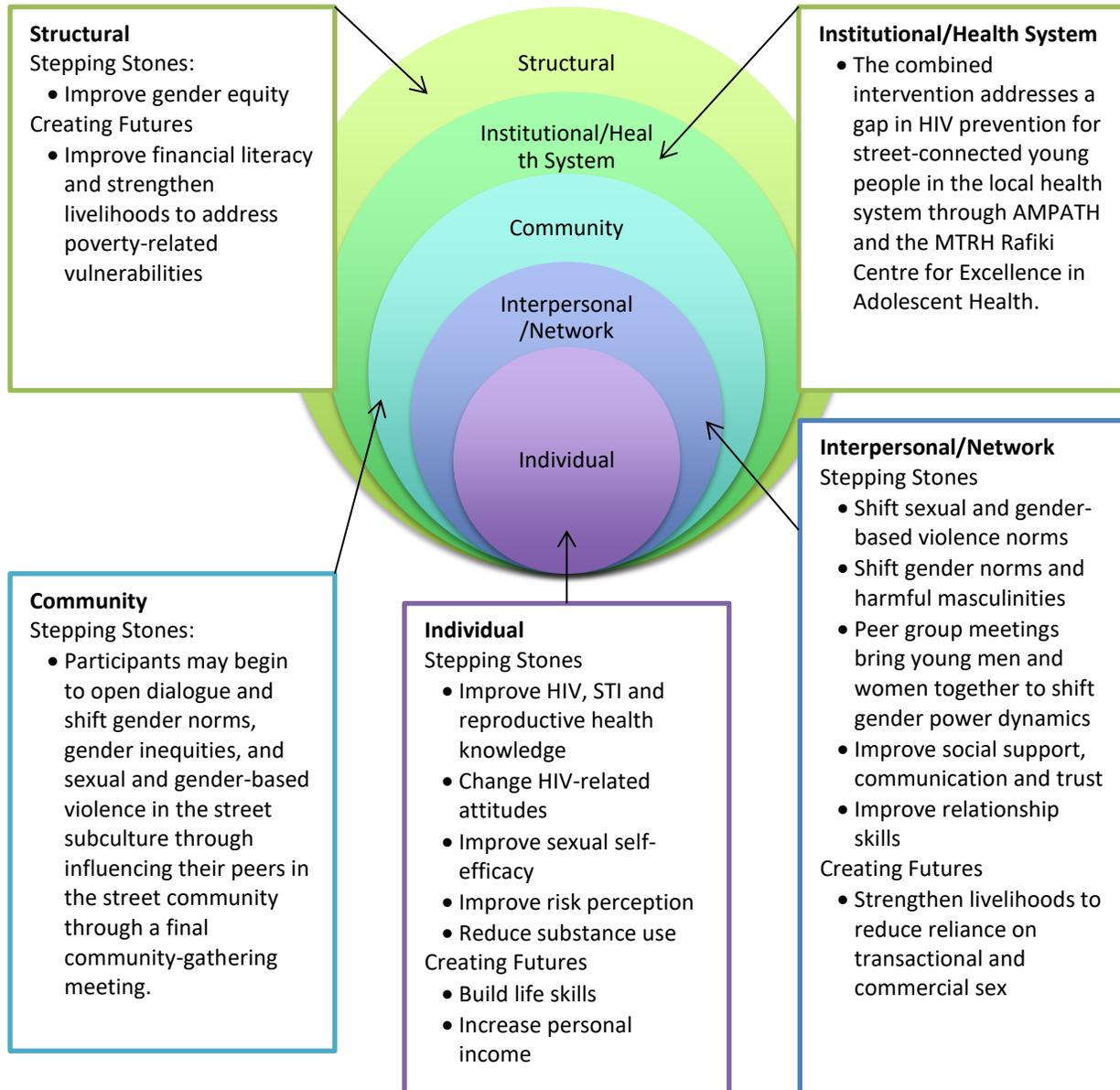


Figure 5 Shows the components of the combined Stepping Stones and Creating Futures interventions in the social-ecological model and its potential impact on HIV vulnerabilities from the micro-to macro-level

2.5. Intervention Planning and Development

2.5.1. Integrating a matched-savings programme conditional on attendance into Stepping Stones and Creating Futures programme for street-connected young people in Eldoret, Kenya

Prior to adaptation, the Stepping Stones and Creating Futures programme materials were obtained (Jewkes, Nduna, & Jama, 2010b; Misselhorn et al., 2013) and a group-led matched-savings programme conditional on attendance was integrated into the proposed intervention, to further address structural drivers of HIV and gender inequity in this context. It was proposed that participants would form savings groups at the outset of the intervention to promote participation and retention in the programme. Given the issues raised with microcredit for vulnerable young women (Dunbar et al., 2014, 2010; Wamoyi et al., 2014), group-led matched-savings was proposed as an alternative that would not induce engaging in additional sexual risk practices with participation. This group approach was selected given the existing use of Group Integrated Savings for Empowerment (GISE Groups) at AMPATH, which have been implemented as a successful livelihood-strengthening mechanism with adults (AMPATH, n.d.). GISE Groups established through AMPATH provide an alternative community-based model of savings and microloans to individuals unable to access the formal banking system in Kenya. The group model has been integrated in the delivery of chronic disease care through AMPATH with the creation of the Bridging Income Generation with Group Integrated Care (BIGPIC) (Mercer et al., 2018; Pastakia et al., 2016). Through these group-led community microfinance programs, group members pay in a contribution to a communal savings fund, which accrues interest and group members can also take loans from the communal savings fund, based on their 'portion

contributed'. Their savings with accrued interest is redistributed annually based on group member's contributions. Therefore, it was proposed that the concept of group-led saving, without the ability to take loans, might be an effective and culturally appropriate economic strengthening approach to integrate into the Stepping Stones and Creating Futures intervention. It was posited that the economic strengthening component might reduce sexual practices that elevate exposure to HIV among street-connected young people in Eldoret, Kenya through the following mechanisms. First, it was hypothesized that by accruing savings and giving participants a boost through matching, it may enable participants to commence an income generating activity or training course upon completion of the intervention. This would thereby reduce street-connected young women's reliance on transactional and commercial sex and lessen their economic dependence on young men. For young men participating in the programme, it would also allow them to work towards an income generating goal and potentially reduce harmful expressions of masculinity, which may be associated with street-connected young men's economic marginalization and oppression and inability to achieve traditional masculine ideals in eastern and Southern Africa (Embleton, Wachira, et al., 2018; Gibbs, Sikweyiya, et al., 2015; Izugbara, 2015).

Additionally, integrating group-led matched-savings conditional on attendance into the combined Stepping Stones and Creating Futures intervention sought to address issues with participation that arose in previous studies (Gibbs, Jewkes, Mbatha, et al., 2014) by providing an added incentive to attend sessions. It was hypothesized that matching-savings conditional on full group participation in the intervention would provide the added encouragement for intervention attendance and build social cohesion among participants. Finally, it was thought

that the savings programme would teach participants basic financial skills, build the capacity of street-connected young people to accrue savings, increase their economic resources, and allow them to invest in income generating activities or training courses to complement the skills gained through livelihood-strengthening programme Creating Futures.

To integrate group-led matched-savings into the combined Stepping Stones and Creating Futures intervention it was proposed that at the outset of the intervention (week 1), participants would form groups of 10 to coordinate their savings groups. Thereby resulting in two single-gender similar age (age groups: 16-19 and 20-24) savings groups per session, with 20 participants per session (Table 2).

Table 2 Proposed intervention and savings group structure

	Intervention Session Groups	Savings Groups	
1	Boys 16-19 (n=20)	GISE A, n=10	GISE B, n=10
2	Boys 20-24 (n=20)	GISE C, n=10	GISE D, n=10
3	Girls 16-19 (n=20)	GISE E, n=10	GISE F, n=10
4	Girls 20-24 (n=20)	GISE G, n=10	GISE H, n=10
	N=80	8 GISE Groups	

It was proposed during initial intervention planning that groups would self-select to work with peers they know, trust, and with individuals whom

they would consider continuing to run a savings group with post-intervention. It was proposed that after participants formed a group of 10 based on their preference they would nominate a group leader. As a team they would decide whether they would contribute between 50 to 100 Ksh per person (~\$0.51 – \$1.33 CAD) on a weekly basis to their savings. Each member would be required to contribute the set agreed upon amount. It was expected that this range would not induce increased sexual risk practices based on their reported daily earnings (Sorber et al., 2014). It was proposed that when all group members attended the intervention session, their savings would be matched as a group. When all group members attended, the group’s weekly

savings would be matched up to 1000 Ksh (~ \$12.75 CAD) per week for the duration of the intervention. It was proposed that street-connected young people would collectively be able to use their savings as a group to commence an income generating activity together or equally distribute the matched-savings to members at the end of the intervention.

Chapter 3 Objectives and Research Questions

3.1. Overall Objective

The overall objective of this research was to adapt and pilot a combined gender, livelihoods, and HIV prevention intervention with street-connected young people aged 16-24 years in Eldoret, Kenya using a multi-stage mixed methods design.

3.2. Research Questions

This study asked the following research questions for two specific objectives:

3.2.1. Adaptation objective

To adapt Stepping Stones, Creating Futures, and group-led matched-savings to form a combined gender, livelihoods and HIV prevention intervention with street-connected young people aged 16-24 years.

1. What programme components from Stepping Stones, Creating Futures, and group-led matched-savings are acceptable and appropriate, and what components are not, for street-connected young people in Eldoret, Kenya? Why are they or why are they not acceptable and appropriate in this context?
2. How were the programme components adapted and integrated together into a combined gender, livelihoods, and HIV prevention intervention for street-connected young people in the context of Eldoret, Kenya?

3.2.2. Pilot objective

To quantitatively and qualitatively evaluate the impact of piloting the adapted intervention on changing HIV knowledge (primary outcome), gender equitable attitudes (primary outcome), sexual practices, condom use self-efficacy, economic resources, and livelihood activities for participants.

1. What was the magnitude and direction of change in HIV knowledge and gender equitable attitudes for participants after completing the combined intervention?
2. Do participants' age, gender, relationship status, time street-involved, living circumstances, and education, impact changes in HIV knowledge and gender equitable attitudes for participants completing the combined intervention?
3. Do participants' attendance rates impact changes in HIV knowledge and gender equitable attitudes for participants completing the combined intervention?
4. How did participation in the gender, livelihoods and HIV prevention intervention change street-connected young people's sexual practices, condom use self-efficacy, economic resources, and livelihood activities?

3.3. Logic Models

Figure 6 and 7 show the inputs, activities, outputs, and hypothesized short- and medium-term outcomes, and the long-term intended impacts of the intervention in two logic models for stage one and stage two of the study. Figure 6 presents the pathway to achieving the adaptation objective in stage one of the study leading to the production of the adapted programme materials for use with street-connected young people in Kenya. Figure 7 presents the pathways

to achieving the pilot objective and hypothesized changes in outcomes. For the pilot, the pathways to improving HIV knowledge and gender equitable attitudes (primary outcomes) are shown as short-term objectives of the intervention. In addition, secondary short- and medium-term outcomes of intervention participation are shown, which aim to increase condom use and improve condom use self-efficacy, savings, livelihood activities, economic resources, and decrease transactional sex and number of sexual partners among participants. The long-term intended impact of the combined intervention is to reduce incident HIV and STI infections, and increase economic independence and secure livelihoods to reduce street-involvement.

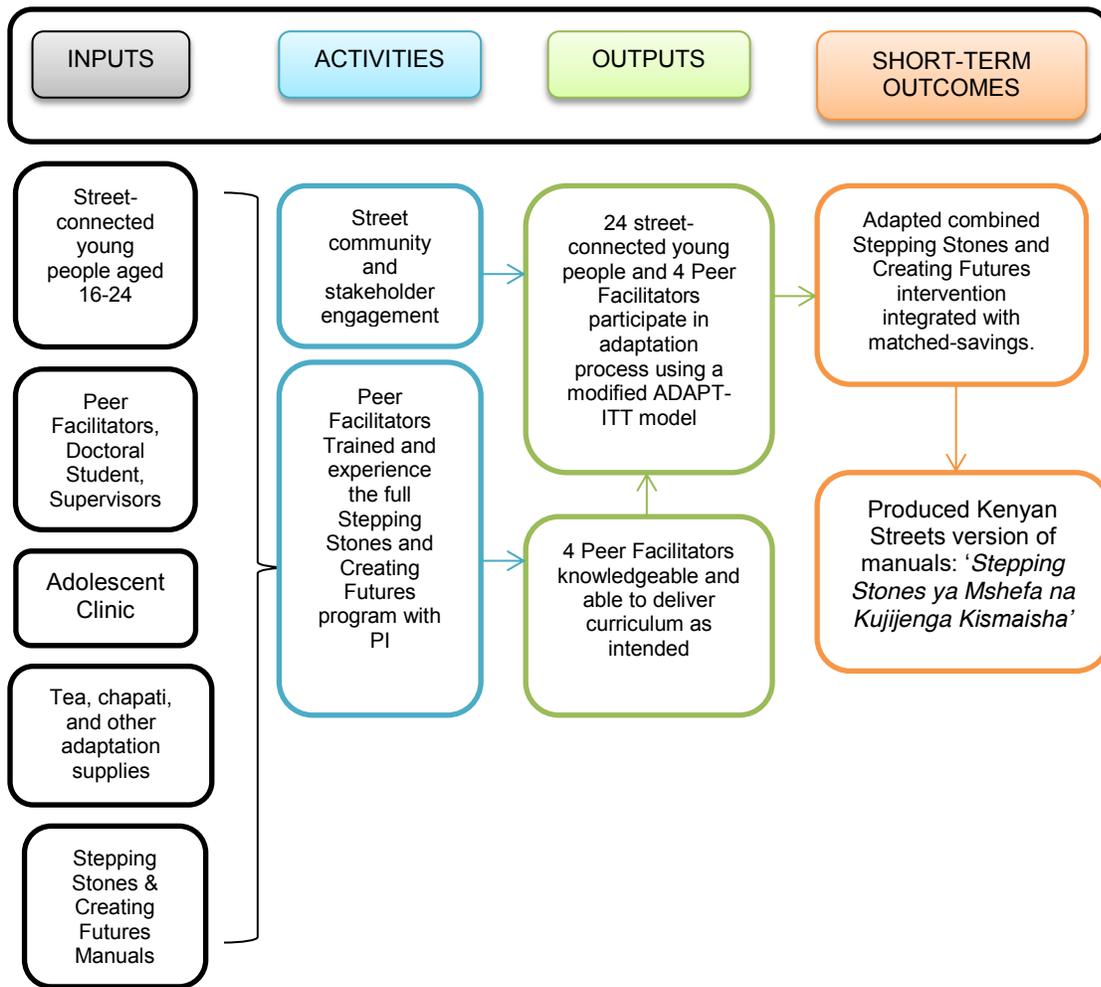


Figure 6 Logic model for stage one of the study and pathway achieving the adaptation objective for the study resulting in an adapted combined programme for street-connected young people in Kenya.

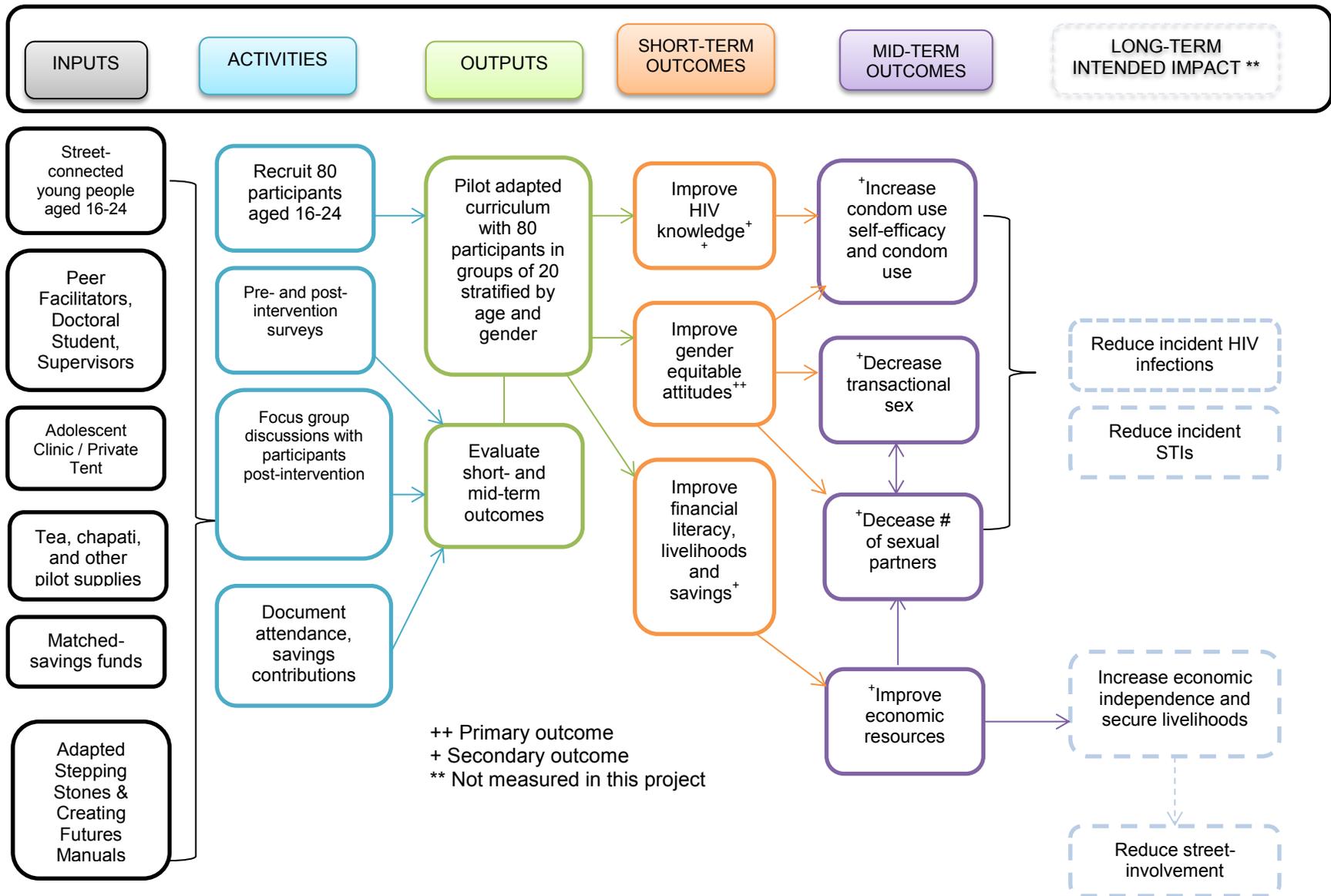


Figure 7 Logic model for stage two of the study demonstrating the pathways to the pilot objectives and short- mid-term outcomes and long-term intended impact.

Chapter 4 Methods

4.1. Study design overview

From May 2017 to January 2018 a multi-stage mixed methods design was used to adapt and pilot a gender, livelihoods, and HIV prevention intervention with street-connected young people aged 16-24 in Eldoret, Kenya (Figure 8). In such mixed methods designs, multiple stages of data collection are used and researchers may use various mixed methods approaches (Fetters, Curry, & Creswell, 2013). The use a combination of mixed methods approaches in multiple stages has been used in studies evaluating the design, implementation, and effectiveness of an intervention, and these multi-stage combination approaches have also been used in HIV prevention research to explore and understand intervention outcomes (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014). Using mixed methods in prevention research can ameliorate understanding of the successes or limitations of intervention strategies, barriers to implementation, identify and investigate contextual factors that influence the intervention, and allow researchers to assess the effectiveness of a programme design (Zhang & Watanabe-Galloway, 2014). The present multi-stage intervention study used two stages, whereby the first stage used community-based research methods and the second stage included a convergent design component (Fetters et al., 2013) (Figure 8). The convergent design used in the second stage, collected qualitative and quantitative data separately in a similar time frame on the same phenomenon of interest. In the convergent design, the different results are then integrated in a process of merging during analysis and interpretation. This process of merging and integrating

in a convergent design allows researchers to confirm, expand on, or uncover discordant findings (Fetters et al., 2013; Zhang & Creswell, 2013).

In the first stage of this study, from May 2017 to August 2017, Stepping Stones, Creating Futures, and group-led matched-savings interventions were adapted using a modified ADAPT-ITT model (Appendix II) (Wingood & DiClemente, 2008) with community-based research methods informed by a rights-based approach whereby street-connected young people were respected as rights holders and actively participated in the design and adaptation activities (OHCHR, 2017). The programme materials and overall intervention were adapted to the local social, cultural, and economic context of street-connected young people in Kenya and within the financial means of the research project. This first stage of the research resulted in the findings presented in Chapter 5 (Embleton, Di Ruggiero, et al., 2019) and the production of intervention programme materials (Appendix III).

The second stage of this multi-stage design occurred from September 2017 to January 2018 when the adapted gender, livelihoods, and HIV prevention intervention was piloted with 80 street-connected young people aged 16-24 years. This second stage included a convergent mixed methods approach to explain and explore the pilot outcomes, and the successes or limitations of the intervention strategy in this context (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014). In stage two, quantitative and qualitative data were collected from September 2017 to January 2018 in a similar time frame to study the same outcomes of interest. In the present convergent design, data were collected and analysed separately and converged during integration to interpret and explain the pilot outcomes that are presented in Chapters 6 and 7 (Figure 8).

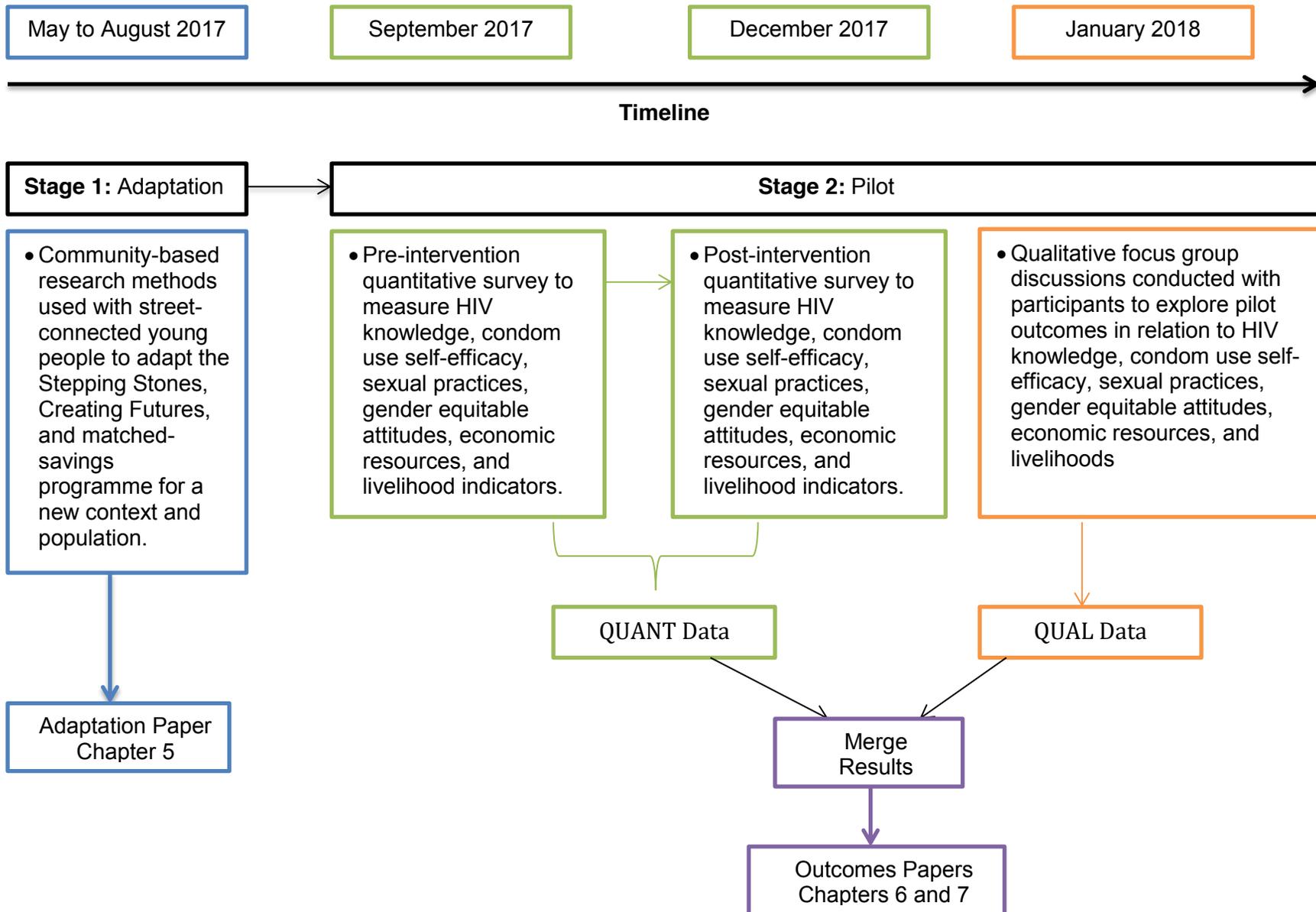


Figure 8 Multi-stage mixed methods study design

4.2. Ethics approval and consent to participate

This study received ethics approval from Moi University and the Moi Teaching and Referral Hospital Institutional Research Ethics Committee and University of Toronto Research Ethics Board. We used ethical guidelines and a consent process that was developed to use in research with street-connected children and youth in low- and middle-income countries (Embleton, Ott, et al., 2015). The study received a waiver of parental consent for minors, as parental consent is generally not safe or feasible for street-connected young people who have limited contact with parent(s) and/or guardian(s), and would make the research impracticable (Embleton, Ott, et al., 2015). The study received approval to occur from the UG County Children’s Coordinator, who is considered the de facto guardian of street-connected children and youth. At enrolment, participant eligibility was confirmed and participants were referred to a specially trained social worker to provide informed consent for their participation. Separate enrolment and informed consent procedures occurred for the adaptation and pilot stages. Written informed consent was obtained from all participants (or a fingerprint for those unable to write) in stage one and stage two. Tea and chapati were provided to participants during adaptation processes that occurred at the adolescent-friendly clinic and were also provided at each session of the intervention. In addition, intervention participants received transport reimbursement of 40 Ksh (~ 0.53 CAD) each time they attended an intervention session.

4.3. Study participants

Street-connected young people who met our eligibility criteria were eligible to participate in both the adaptation process as well as the pilot. However, they were not required to participate in both stages of the study. In stage two participants were randomly selected from sampling lists of eligible participants who expressed their interest in participating in the intervention, and therefore they may or may not have participated in both the adaptation process and pilot. The study eligibility criteria were as follows:

Inclusion Criteria: Street-connected young people were eligible to participate if they were: 1) aged 16-24 years, 2) had been street-connected for ≥ 6 months and (3) were not enrolled in or attending school.

Exclusion Criteria: Street-connected young people were ineligible to participate if they did not meet the age criteria, came to the enrolment dates intoxicated, high or in an altered state due to drug or alcohol use, or if they were unable to comprehend basic study information and the informed consent process as assessed in a comprehension test. Intoxication and altered states were assessed by a social worker upon recruitment and enrolment.

4.4. Adaptation methods

4.4.1. Adaptation study design and participants

From May 2017 to August 2017, using community-based research methods and a rights-based approach we adapted the Stepping Stones, Creating Futures, and group-led matched-savings programmes with and for street-connected young people aged 16 to 24 years in Eldoret, Kenya.

A modified ADAPT-ITT model was used to guide the adaptation process, whereby step 7 ‘training’ was integrated into step 3 ‘administration’ (Appendix II).

Our community-based research methods were informed by a rights-based approach with street-connected young people. A rights-based approach is one whereby the child/youth is consulted or participates in decisions affecting their health and well-being and is respected as a rights holder (OHCHR, 2017). The Convention on the Rights of the Child General Comment on No. 21 on Children in Street Situations outlines in Article 12 that children have the right to be heard (OHCHR, 2017). This includes street-connected children and youths’ right to fully participate in the design, implementation, coordination, monitoring, and evaluation of policies and interventions targeting the population (OHCHR, 2017). When street-connected children and youth actively participate in the research process, through assessing needs, creating solutions, shaping strategies and carrying them out, there is a higher likelihood that the policy and/or intervention will be beneficial, successful, suitable, and sustainable (Berckmans et al., 2012; Coren et al., 2016; OHCHR, 2017). Street-connected young people’s participation should go beyond tokenistic inclusion, and ensure strategies are in place to actively involve them in the design, data collection, implementation, and dissemination of research findings (Panter-Brick, 2002). Over the course of several years, our research team has built a participatory and trusting relationship with street-connected children and youth in Eldoret and this long-standing relationship was the foundation of this work. The Street Youth Peer Navigator programme at AMPATH demonstrated the power and ability of street-connected young people to engage their peers in HIV testing and linkage to care, as well as their ability to collect data through initial and follow-up encounters (Shah et al., 2018). Building on the successes of the Peer Navigator

programme, this research project hired four Peer Facilitators aged 19-23 years (2 young women and 2 young men) who had been or currently were connected to the streets to be part of the research team at the outset of the adaptation process. Not only were the Peer Facilitators the primary facilitators of the intervention, but also they were also meaningfully involved in the adaptation process (described in detail in Chapter 5) and in the study's outreach, recruitment, sampling of participants, and data collection (described in the below Adaptation and Pilot Methods and Chapters 6 and 7). Finally, there are plans to include them in future dissemination processes in Kenya (Chapter 9). The engagement of Peer Educators with street-connected young people in other settings has revealed that they play a vital role in building trusting relationships with intervention participants as they share lived experience, language, and are able to discuss difficult or sensitive sexual and reproductive health topics with their peers in a way adults are unable to (Berckmans et al., 2012).

Next we engaged street-connected young people in the adaptation process in a series of community-based research activities informed by a rights-based approach, which included: 1) street outreach and hosting a series of *mabaraza* (a traditional form of community assembly in Kenya used to disseminate information and make decisions) (Kamanda et al., 2013; Vreeman et al., 2012a, 2012b) in locations in and around Eldoret where street-connected young people live and work to explain the purpose of the research, to describe the proposed intervention and elicit initial feedback; 2) we engaged 24 street-connected young people aged 16 to 24 years as 'Topical Experts' who participated in focus group discussions and small working groups to further adapt the intervention; and 3) we engaged talented artists from the street community to illustrate imagery for the adapted manual programme materials.

While we attempted to include street-connected young people in the entire research process, we did not fully involve them in the 'Assessment' and 'Decision' steps of the modified ADAPT-IT framework, as this was completed prior to commencing this doctoral research project. Street-connected young people did not actively identify the health and social priorities of gender, livelihoods, and HIV prevention, as our prior research had identified these specific needs. Additionally, street-connected young people were not involved in selecting measurements, outcomes, and markers of success of the intervention as these were developed a priori through protocol development as part of my doctoral work. However, two Peer Navigators (Shah et al., 2018) did participate in Step 2 'Decision', when the research team held meetings about potentially feasible, suitable, and effective interventions for street-connected young people in Eldoret, Kenya.

4.4.2. Adaptation sample size

We purposively engaged 24 street-connected young people across age and gender stratified groups of six participants each to reflect the composition of the proposed intervention sessions (young women aged 16-19 years and 20-24 years and young men aged 16 to 19 years and 20-24 years) to participate as 'Topical Experts' in the adaptation process. Each focus group was comprised of 6 participants, for a total of 24 participants (young men aged 16-19 years n=6, young men aged 20-24 years n=6, young women aged 16-19 years n=6, young women aged 20-24 years n=6).

4.4.3. Adaptation recruitment and enrolment

The research team conducted outreach in the 'barracks' and other locations in and around Eldoret town where street-connected young people are known to live and work. In these outreach sessions conducted by the Peer Facilitators and the Principal Investigator, *mabaraza* were conducted to discuss the proposed research with the street community and elicit preliminary feedback. In each location where we held a *baraza*, street-connected young people nominated a representative from their location to participate in the adaptation process as 'Topical Experts' until the desired sample size of 24 participants across the age and gender stratified groups was reached. Nominated representatives were invited on specific days and times of the week to enrol in the adaptation process at the Rafiki Centre for Excellence in Adolescent Health.

4.4.4. Adaptation sources of data

Multiple sources of data were used during the adaptation process. Throughout the process of adaptation, a detailed journal was kept documenting the adaptation processes, and feedback from community outreach and the Peer Facilitators. Documentation of adaptations occurred by writing directly on the original program materials used in the adaptation process. Additionally, four age and gender stratified focus group discussions occurred to understand what should be adapted in the proposed intervention to ameliorate the intervention for the specific context and population. Focus group participants were given a presentation on the proposed intervention components of Stepping Stones, Creating Futures, and the proposed group-led

matched-savings programme by two Peer Facilitators of the same gender. An interview guide for the adaptation focus group discussions can be found in Appendix IV. The focus groups sought to generate discussion about the proposed intervention and what components of the intervention were acceptable and appropriate for the specific context and street-connected young people and what components were not. Participants from these focus group discussions were invited to further adapt the intervention in small working groups based on their initial feedback.

4.4.5. Adaptation analysis

Audio-recorded data collected through focus group discussions were transcribed into Swahili and translated into English. Transcribed and translated data were imported into NVivo software for analysis. Data collected during focus group discussions was analyzed using thematic analysis (Braun & Clarke, 2006), driven by an interest to identify key concepts in relation to the appropriateness and acceptability of the proposed intervention and other issues that arose in relation to the proposed gender, livelihoods, and HIV prevention intervention programme components. These data were used in the process of creating a second draft of the adapted evidence-based intervention in the modified ADAPT-ITT model process.

The process of adaptation was thoroughly documented step-by-step to describe in detail how the gender, livelihoods, and HIV prevention intervention was adapted with and for street-connected young people in the context of Eldoret, Kenya. A detailed description of the adaptation process in this context was produced drawing on multiple data sources including: extensive documentation from the doctoral candidate's research journal and notes, and the

adaptation focus group discussions, and small working groups. The full process is described in Chapter 5 (Embleton, Di Ruggiero, et al., 2019), and provides a model for others seeking to adapt an existing evidence-based intervention with street-connected young people.

4.5. Pilot Methods

4.5.1. Pilot Study Design

From September 2017 to January 2018, we piloted the adapted intervention with 80 street-connected young people in Eldoret, Kenya using a pre- and post-intervention convergent mixed methods design. Quantitative and qualitative data were collected and analyzed separately in a similar timeline using pre- and post-intervention surveys and post-intervention focus group discussions to explain and explore the pilot outcomes. Data were then merged and integration sought to confirm, expand on, or uncover discordance in primary and secondary outcomes (Fetters et al., 2013).

4.5.2. Adapted intervention description

Our adapted intervention *Stepping Stones ya Mshefa na Kujijenga Kimaisha* (Appendix III) included 24 sessions and occurred over the course of 14 weeks (Embleton, Di Ruggiero, et al., 2019). Each session lasted from 1.5 to 3 hours and was conducted in a private tent outside of the adolescent-friendly clinic. Peer Facilitators of the same gender facilitated the program under the supervision of the Principal Investigator, in single-gender age stratified sessions with groups of 20 participants (age groups: 16-19 and 20-24). Groups were stratified by age to reflect the developmental differences and potential power dynamics between adolescents (≤ 19 years) and young adults (> 19) on the street, and gender (young women and young men) to

account for the varying needs of young women and young men. The Peer Facilitators (2 young women and 2 young men) were respected and trusted members of the street youth community in Eldoret. As former street-connected young people, they intimately understood the challenges of being street-connected in this context. The Peer Facilitators underwent one month of in-depth training in May 2017 as part of the adaptation process. This training ensured and that they were knowledgeable about the intervention curricula and content, and that they were well versed in the project objectives, data collection, intervention facilitation techniques, research guidelines and conduct for this specific study. Peer Facilitators and the Principal Investigator had on-going weekly meetings that were documented and additional training as necessary throughout the pilot intervention.

The matched-savings programme began in the first week of the intervention. Participants contributed 25 to 200 Ksh ($\sim 0.33 - 2.60 \sim \text{CAD}$) per week and were able to make contributions at each session they attended. Individual participants' savings were matched (1:1) on a weekly basis conditional on attending both scheduled weekly sessions. Participants were ineligible for matching if they only attended one session. The purpose of the matched-savings programme was to increase attendance and retention in the intervention while providing participants a significant boost to kick-start their savings, which could then be used to commence an income generating activity or to attend a training course. Additionally, it was posited that the integration of matched-savings would further address structural drivers of HIV and gender inequity in the street subculture. It was thought that participation in the matched-savings programme would enable participants to commence an income generating activity or training course upon completion of the intervention. Moreover, it would teach participants

financial skills, and increase savings and their economic resources over time. Together, it was hypothesized this would reduce street-connected young women's reliance on transactional and commercial sex and lessen their economic dependence on young men. For young men participating in the programme it would potentially reduce harmful masculinities associated with young men's oppression and inability to achieve traditional masculine ideals in eastern and Southern Africa (Embleton, Wachira, et al., 2018; Gibbs, Sikweyiya, et al., 2015; Izugbara, 2015), by allowing them to possibly commence an income generating activity and influence their livelihoods.

For eight weeks participants attended the *Stepping Stones ya Mshefa* portion of the intervention that used participatory learning approaches, including role-play and critical reflection using dialogic methods. The *Stepping Stones ya Mshefa* program and included topics on: communication, gender norms in society, reflecting on love, sexual health joys, body mapping, menstruation, contraception and conception, unwanted pregnancy, HIV and STIs, condom use, gender-based violence, drug and alcohol use, and peer pressure. Typically the Stepping Stones intervention has 3 peer group meetings where young men and women come together to facilitate communication and understanding (Jewkes et al., 2014; Welbourn, 1995). We were only able to conduct one mixed gender peer group meeting due to the political context in Kenya. The Supreme Court annulled the results of the August presidential election, and Kenya held a second presidential election on October 26, 2017. This election date coincided with week 7 of the pilot and therefore it disrupted the *Stepping Stones ya Mshefa* component of the intervention, which occurred over the first 8 weeks of the pilot. This required us to adjust the intervention to accommodate a two-week period of disruption. It was decided that we

would omit delivering the second and third peer group meeting from the *Stepping Stones ya Mshefa* programme to ensure we could complete the intervention by December 15th 2017 in 14 weeks prior to the Christmas holidays. During the two-week election break, participants were encouraged to come during their scheduled session times and meet with the Peer Facilitators to make contributions to their matched-savings. During these two weeks when participants attended they worked with the Peer Facilitators on music, dance, or spoken word performances in relation to the programme content that they had learnt to date, which a small group presented at World AIDS Day celebrations at MTRH and AMPATH on December 1st 2017. This activity was intended to be akin to what may have taken place during a third peer group meeting or community dissemination event.

Weeks 9 through 14 of the pilot intervention covered the *Kujijenga Kimaisha* (Creating Futures) program. The *Kujijenga Kimaisha* program focussed on having participants reflect on their existing livelihood skills and resources, and examine how they can strengthen them. The program aimed to support and encourage participants to set a clear and achievable personal goal, and to work towards commencing income generating activity or training course in conjunction with their matched-savings. The sessions covered: social resources for livelihoods, saving, debt, exploring learning experiences, coping with crises, building basic business principles, and developing an incoming generating activity.

4.5.3. Pilot sample size

Sample sizes for the quantitative component of the pilot were calculated for the primary outcomes of interest: HIV knowledge and gender equitable attitudes. A sample size of 80

participants was determined based on calculations to detect significant mean difference in our primary outcomes of gender equitable attitudes and HIV knowledge ($\alpha=0.05$ $\beta=0.20$ Power=0.8 SD=10) by estimating high, medium, and low baseline scores and hypothesized percentage increase in score (25%, 15%, or 10%). As this is a pilot and feasibility study it was not be powered to detect statistically significant changes in secondary outcomes measured (condom use self-efficacy, sexual practices, economic resources, and livelihoods) or between age and gender groups. The sample of 80 participants was stratified into gender groups for the intervention, whereby we sampled 40 street-connected young men, and 40 street-connected young women. The intervention sessions occurred in four age and gender stratified groups of 20 participants per group (young women aged 16-19, n=20; young women aged 20-24, n=20; young men aged 16-19, n=20; young men aged 20-24, n=20). A sample size of 24 street-connected young people was sought for the post-intervention qualitative focus group discussions. These 24 street-connected young people were purposively sampled to represent intervention participants across attendance levels, which were categorized into low (0-7), medium (8-16), and high (17-24) based on the number of sessions attended to generate diverse discussion about the pilot outcomes of interest.

4.5.4. Pilot recruitment and enrolment

The Peer Facilitators conducted outreach in the barracks and other locations in and around Eldoret where street-connected young people congregate to mobilize the community and to explain the purpose of the research and intervention. Peer Facilitators created four age- and gender-stratified sampling lists of street-connected young people whom met the eligibility

criteria and whom indicated their interest in participating in the intervention during outreach sessions. Participants were selected using a simple random sampling procedure by the Principal Investigator by generating random numbers. Selected participants were invited to enrol at the Rafiki Centre for Excellence in Adolescent Health where their eligibility was confirmed by the social worker. If a selected participant declined to participate or did not come on the enrolment date, another participant from the numbered list was randomly selected until the desired sample size of 80 participants was reached, consisting of 20 participants for each age- and gender-stratified group (young men aged 16-19 years and 20-24 years and young women aged 16-19 years and 20-24 years).

4.5.5. Pilot study procedures

Participants underwent consent with a specially trained social worker prior to enrolment. After participants consented to participate, they were enrolled in the intervention and completed a paper-based standardized questionnaire administered by the Peer Facilitators. Surveys were administered face-to-face in Swahili/Sheng in a private tent outside of the adolescent-friendly clinic under the supervision of the Principal Investigator. At enrolment participants were assigned an intervention group and given set days and times of the week to attend the intervention. At the commencement of each session, participants would check in with the Principal Investigator and deposit money into their savings account and their attendance at the intervention session was documented. In week 14 participants completed a post-intervention survey on the final day of the intervention administered by the Peer Facilitators. Of the 80 participants that completed pre-intervention surveys, 67 completed post-intervention surveys.

Participants then met with the Principal Investigator and received and signed for their savings to document their completion of the intervention.

In January 2018, a group of 6 participants from each of the age- and gender-stratified intervention groups were purposively invited to participate in post-intervention focus group discussions about their participation and experience in the intervention, what they learnt, and how it changed or did not change their knowledge, attitudes, or practices in relation to the primary and secondary outcomes of interest. Twenty-one participants returned to attend focus group discussions, which were conducted in Swahili/Sheng by a trained Peer Facilitator and the Principal Investigator. Focus groups took 1 to 1.5 hours and occurred in a private tent at the Rafiki Centre for Excellence in Adolescent Health.

4.5.6. Pilot measures

A pre- and post-intervention standardized questionnaire was pre-tested for use with 5 male and 5 female street-connected young people aged 16-24 who provided feedback regarding the clarity and acceptability of the questions. Minor changes to the Swahili wording of questions for clarity and ease of comprehension occurred. The questionnaire (Appendix IV) captured basic socio-demographic data including: age, school attendance, relationship status (single, having a girlfriend or boyfriend, married, widowed, divorced), orphan status (mother deceased/vital status unknown, father deceased/vital status unknown, both parents deceased, both parents alive), time typically spent on the streets (days and nights, days only, varies), time street-involved (6 months to 1 year, 1 to 2 years, 2 to 5 years, more than 5 years), and economic resources (sources of income, amount earned daily, personal assets). The primary outcomes of

interest were HIV knowledge and gender equitable attitudes. HIV knowledge was assessed using the 18 item (Cronbach's $\alpha=0.60$) HIV-KQ-18 questionnaire (Carey & Schroeder, 2002), a validated instrument that has been tested and used in low-income, low-literacy, and adolescent populations. Answer options for questions on the HIV-KQ-18 are 'true', 'false' or 'don't know', and each correct answer is given one point; scores are then summed. A higher score represents greater HIV knowledge (Carey & Schroeder, 2002). Gender equitable attitudes were assessed using the 24 item (Cronbach's $\alpha=0.81$) Gender Equitable Men (GEM) scale, a validated instrument that has been tested and used in Kenya. The scale measures attitudes towards gender norms in relationships and differing social expectations for men and women (Nanda, 2011). Answer options for questions on the GEM scale are 'agree', 'partially agree' or 'do not agree'. Responses for each item were scored as 1 = agree, 2 = partially agree, and 3 = do not agree. Higher scores represent higher support for gender equitable norms, with a highest possible score of 72 (Nanda, 2011). Secondary outcomes included condom use self-efficacy, sexual practices, economic resources, and livelihood activities. Condom use self-efficacy was measured using the 9-item (Cronbach's $\alpha=0.73$) Condom Use Self-Efficacy Scale – Ethiopia, which has been validated for use with young people in Ethiopia. Responses for each item were scored as 0 = strongly disagree, 1 = disagree, 2 = undecided, 3=agree and 4=strongly agree. Items that were negatively worded were reverse coded. Higher scores indicate greater condom use self-efficacy (Shaweno & Tekletsadik, 2013). Sexual practices were measured by asking participants the following questions: ever engaged in vaginal sex, age of first vaginal sex, was the first vaginal intercourse voluntary, ever engaged in anal sex, age of first anal sex, was first anal intercourse voluntary, currently sexually active, who do you have sex with (men/boys,

women/girls, both), last vaginal sex (within the past 1 week, within the past month > 1 month ago), last vaginal sex condom use, frequency of condom use (always, most of the time, sometimes, never) number of vaginal sex partners in the past month, ever exchange sex for money, shelter, food, security or other material items, in the past month exchange sex, frequency of exchanging sex (daily, weekly, once per month, in the past but not in the past 6 months, don't know, refuse to answer), ever tested for HIV, and when was the last HIV test (within the past month, 1 to 3 months, three to 6 months, more than 6 months or don't know). Livelihoods, economic resources, and personal assets were measured by asking participants how they earn money, how much money they earn per day, what personal assets they own, and where they typically sleep at night (in the barracks, on the streets, someplace different every night, in a shelter I share with friends, in my own rented house, at my parent(s)/guardian(s) house). This was categorized into housed (in a shelter with friends, in my own rented house, at my parent(s)/guardian(s) and un-housed (in the barracks, on the streets, someplace different every night) groups.

Focus group discussions used an interview guide (Appendix IV) that asked participants about their experience participating in the intervention, what they learnt in relation to HIV, condom use, and sexual and reproductive health, and how the program changed or did not change their sexual practices, as well participants were asked what they learnt in relation to how men and women live and relate to each other, how their experience was participating in the matched-savings programme, how participation the intervention changed or did not change their livelihoods and resources.

4.5.7. Pilot textual and statistical analysis

Qualitative analysis: Qualitative audio-recorded data were transcribed into Swahili and translated into English by a hired transcriptionist. Transcripts were imported into NVivo software for analysis. I developed a codebook to capture data related to the primary and secondary outcomes of interest. This included primary codes for HIV and sexually transmitted infections knowledge, condom use self-efficacy, sexual practices, gender equitable attitudes, savings, and livelihood activities. Through an in-depth initial reading of the data additional codes for family planning, health-seeking behaviour, drug and alcohol use, and social skills were created. A number of sub-codes were created for each primary code to capture sub-themes. Transcripts were then coded and I conducted a deductive thematic analysis driven by analytic interest (Braun & Clarke, 2006) to identify concepts in relation to how participation in the intervention changed or did not change street-connected young people's HIV knowledge, condom use self-efficacy, sexual practices, other health related outcomes, gender equitable attitudes, economic resources, and livelihoods.

Quantitative analysis: Quantitative data collected on paper surveys was checked for errors and missing data, and manually entered into Epi Info (version 7.2.1). Data were exported from Epi Info into R Studio for analysis. Post-intervention all participants were sought to complete questionnaires, and analysis included all enrolled participants, irrespective of program attendance or completion. Thirteen participants were not interviewed post-intervention: 8 were lost to follow-up, 1 dropped out of the program, and 4 had moved during the program and could not be located. Pre-intervention scale scores were carried forward post-intervention

for these participants. When outcomes are not expected to decline post-intervention, this provides a conservative estimate of the intervention effect (European Medicines Agency, 2011). Two single items were missing from the gender equitable men scale for two participants. For these, scale items were imputed using the individual mean. In total, 4 single-items for 4 participants were missing from the HIV and CUSE scales. For these, scale items were imputed using the mode (HIV scale) and individual mean (CUSE scale) (Shrive, Stuart, Quan, & Ghali, 2006). To test the accuracy of results using these missing data strategies, a complete case analysis was conducted. There were no differences in outcomes or statistical significance compared to the imputed analyses. We present both complete cases and last value carried forward outcomes in our findings in Chapter 7 and 8.

Categorical variables were summarized using frequencies and percentages. Continuous variables were summarized using either median and interquartile range or mean and standard deviation. Changes in sexual practices, economic resources, and livelihood activities were compared using McNemar's test for paired nominal data. A Shapiro-Wilk test and visual analysis of histogram and Q-Q plots were used to test for normality of the outcome variables for HIV knowledge, gender equitable attitudes, and condom use self-efficacy scores. Due to the non-normality of the HIV knowledge and gender equitable attitude scores, a Wilcoxon signed rank test was used to test whether participants had improved their HIV knowledge and gender equitable attitudes from pre- to post-intervention. Condom use self-efficacy scores were normally distributed and a paired t-test was employed to compare mean pre- and post-test scores. Difference scores were calculated for HIV knowledge, gender equitable attitude, and condom use self-efficacy scores by taking the post-intervention scores minus the pre-

intervention scores. Multiple linear regression models were fit to predict HIV knowledge and condom use-self efficacy change scores adjusting for the covariates of age, gender, education level, attendance, time street-connected, relationship status, and ever tested for HIV. A multiple regression model was fit to predict gender equitable attitudes change scores adjusting for the covariates of age, gender, education level, attendance, time street-connected, relationship status, money earned per day, orphan status, housing status, and engaging in casual labor at baseline. Pre-intervention scores were controlled for in all of the models, to adjust for the confounded effects of the pre-intervention scores. Including pre-intervention scores in the model counteracts problems regarding the use of difference scores (Dalecki & Willits, 1991).

4.5.8. Mixed methods integration

Different procedures exist for integrating, mixing, and presenting mixed methods data (Fetters et al., 2013; Guetterman, Fetters, & Creswell, 2015; Zhang & Creswell, 2013). Integration can occur at three levels of mixed methods research: the study design level, the methods level, and interpretation and reporting levels (Fetters et al., 2013). At the study design level, the present research used a multi-stage mixed methods design, whereby the second stage included a convergent design component. In the convergent design component quantitative and qualitative data were collected concurrently in a similar time frame (Figure 8). At the methods level, quantitative and qualitative data were analyzed separately and in a similar time frame, the results were then merged and triangulation was used to integrate the results together to interpret findings (O’Cathain, Murphy, & Nicholl, 2010; Zhang & Creswell, 2013; Zhang &

Watanabe-Galloway, 2014). Merging generally occurs after textual analysis of qualitative data and statistical analysis of quantitative data (Fetters et al., 2013). Through the process of triangulation, findings were compared across qualitative and quantitative data to determine if the study's findings from each method were in agreement, contradicted each other, or offered more information (O'Cathain et al., 2010). At the interpretation and reporting level, findings in the present study were integrated through a weaving approach whereby qualitative and quantitative findings are presented together on a theme-by-theme basis in Chapters 7 and 8, where integration confirmed, expanded on, uncovered discordance, and revealed 'silent' findings (Fetters et al., 2013; O'Cathain et al., 2010). Silence occurs when a theme or finding occurs in one data set and not another (O'Cathain et al., 2010). Confirmation occurs when qualitative and quantitative data confirm the results of the other, giving the findings greater credibility. Expansion occurs when results from the two findings reveal new insights into the outcomes of interest. Lastly discordance occurs when findings from the different methods are divergent or inconsistent (Fetters et al., 2013). Zhang and Creswell (2013) and Guetterman, Fetters, and Creswell (2015) suggest summarizing convergent mixed methods findings side-by-side in this integration reporting approach. Summaries of the mixed methods findings from this research using this suggested side-by-side approach are presented in Chapter 9 in Tables 12 and 13.

Chapter 5 Adapting an evidence-based gender, livelihoods, and HIV prevention intervention with street-connected young people in Eldoret, Kenya

Embleton L¹, Di Ruggiero E², Odep Okal E³, Chan AK^{2,4,5}, Logie CH⁶, Ayuku D⁷, Braitstein, P^{2,3,8}.

1. Institute of Medical Science, Faculty of Medicine, University of Toronto, Toronto Canada
2. Dalla Lana School of Public Health, University of Toronto, Toronto, Canada
3. Academic Model Providing Access to Healthcare, Eldoret, Kenya
4. Division of Infectious Diseases, Sunnybrook Health Sciences Centre, University of Toronto, Toronto, Canada
5. Dignitas International, Zomba, Malawi
6. Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada
7. Moi University, College of Health Science, Department of Behavioural Science, Eldoret, Kenya
8. Moi University, College of Health Sciences, School of Medicine, Eldoret, Kenya

Erica Di Ruggiero: e.diruggiero@utoronto.ca

Evans Odep Okal: okalevans2@gmail.com

Adrienne K. Chan: adrienne.chan@sunnybrook.ca

Carmen Logie: carmen.logie@utoronto.ca

David Ayuku: dayuku_2000@yahoo.com

Paula Braitstein: pbraitstein@gmail.com

Corresponding Author

Lonnie Embleton, MPH

PhD Candidate

Institute of Medical Science

Faculty of Medicine

University of Toronto

lonnie.embleton@gmail.com

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5.1. Abstract

Despite being highly vulnerable to acquiring HIV, no effective evidence-based interventions (EBI) exist for street-connected young people (SCY) in low- and middle-income countries (LMICs). Therefore, this paper describes the research process of adapting an existing EBI in Eldoret, Kenya using a modified ADAPT-ITT model with a young key population. From May to August 2017 we adapted the combined Stepping Stones and Creating Futures interventions. We used community-based participatory methods, focus group discussions, and working groups with four Peer Facilitators and 24 SCY aged 16 to 24 years. At the inception of this project, a matched-savings programme was integrated into the intervention to further address structural drivers of HIV. Numerous adaptations came forth through the participatory process. Engaging SCY in the adaptation process ensured the programme was responsive to their needs, relevant to the street context, and respected their right to participate in the research process.

Keywords: street youth; HIV prevention; intervention; adaptation; Kenya

5.2. Introduction

The number of new HIV infections in sub-Saharan Africa continues to decline. Nevertheless, young people living on the continent still account for a large proportion of new cases of HIV, with young women aged 15-24 disproportionately acquiring HIV (UNAIDS, 2018a).

Consequently, continued efforts to prevent HIV acquisition among young key populations are essential using combined biomedical, behavioural and structural interventions (Pettifor et al., 2015). Street-connected young people (SCY), for whom the streets play a central role in their lives and identities (OHCHR, 2017), can be classified as a young key population given their substance use, precarious housing, experiences of violence, and engagement in selling sex (Woan et al., 2013).

Driven by structural and social inequities and their need to survive on the street, SCY in sub-Saharan Africa are highly vulnerable to acquiring HIV. In sub-Saharan Africa, SCY participate in transactional sex (Winston et al., 2015; Woan et al., 2013), experience sexual and gender-based violence (Kudrati et al., 2008; Wachira et al., 2015), have multiple concurrent partners (Anarfi, 1997; Embleton, Wachira, et al., 2015), engage in sex under the influence of drugs and alcohol (Embleton et al., 2012), and report inconsistent condom use (Kayembe et al., 2008; Winston et al., 2015).

Research in Kenya suggests that SCY are contracting sexually transmitted infections (Embleton, Wachira, et al., 2016; Kaime-Atterhög et al., 2007; Winston et al., 2015), and may have an HIV prevalence that exceeds that of other young people in the country, with street-connected young women disproportionately acquiring HIV (Braitstein et al., 2019; Goldblatt et al., 2015; Shah et al., 2018; Winston et al., 2015). This heightened prevalence may be due to

engaging in transactional sex, gender inequities, and experiencing sexual and gender-based violence in the street subculture (Embleton, Wachira, et al., 2016, 2018; Sorber et al., 2014; Wachira et al., 2015; Winston et al., 2015). Street-connected young women engage in transactional sex with young men connected to the streets for survival, and also with individuals outside of the street subculture for economic benefit (Embleton, Wachira, et al., 2016, 2015, 2018). Likewise, street-connected young men engage in transactional sex with both street-connected and non street-connected individuals (Embleton, Wachira, et al., 2015). However, street-connected young men's reported engagement in transactional sex is very limited in comparison to street-connected young women's (Sorber et al., 2014; Winston et al., 2015). SCY in Kenya are economically marginalized, typically earning less than 100 Kenyan Shillings (Ksh) (~\$1.27 CAD) per day (Sorber et al., 2014). Street-connected young men engage in a range of income generating activities and earn more per day in comparison to street-connected young women whom primarily rely on begging and transactional sex for survival (Embleton, Wachira, et al., 2015, 2018; Sorber et al., 2014). Importantly, SCY's primary sexual partners and relationships are with each other. Sexual relationships are engaged in for economic benefit, desire, procreation, and for informal 'marriages' in the street subculture (Embleton, Wachira, et al., 2015, 2018; Wachira et al., 2016, 2015). Moreover, the street subculture propagates harmful social and gender norms, which promote substantial gender inequities and is the source of much of the sexual and gender-based violence experienced by street-connected young women (Embleton, Wachira, et al., 2018; Sorber et al., 2014; Wachira et al., 2015). Therefore, including both street-connected young women and men in interventions to reduce gender inequities and sexual risk practices while improving livelihoods,

is critical to addressing SCY's HIV vulnerability in this context. Changing deeply engrained social and gender norms, such as those present in the street subculture (Embleton, Wachira, et al., 2018) is challenging; however using strengths-based approaches from within a community by building on a community's strengths and examining harmful practices can catalyse change (CUSP, 2017).

To date, there is a dearth of evidence on effective interventions to reduce sexual risk practices among SCY (Naranbhai et al., 2011), and very few interventions have been tested and evaluated with this highly marginalized population in low- and middle-income countries (LMICs) (Berckmans et al., 2012; Coren et al., 2016; Dybicz, 2005). As no specific HIV prevention interventions have been rigorously tested and evaluated for SCY in LMICs (Berckmans et al., 2012; Coren et al., 2016; Naranbhai et al., 2011), adapting an existing evidence-based intervention (EBI) with and for SCY may be a viable approach to fill this gap. A number of systematic reviews have been conducted to identify and assess effective HIV prevention interventions for young people in sub-Saharan Africa (Maticka-Tyndale & Brouillard-Coylea, 2006; Michielsen et al., 2010; Napierala Mavedzenge et al., 2014), many of which may be suitable, acceptable, and effective for SCY. Many of these interventions use combination approaches to address structural and social drivers of HIV acquisition. Given the structural and social inequities impacting SCY's vulnerability to HIV acquisition, combination and multifaceted interventions are particularly suitable for this population. To our knowledge, no one has adapted an existing EBI with SCY in sub-Saharan Africa. With the lack of effective interventions for this population in LMICs, determining the feasibility of and providing a model for adapting

existing interventions is an important step in increasing the number of effective interventions for this marginalized population.

Adaptation is defined as the process of modifying or altering an EBI for a new context to reduce mismatches, without conflicting with or negating its core elements, thereby maintaining intervention fidelity (Card et al., 2011; Gordon et al., 2017; Wingood & DiClemente, 2008). Adaptations may involve modifying programme content or the method of programme delivery (Castro et al., 2004), and should take into account the local context to ensure content and delivery are culturally appropriate. The term context broadly encompasses multiple features (e.g. geographical, political, social, or cultural) that may interact with the intervention to produce variation in implementation processes or outcomes (Craig et al., 2018). Few models and theoretical frameworks exist for adapting interventions; however, the eight-step ADAPT-ITT model (Wingood & DiClemente, 2008) has been used successfully for adapting HIV interventions with adolescents (Latham et al., 2010).

Given the paucity of interventions that have been rigorously adapted, piloted, and evaluated in LMICs with and for SCY, this paper describes the participatory research process of adapting the evidence-based combined Stepping Stones and Creating Future interventions (Alvarado et al., 2017; Jewkes et al., 2014; Jewkes, Nduna, et al., 2010b; Misselhorn et al., 2013) with SCY in a new setting in Eldoret, Kenya using a modified ADAPT-ITT model. We describe the use of a rights-based participatory adaptation process focusing on Steps 3 (Administration) through to Step 7 (Integration) of the ADAPT-ITT model.

5.3. Materials and Methods

5.3.1. Study design

From May 2017 to January 2018 a two-phase mixed methods study was used to adapt, pilot, and evaluate a gender, livelihoods, and HIV prevention intervention for SCY in Eldoret, Kenya. In the first phase, we adapted the combined Stepping Stones and Creating Futures interventions using a modified ADAPT-ITT model based on the following 7-step process: 1. Assessment, 2. Decision, 3. Administration, 4. Production, 5. Topical Experts, 6. Integration, 7. Testing. This modified model omitted 'Training' as Step 7 and integrated training into Step 3 (Administration). Step 1 (Assessment) and Step 2 (Decision) occurred between 2013-2016 as part of other studies.

From 2013 to 2015 our research team identified needs in relation to HIV, gender equality, and livelihoods among SCY in Eldoret, Kenya (Step 1. Assessment) (Embleton, Wachira, et al., 2016, 2015; Shah et al., 2018; Sorber et al., 2014; Wachira et al., 2015). Subsequently, we conducted a scoping review using Arksey and O'Malley's five-stage framework (Arksey & O'Malley, 2005) to identify HIV interventions for high-risk youth. The combined Stepping Stones (South Africa 3rd Edition) and Creating Futures (Jewkes et al., 2014) programme was identified as an intervention our research team sought to adapt, pilot, and evaluate to determine if it would be suitable, feasible, acceptable, and potentially effective in our setting (Step 2). Stepping Stones and Creating Futures were selected because they address identified social and structural drivers of SCY's HIV acquisition and identified needs (Step 1).

From May 2017 to August 2017 we completed step 3 (Administration) through 6 (Integration) to adapt the intervention. Throughout this process, we used community-based participatory methods with four Peer Facilitators and 24 street-connected young people aged 16 to 24 years, to adapt the intervention for the context through a series of community meetings, focus group discussions (FGDs), and small working groups. In our study, context referred to the social, cultural, economic and political circumstances in which street-connected young people live and work and the financial circumstances of the research project.

5.3.2. Intervention description

Stepping Stones is a behavioural intervention that was developed in Uganda (Gordon et al., 2017; Welbourn, 1995). The original curriculum consists of 13 participatory sessions that aim to improve sexual health and promote greater gender equity in relationships among men and women. Topics covered over the 13 three-hour sessions include: reflecting on love, sexual joys, body mapping, menstruation, contraception and conception, sexual problems, unwanted pregnancy, HIV, STIs, safe sex, gender-based violence, motivations for sexual behaviour, dealing with grief and loss, and communication skills (Welbourn, 1995). The training programme has since been adapted for use in different settings and has been used with children, adolescents, and adults (Gordon et al., 2017; Holden et al., 2018). The Stepping Stones programme is designed to be participatory and uses critical reflection, role-playing scenarios, and drama, which draw on the everyday reality of participants' lives (Gordon et al., 2017; Welbourn, 1995), and therefore works towards shifting social norms from within a community through critical reflection and building on strengths (CUSP, 2017). The programme has been tested in multiple

settings and shown to reduce transactional sex, intimate partner violence, and multiple partnerships, increase HIV knowledge and condom use, and improve gender equity; however, no study has proven its effectiveness in reducing HIV incidence (Alvarado et al., 2017; Paine et al., 2010; Skevington et al., 2013). Stepping Stones has also been effective at diffusing knowledge beyond participants into the community (Paine et al., 2010). Potential for diffusion of knowledge in our setting is particularly important given the substantial gender inequities and sexual and gender-based violence in the street subculture (Embleton, Wachira, et al., 2015; Wachira et al., 2015).

Creating Futures is a structural intervention designed to build on Stepping Stones, based on sustainable livelihoods theory (Jewkes et al., 2014; Misselhorn et al., 2014). The livelihood-strengthening curriculum consists of 11 peer facilitated single gender sessions in groups of 20, focusing on five types of capital: financial, natural, human, physical, and social. The sessions cover: securing and keeping jobs, budgeting, saving, debt, social resources for livelihood, coping with crises, incoming generating activities, setting goals and building basic business principles. The goal of the programme is to empower young people to find pathways out of poverty and vulnerability (Jewkes et al., 2014; Misselhorn et al., 2014). In South Africa, the combined Stepping Stones and Creating Futures intervention was delivered over 12 weeks with out-of-school youth living in informal settlements, in twice weekly 3-hour single-sex sessions, by trained facilitators of a similar age (Jewkes et al., 2014). Participants in the combined programme saw a significant increase in their earnings, had improved gender attitudes, and women (aged 18 to 30) experienced a significant reduction in intimate partner violence (Jewkes et al., 2014).

Prior to adaptation we obtained the South African programme materials for Stepping Stones (Jewkes, Nduna, et al., 2010b) and Creating Futures (Misselhorn et al., 2013) and integrated a group-led matched-savings programme conditional on attendance to further address structural drivers of HIV and gender inequity in our context. It was proposed that participants would form savings groups at the outset of the intervention to promote participation and retention in the programme. As a group they would decide whether they would contribute between 50 to 100 Ksh per person (~ \$0.63-\$1.27 CAD) on a weekly basis to their savings. If all group members were in attendance at the weekly intervention sessions, the group's savings would be matched. In order to maintain fidelity of the intervention, we identified the core elements of the programme that resulted in its effectiveness and that should remain in our adapted EBI. For Stepping Stones, these included programme principles including Freirian Critical Pedagogy (Jewkes et al., 2006), the sequential structure, dosage and duration (Gordon et al., 2017) and for Creating Futures, sustainable livelihoods theory (Misselhorn et al., 2014).

5.3.3. Study setting

This study occurred in Eldoret, Kenya, located in Uasin Gishu (UG) County. In 2010, UG County had approximately 894,179 individuals from 202,291 households, of whom 41.5% were aged 14 years or less. Approximately 51.3% of the UG County population lives below the Kenyan poverty line. Eldoret town has a population of 289,389. It is home to Moi University (MU), Moi Teaching and Referral Hospital (MTRH), and the Academic Model Providing Access to Healthcare (AMPATH) programme, which is a partnership between MTRH, MU, and a

consortium of universities from North America including the University of Toronto. AMPATH began as an HIV care and treatment programme, and with support from PEPFAR currently has over 80,000 HIV infected patients in care across western Kenya. Recently AMPATH and MTRH established the Rafiki Centre for Excellence in Adolescent Health in Eldoret, which became the study site for this project.

5.3.4. Ethics approval and consent to participate

This study received ethics approval from the University of Toronto Research Ethics Board and Moi University and Moi Teaching and Referral Hospital Institutional Research and Ethics Committee. We received a waiver of parental consent for minors and participants provided written consent (or a fingerprint for those unable to write) for their participation in this research project with a specially trained social worker. The study received approval from the UG County Children’s Coordinator to occur. Participants did not receive compensation for their participation in the adaptation activities. Tea and chapati were provided to participants in focus group discussions and working groups.

5.3.5. Study participants

SCY were eligible to participate in the adaptation process if they were: 1) aged 16-24 years, 2) had spent a portion or majority of their time on the streets for the past 6 months, and 3) were not enrolled in or attending school.

5.3.6. Recruitment and enrolment

As part of the adaptation process, we conducted a series of community meetings with the street community in different barracks (primary locations in which SCY congregate in the town) and six other residential locations around Eldoret to discuss the proposed intervention and seek their input. In each location, SCY nominated a representative to engage in FGDs and other participatory activities. It was explained that their elected representative would communicate ideas and concerns with the study team regarding the proposed programme. This system of nominating a representative from each location ensured that a diverse group of SCY across the city were involved in the intervention adaptation process. Those that were eligible and indicated their willingness to participate were invited to the adolescent-friendly clinic at AMPATH for enrolment and to undergo the assent or consent process with a specially trained social worker. In total we recruited 24 SCY in age and sex stratified groups (young men aged 16-19 n=6 and 20-24 n=6, young women aged 16-19 n=6, and 20-24 n=6). The median age of participants was 19.5 years (IQR: 17-23). The majority (79%) of participants had some level of primary education, 17% had some secondary, and 4 % had no formal education.

5.3.7. Data collection

Data to inform adaptation was collected through field notes and FGDs. The principal investigator (LE) maintained notes throughout the adaptation process. We held four age and sex stratified FGDs in a private room at the Rafiki Centre for Excellence in Adolescent Health. FGDs took an average of 60 minutes, were audio-recorded, and conducted by Peer Facilitators of the same sex in Swahili and Sheng (a dialect used on the streets). Peer Facilitators gave

participants a presentation about the intervention. Participants were then asked a series of questions regarding what components of the intervention were acceptable and appropriate, those that were not, what they liked and did not like, what they would add to the intervention or take away, what they would like to change, suitable days and times of the week for attendance, programme location, and how they would like the matched-savings groups to function. Participants were also given the opportunity to provide any additional feedback or ideas. Participants from FGDs sessions were invited to further adapt the intervention based on their initial feedback in working groups.

5.3.8. Data analysis

Audio-recorded data collected through FGDs was transcribed into Swahili and translated into English. Transcribed and translated data was imported into NVIVO software for analysis. Data collected during FGDs was analysed using thematic analysis (Braun & Clarke, 2006), to identify patterns and key concepts in relation to the appropriateness, acceptability, and other themes that emerged in relation to the proposed HIV prevention programme components.

5.4. Results

The modified ADAPT-ITT model framework that guided the community-based participatory adaptation process with SCY can be found in Appendix II. It outlines the original ADAPT-ITT model methodologies and our modified approach with examples. Figure 8 shows the timeline, participants, activities, and outcomes used in the modified ADAPT-IT process with SCY.

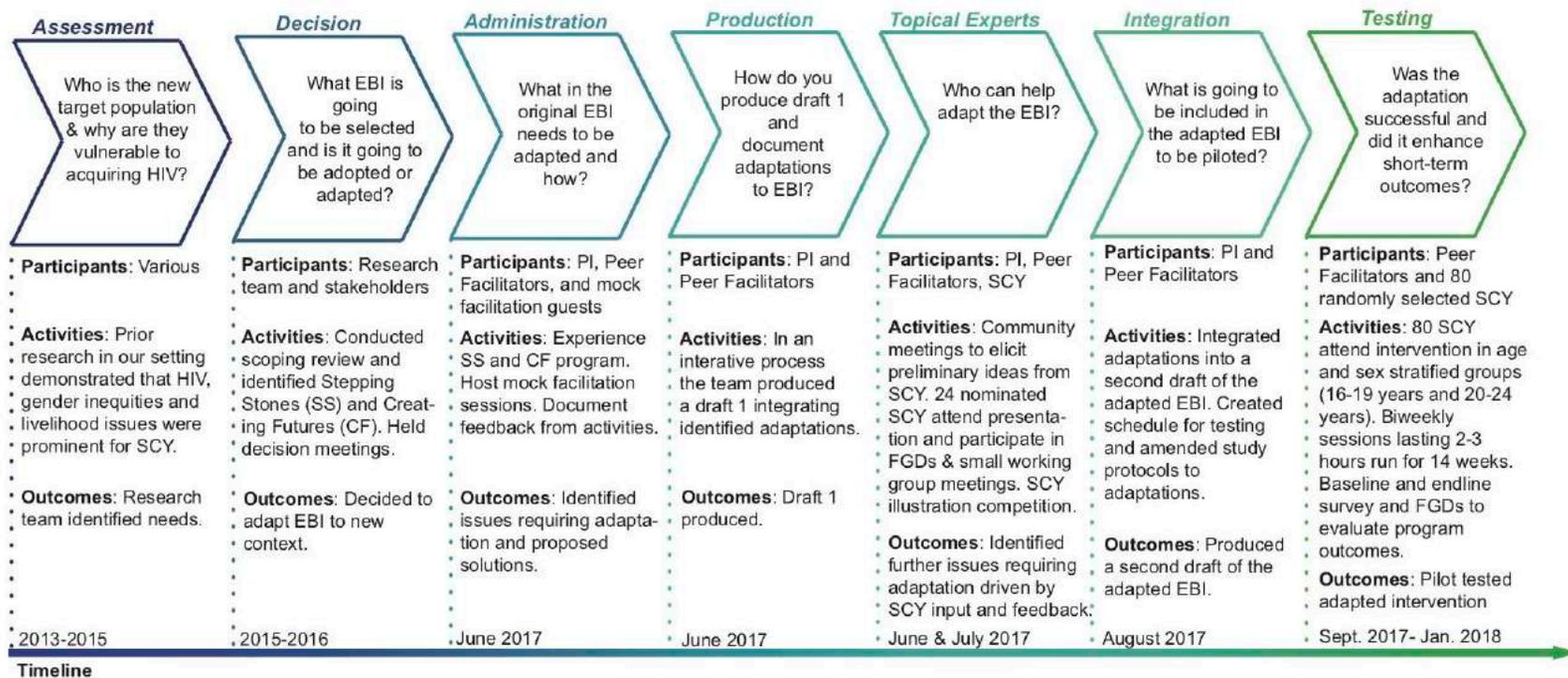


Figure 9 Timeline, participants, activities, and outcomes used in the modified ADAPT-IT process with SCY

5.4.1. Administration

In May 2017, to adapt and facilitate the proposed programme, we hired four young people (two young women and two young men aged 19-23 years) who had been or currently were connected to the streets to become Peer Facilitators. The PI trained Peer Facilitators over the course of 4 weeks. The Peer Facilitators were the starting point for community-based participatory research approaches to adaptation, given their lived experience, extensive knowledge of the local street context, and on-going connection to the street community.

As part of the Stepping Stones curriculum, it is recommended that when training facilitators they first experience the full programme. We started as a team by experiencing each session of Stepping Stones and Creating Futures, over the course of two weeks. Through experiencing the programme, session-by-session, the Peer Facilitators provided ideas and suggested both programme content and delivery adaptations. All ideas and adaptations were documented by writing notes directly on the original manual materials and in the research team journal. During this initial process the following key issues and proposed adaptations arose including: low literacy levels and identifying a suitable dialogic method for intervention delivery; ensuring services, laws and products matched the political context in Kenya; the integration of drug and alcohol content; creating stories, names, role plays and imagery that reflected the social, cultural, and economic context on the streets in Kenya; modifying the Creating Futures curriculum to be relevant to the livelihood needs of SCY; and creating one comprehensive curriculum with a new title.

One major programme delivery concern was adapting the curriculum extensively for low literacy levels among SCY. The programme was adapted to be primarily dialogical. We omitted

written exercises, homework, and journals. We integrated an Indigenous Talking Circle approach for programme delivery to foster dialogue, understanding, and active listening. Typically, an object of importance is held by the person speaking, and is circulated clockwise around the Circle, person-by-person. In our setting we used a beaded 'Maasai Stick' or 'Rungu', which signifies respect and leadership in Kenyan culture. This methodology suited the Freirean Critical Pedagogy theoretical underpinnings of the Stepping Stones and Creating Futures (Gibbs, Jewkes, Sikweyiya, et al., 2014; Jewkes et al., 2006).

We had to make substantial alterations to the Creating Futures curriculum in relation to programme content. This included: creating two new character stories that related to SCY and their social, economic, cultural, and political contexts on the streets in Kenya; omitting journals and homework sections that required writing; creating a resume; attending job interviews; and content related to scholarships and post-secondary education. We altered the curriculum to be dialogic using the same Talking Circle approach and to focus on livelihood opportunities and income generating activities. The majority of SCY in our setting have limited education, and are not in the position to apply for formal employment or scholarships to further their education. Given the need for survival on the streets, the programme was altered to encourage participants to work towards an income generating activity goal in conjunction with the matched-savings groups that were structured to commence at the outset of the Stepping Stones programme.

Finally, the Peer Facilitators suggested combining the programme into one comprehensive manual with a new title for the programme that utilized Sheng and terms that SCY would identify with. The programme was renamed *Stepping Stones ya Mshefa & Kujijenga*

Kimaisha (Stepping Stones for Street Youth & Build Your Life Up). *Mshefa* is a Swahili slang word that means a hustler (one who works hard to survive). It is a label used by SCY themselves as an identity. *Kujijenga Kimaisha* translates to ‘*build yourself and your life up*’, and represents the Creating Futures programme.

As part of their training, Peer Facilitators hosted 4 mock facilitation sessions with guest participants who included Peer Navigators (Shah et al., 2018), youth from the community and healthcare providers. During these mock facilitation sessions, we tested our Talking Circle approach and it was well received among guest participants. Following the mock facilitation sessions, the Peer Facilitators suggested that a mixed language manual would be most useful and make the content more relevant to the streets. We therefore translated titles, discussion questions, and other key text into Swahili/Sheng, as Sheng is primarily used on the streets.

5.4.2. Production

Drawing on documentation from our training and mock facilitation sessions we produced a first draft of our adapted EBI while maintaining programme fidelity and core components. As each session was produced in draft format, the Peer Facilitator team reviewed the adapted sessions for content that reflected the streets and translated titles, discussion questions, and scenarios into a language that SCY use and comprehend by using a mix of English, Sheng, and Swahili. In an iterative process, this was then integrated into the manual as we produced a first draft of our adapted programme.

5.4.3. Topical experts and integration

To engage topical experts, we took a rights-based participatory approach, where SCY in our setting became our topical experts over the course of two months (OHCHR, 2017). We conducted a series of community meetings in the different barracks in town and in six locations around Eldoret. From these meetings we elicited preliminary ideas and responses about the programme. Generally, the response was positive, but SCY expressed many concerns regarding the matched-savings programme; particularly in regards to trust with their finances and disbelief that funds would be matched. In community meetings, SCY voiced concerns that they would not be able to travel to the adolescent-friendly clinic two times per week without support for transportation. As a team we decided it was feasible to propose providing 40 Ksh to participants each time they attended a programme session based on the cost of public transport and within the financial context of the research.

Following community meetings, we hosted four FGDs with 24 participants. The Peer Facilitators created a visual and detailed



Figure 10 Visual presentation used in FGDs to discuss the proposed programme and components

presentation about the programme that they presented to participants (Figure 9). Key themes

from the FGDs included: program acceptability, match-savings programme alterations, location of programme, days and times of the week to attend, using their existing 'talents/skills', and a desire to focus on livelihoods to change their circumstances.

Programme acceptability:

In general, participants thought the programme was acceptable for SCY and did not have any components they wanted to add or take away. The programme delivery twice per week and concept of matched-savings were well received amongst participants as one young woman demonstrates: *'I liked where we come for those sessions twice per week, then we have our savings doubled. Double, double save.'* (Female, 16-19)

Despite positive support and belief that the programme could have a positive impact on SCY, participants expressed some scepticism regarding the implementation of the programme as conveyed by one young man:

'In my opinion this programme is fine. And if it is true what is written there, you know you have written, but it hasn't been done yet. Therefore if it is true...because as I see it lots of boys will come. And not only that, but this could potentially end homelessness on the street. If we will succeed, but if it is just propaganda and talking...' (Male, 20-24)

In general, feedback regarding the programme content of both Stepping Stones and Creating Futures was positive, as one male participant states:

'Let me start. Tubonge (Let's Communicate), there I don't see any problem. We are supposed to look deeper and direct each other. We need to know both sexes. 100%. That is perfect. We need to know about sex and love. That is perfect too.' (Male, 16-19)

However, one group of female participants 16-19 years debated the importance of also including health and drug and alcohol use content. Overall, all groups came to a consensus that the programme delivery and content was suitable and would be accepted by SCY in our setting. One exception to this was with the structure of the matched-savings programme.

Matched-Savings Programme Issues:

Many issues regarding the proposed matched-savings programme came forth in community meetings and focus groups. SCY expressed a desire to contribute a larger sum of money on a weekly basis as stated by one male aged 16-19: *'On Friday I will bring 100 bob. I cannot give 25. That is little.'* Participants also questioned the facilitators regarding the frequency of contributions: *'I would like to ask this. Why not let us give twice a week?'* (Male, 20-24). Participants explained that twice-weekly contributions would give them a safe place to keep their money over the course of the week, as affirmed by one young man:

'Let me ask you something. There is somewhere you haven't gotten me. From what I have understood you have said we should give on Friday, but if I am willing, parking gives me money and instead of spending it, I'd rather keep it somewhere. We can be giving it to you on Monday and Friday.' (Male, 16-19)

All participants discussed that they could not rely on their peers to attend the sessions and that if their savings were matched on group attendance this could create conflict among participants. SCY expressed a desire to have their savings matched based on individual attendance. Participants also discussed distrust about leaving their money with the investigator as one young female aged 20-24 stated: *'What if she runs away to her country?'*

In response to these issues raised, we changed the mechanism of matching from conditional on full group attendance to individual attendance to decrease the chances of conflict. Second, we increased the amount and frequency participants could contribute to the matched-savings programme. We decided that it was feasible for participants to bring money to each session as long as over the course of the week it did not exceed 200 Ksh. Based on SCY's reported daily earnings, we concluded this would not induce increased sexual risk practices (OHCHR, 2017). Lastly, to address issues of trust, we explained why and how the study would be keeping their savings safe, and referred participants to the study social worker to reassure them.

Programme Location and Times:

Given the stigmatization SCY face, issues regarding where the programme would take place arose, as well as days and times of the week that each group would attend. Participants expressed different opinions about where the programme should occur, but all were in agreement that they wanted a dedicated private space to attend the weekly sessions. A young woman aged 20-24 suggested: *'Even put up a tent. That will be fine. Don't just call us to the*

clinic. You see we don't all come?'. As a team we agreed to set up a dedicated tent outside of the adolescent-friendly clinic that would be used solely for the programme.

We reviewed the days and times of the week put forth by each age and sex stratified group in the FGDs and came up with a proposed schedule that aimed to meet each group's interest. Young men in both age strata came to the consensus to have their sessions in the morning hours to ensure they would leave the programme with enough time to generate income in the afternoons, as stated by one young man aged 20-24: *'That is good. At least one leaves here and goes to look for money.'* Whereas, young women said they would prefer afternoon sessions, as many have domestic chores and childcare they complete in the mornings as stated by young women aged 20-24: *'If you had a child, what time would you reach here? You can't.'*

Talents & Livelihoods:

Finally, in response to a desire to focus on livelihoods and use existing talents and skills, we reassured groups that the *Kujijenga Kimaisha* programme was dedicated to topics that would assist young people in establishing income generating activities, setting goals, and savings. In addition, the team decided that we could invite SCY who were talented artists to adapt the imagery in the original programme documents for the streets version. We hosted an illustration competition for the programme manual covers. Prizes were given for first, second, and third place, and the winning illustrations were featured as the manual covers (Figure 10). Subsequently, we invited all illustrators back to illustrate the complete manual. SCY were compensated 50 Ksh for each illustration they created for the manual. This resulted in creating

a comprehensive manual with imagery they strongly identified with. This process was particularly effective as they had ownership over the manual, were credited as illustrators, and they felt proud of their talents being used.

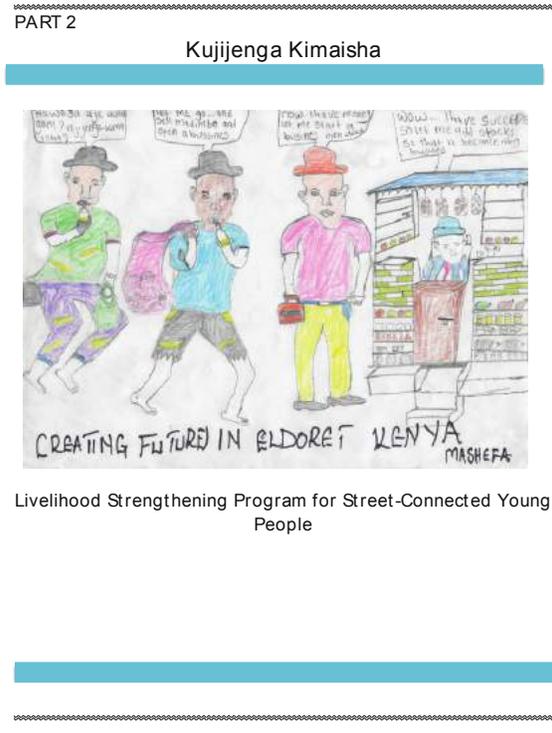
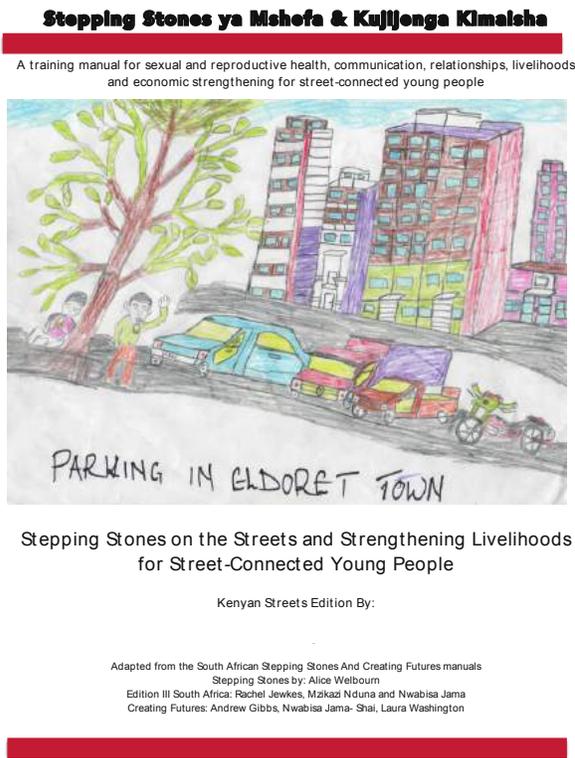


Figure 11 Manual cover illustrations by SCY

Finally, we hosted four working groups to discuss changes to the programme based on all of the feedback provided by SCY. Participants responded that they were very satisfied with how we listened to their ideas, altered the matched-savings programme, and harnessed the skills of their peers to illustrate the manual. They were content with the proposed location of

the programme, provision of transport support, and the programme schedule. The representatives in the working groups said they had no further issues to address with the proposed programme. We then finalized a second draft of the adapted manual (Appendix V shows the final table of contents).

5.4.4. Testing

From September 2017 to January 2018, we piloted and evaluated the adapted programme with 80 SCY. We randomly selected 80 participants from a list of eligible SCY who indicated their interest in participation into age and sex stratified groups (16-19 years and 20-24 years), to attend biweekly sessions over 14 weeks. We measured changes in short-term outcomes using a mixed-methods pre- and post-test study design. Outcomes measured included: HIV-knowledge, gender equitable attitudes, condom use self-efficacy, sexual practices and economic status. Results are expected later in 2019.

5.5. Discussion

This paper describes the application of a model for adapting EBIs for SCY in LMICs. Importantly, this paper demonstrates the feasibility of adapting EBIs for this young key population. Taking a rights-based participatory approach to adaptation and using an established adaptation framework ensured that we maintained programme fidelity while being responsive to the key population's concerns and their right to participate fully in the research process. Our process ensured the programme was suitable and relevant to the local social, cultural, and economic contexts of the streets, resulting in programme acceptability in our setting. Our results highlight

the acceptability of the combined Stepping Stones and Creating Futures programmes, and its potential for use with SCY in other LMICs. Furthermore, our findings demonstrate the acceptability and suitability of the innovative matched-savings programme to give SCY an avenue for savings when formal banking systems are inaccessible.

Poverty is a driving factor for young people finding themselves in street situations in LMICs (Embleton, Lee, et al., 2016), and the need to earn money once on the streets results in a significant number of young women in our setting engaging in transactional and survival sex (Embleton, Wachira, et al., 2016, 2015; Winston et al., 2015). The focus on savings and building livelihoods was an important programme component for SCY in our setting. Interventions for SCY focused on livelihoods are an approach that have not received significant attention in the academic literature, and as Berckmans' et al (2012) suggests, a sustainable livelihoods approach may be a viable and important avenue for interventions with SCY (Berckmans et al., 2012). Moreover, this approach aligns with what Dybicz (2005) terms secondary prevention, aimed at ensuring SCY can safely transition into adulthood and increase their ability to secure income on the street (Dybicz, 2005). Our adaptation results suggest that combining a livelihoods approach with other programmatic goals, such as HIV prevention, is feasible, suitable, and highly acceptable with this population in our context.

Given the complexity of SCY's circumstances in LMICs, no one intervention will meet all of their needs, but involving them in the process of identifying health priorities, in intervention development, implementation, and evaluation processes may increase the effectiveness and sustainability of any programme (Gordon et al., 2017; OHCHR, 2017). Service provision in the form of drop-in centres, healthcare facilities, shelters, and child welfare and protection, are

critical in upholding SCY's rights (OHCHR, 2017), and improving their health and well-being. As Coren (2016) found in high-income settings, both time limited therapeutic programmes and standard services such as shelters and drop-in centres resulted in favourable changes in outcomes for participants (Coren et al., 2016). Yet, EBIs for specific health issues, such as HIV prevention, are vital given their vulnerability to acquiring HIV (Naranbhai et al., 2011). Overall, the body of literature reviewing interventions for SCY points to insignificant evidence and a need for more research on effective interventions (Berckmans et al., 2012; Coren et al., 2016; Dybicz, 2005; Naranbhai et al., 2011). In lieu of creating new interventions to increase the number of robust and potentially effective interventions for SCY, our adaptation process demonstrates the feasibility and suitability of adapting an existing EBI. Others seeking to pilot or implement programmes for this population can use our adaptation process as a model to adapt existing EBIs they can then test in other settings.

This study is with limitations. Our adaptation process occurred in one geographic location in western Kenya where the research team has a long-standing relationship with the study population, and therefore it is likely this impacted the feasibility of the adaptation process. However, in alignment with ethical research practices and a rights-based approach with SCY, researchers or organizations seeking to use this model can most likely do so effectively if they build trusting relationships with the street community prior to implementation and use community-based participatory methods.

Our rigorous adaptation process using community-based participatory methods and a modified ADAPT-ITT model demonstrates that it is feasible to adapt existing EBIs for SCY in LMICs. Engaging SCY throughout adaptation of the intervention ensured the adapted

curriculum was responsive to their needs, relevant to their circumstances, and the local social, cultural, and economic context on the streets. The adaptation methods respected their right to participate in the research process and led to a high level of programme acceptability in our setting. This adaptation model may be an avenue to start address the gap in designing and identifying effective interventions for SCY in LMICs.

Chapter 6 Outcomes of piloting an evidence-based intervention to improve HIV knowledge, condom use self-efficacy, and sexual practices among street-connected young people in Eldoret, Kenya

Embleton L¹, Di Ruggiero E², Logie C.H.³, Ayuku D^{4,5}, Braitstein P^{2,5,6}.

1. Institute of Medical Science, Faculty of Medicine, University of Toronto, Toronto, Canada
2. Dalla Lana School of Public Health, University of Toronto, Toronto, Canada
3. Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada
4. Moi University, College of Health Science, Department of Behavioural Science, Eldoret, Kenya
5. Academic Model Providing Access to Healthcare, Eldoret, Kenya
6. Moi University, College of Health Sciences, School of Medicine, Eldoret, Kenya

Corresponding Author:

Lonnie Embleton, MPH, PhD(c)
Institute of Medical Science
Faculty of Medicine
University of Toronto
lonnie.embleton@gmail.com

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6.1. Abstract

Objectives: This study sought to explain and explore how participation in a pilot adapted evidence-based intervention, Stepping Stones and Creating Futures, changed street-connected young people's HIV knowledge, condom-use self-efficacy, and sexual practices.

Methods: Eighty street-connected young people participated in a pre- and post-intervention convergent mixed methods design in Eldoret, Kenya. The primary outcome of interest was HIV knowledge. Secondary outcomes included condom-use self-efficacy and sexual practices. Multiple linear regression models for change scores with adjustment for socio-demographic variables were fitted. Qualitative and quantitative findings are presented together, where integration confirms, expands on, or uncovers discordant findings.

Results: Participants had a significant increase in HIV knowledge from pre- to post-intervention from a median pre-intervention score of 11 (IQR 8-13) to a post-intervention score of 14 (IQR 12-16). Attendance was a significant predictor of increasing HIV knowledge change scores. Qualitatively, participants reported increased HIV and condom use knowledge, improved condom use self-efficacy, and health-seeking practices.

Conclusions: Our findings support the potential for further testing with a rigorous study design to investigate how best to tailor the intervention, particularly by gender, and increase the overall effectiveness of the programme.

Keywords: HIV; condom use; intervention; street youth; Kenya

6.2. Introduction

In Kenya, street-connected young people (SCY), for whom the streets play a central role in their everyday lives and social identities (OHCHR, 2017), engage in numerous sexual practices that increase their exposure to HIV (Embleton, Wachira, et al., 2016, 2015; Kaime-Atterhög et al., 2007; Wachira et al., 2016, 2015). In Eldoret, Kenya, SCY have an HIV prevalence that exceeds that of other young people locally, and young women connected to the street are disproportionately acquiring HIV (Braitstein et al., 2019; Shah et al., 2018; Winston et al., 2015); whereby young women aged 15-24 have an HIV prevalence almost four times higher than young women nationally (10.8% vs. 3.0%) (Braitstein et al., 2019; NASCOP, 2014). In addition, SCY have high rates of sexually transmitted infections (STIs), low levels of condom use (Winston et al., 2015), engage in transactional sex and multiple concurrent partnerships, (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2015; Winston et al., 2015), and succumb to death due to HIV/AIDS (Embleton, Ayuku, et al., 2018). In addition SCY have a low level of HIV knowledge and several misconceptions in relation to HIV and STIs (Embleton, Wachira, et al., 2016, 2015). Yet, knowledge of HIV is critical in recognizing ones' vulnerability to acquiring HIV and can increase the likelihood of engaging in preventive practices.

An individual's perceived susceptibility of acquiring HIV is a necessary, but not sufficient, condition for behaviour change (Rosenstock, 1974). Knowledge is also essential for an individual's self-efficacy to perform an outcome, such as condom use (Closson et al., 2018). Studies have demonstrated that higher levels of accurate HIV knowledge significantly increases an individual's perceived HIV risk (Bernardi, 2002), and greater perception of risk has been linked to higher levels of condom use self-efficacy (CUSE) (Tenkorang & Maticka-Tyndale, 2014).

However, the relationship between knowledge, risk perception, and CUSE may also be gendered (Closson et al., 2018; Tenkorang & Maticka-Tyndale, 2014). Gender differences in risk perception and CUSE are socially constructed and may be associated with the fact that condom use and sexual decision-making are typically under the control of men. Social norms, gender inequities, and other structural factors reduce young women's ability to practice safer sex with male partners (Appiah et al., 2017; Closson et al., 2018; Tenkorang & Maticka-Tyndale, 2014). Nonetheless, increased knowledge, awareness of risk, and sexual self-efficacy are important foundational components of behaviour change.

Typically, HIV prevention strategies have focused on increasing knowledge, changing attitudes, and sexual practices of adolescents through individual-level behavioural interventions. Behaviour change interventions alone are often insufficient to produce long-term positive effects on outcomes given the structural factors that impact an individual's ability to enact change (Gibbs et al., 2012; Gupta et al., 2008). Structural factors refer to the social, cultural, community, economic, legal, and political factors that impact an individual's ability to engage in HIV prevention (Sumartojo et al., 2000). Outcomes are considerably improved when behavioural interventions are combined with structural approaches addressing factors that shape or limit individual behaviour (Gibbs et al., 2012; Gupta et al., 2008; Wamoyi et al., 2014). Therefore, combining behavioural interventions with structural components may be a viable approach to changing SCY's sexual practices and vulnerability to acquiring HIV (Gupta et al., 2008; Wamoyi et al., 2014).

SCY in Kenya require interventions that provide sexual and reproductive health education and promote safe sexual practices, while addressing salient structural factors, such

as gender inequities and livelihoods given the substantial gender inequities operating in the street subculture (Embleton, Wachira, et al., 2016, 2015, 2018; Wachira et al., 2016, 2015), low levels of HIV and STI knowledge (Embleton, Wachira, et al., 2016, 2015), harmful sexual practices (Embleton, Wachira, et al., 2015; Wachira et al., 2015; Winston et al., 2015), and SCY's social and economic marginalization (Sorber et al., 2014). In response to these needs, we adapted the Stepping Stones and Creating Futures (Jewkes et al., 2014) programmes with SCY in Eldoret, Kenya (Embleton, Di Ruggiero, et al., 2019). The present analysis seeks to explain and explore how participation in the adapted intervention changed SCY's HIV knowledge, CUSE, and sexual practices.

6.3. Methods

6.3.1. Study design

From May 2017 to January 2018 a multi-stage mixed methods study was used to adapt and pilot a gender, livelihoods, and HIV prevention intervention for SCY in Eldoret, Kenya. In the first stage, we adapted the combined Stepping Stones and Creating Futures interventions (Embleton, Di Ruggiero, et al., 2019). From September 2017 to January 2018, we piloted the adapted intervention with 80 SCY using a pre- and post-intervention convergent mixed methods design (Fetters et al., 2013). The convergent mixed methods design (Figure 11) was used to understand and explore the pilot outcomes (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014).

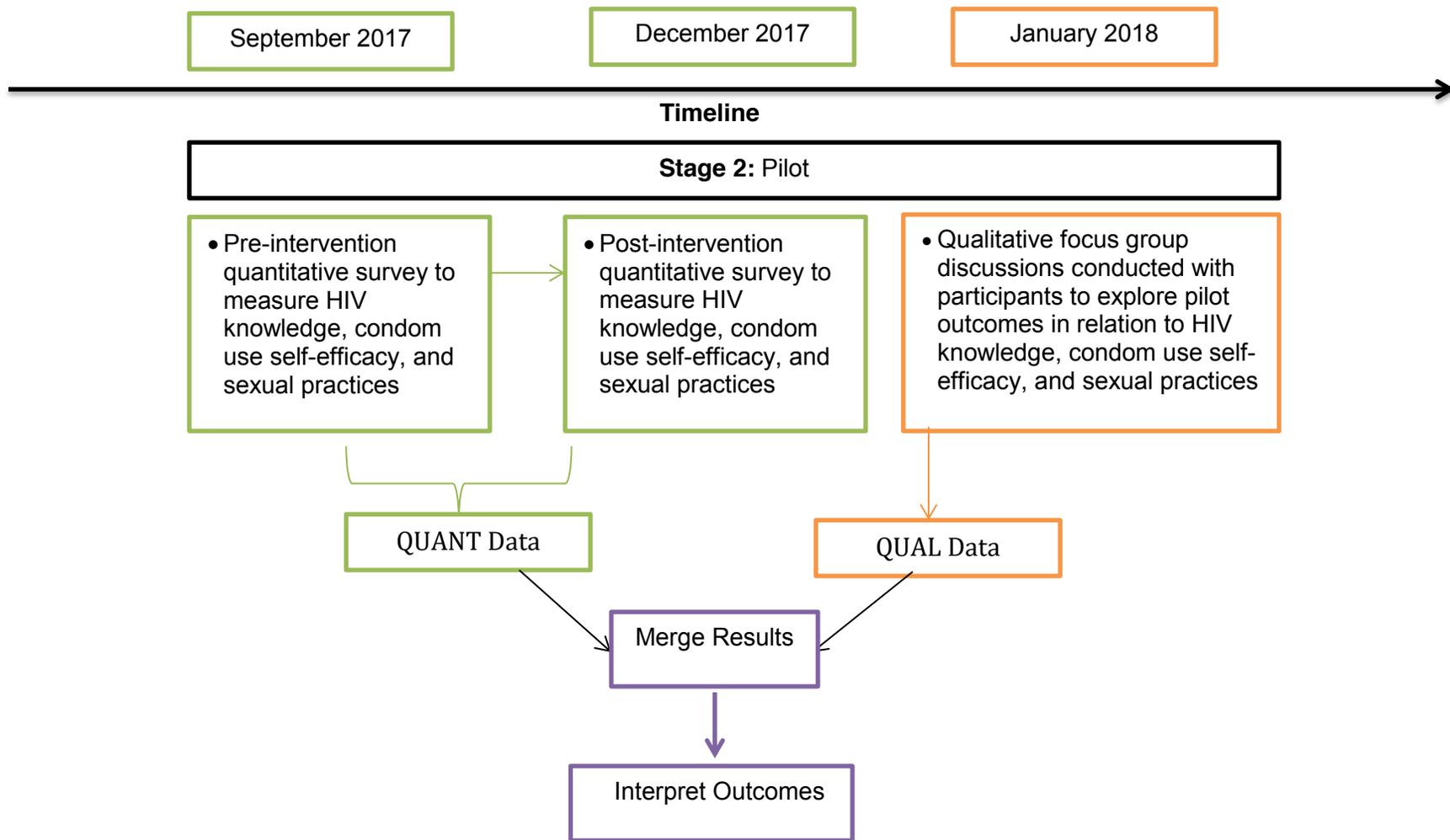


Figure 12 Shows the convergent mixed methods study design, timeline, and quantitative and qualitative components

6.3.2. Study setting

This study occurred in Eldoret, Kenya, the capital of Uasin Gishu County. Eldoret town has a population of 289,389 (CRA, 2013). It is home to Moi University, Moi Teaching and Referral Hospital (MTRH), and the Academic Model Providing Access to Healthcare (AMPATH) Consortium (Einterz et al., 2007), a long-standing partnership between Moi University, MTRH, and a consortium of universities. In January 2017, the MTRH-Rafiki Centre for Excellence in Adolescent Health was established and became the study site for this research project.

6.3.3. Intervention description

Stepping Stones is a behavioural training programme on gender, HIV, and relationship skills (Gordon et al., 2017; Welbourn, 1995). Creating Futures is a structural intervention designed to build on Stepping Stones (Jewkes et al., 2014). In South Africa, the combined programme was delivered over 12-weeks with out-of-school youth in informal settlements (Jewkes et al., 2014). Our adapted programme included 24 sequential sessions over the course of 14 weeks (Embleton, Di Ruggiero, et al., 2019); 8 weeks of Stepping Stones followed by 6 weeks of *Kujijenga Kimaisha*. The Stepping Stones programme covered topics on: communication, gender norms, love, sexual and reproductive health, HIV and STIs, condom use, gender-based violence, drug and alcohol use, and peer pressure. The *Kujijenga Kimaisha* programme focused on having participants reflect on their livelihood skills and resources, and examine how they can strengthen them. The programme aimed to support and encourage participants to set an

achievable personal goal, and to work towards commencing income generating activity or training course of their choice.

Each intervention session lasted from 1.5 to 3 hours and was conducted in a private tent outside of the adolescent-friendly clinic. Peer Facilitators of the same gender facilitated the programme under the supervision of the Principal Investigator (PI) (LE), in single-gender age-stratified groups of 20 participants (ages: 16-19 and 20-24). The Peer Facilitators were respected and trusted members of the street community (Embleton, Di Ruggiero, et al., 2019), who underwent 1 month of training on the intervention, facilitation, research conduct and data collection for this study.

6.3.4. Study participants

SCY were eligible to participate in the pilot intervention if they were: 1) aged 16-24 years, 2) had spent a portion or majority of their time on the streets for the past 6 months, and 3) were not enrolled in or attending school.

6.3.5. Sample size

A sample size of 80 participants was determined based on calculations to detect significant mean difference in our primary outcome of HIV knowledge ($\alpha=0.05$ $\beta=0.20$ Power=0.8 SD=20) by estimating high, medium, and low baseline scores and hypothesized percentage increase in score (25%, 15%, or 10%). As this was a pilot and feasibility study it was not powered to detect changes in secondary outcomes.

6.3.6. Participant Recruitment and Enrolment

The locations where SCY live and congregate were identified and the PI and Peer Facilitators conducted outreach in these settings to explain the purpose of the research and the intervention. An existing relationship between the research team and SCY in Eldoret assisted in this process. Peer Facilitators created four age- and sex-stratified sampling lists of SCY who met the eligibility criteria and who indicated their interest in participating in the intervention. Participants were selected using a simple random sampling procedure generating random numbers. Selected participants were invited to enrol at the adolescent-friendly clinic. If a selected participant declined to participate or did not come on the enrolment date, another participant from the list was randomly selected until the desired sample size of 80 participants was reached, consisting of 20 participants for each age- and sex-stratified group (ages: 16-19 and 20-24).

6.3.7. Study procedures

Consented participants completed a paper-based standardized questionnaire administered by the Peer Facilitators. Pre-intervention surveys were administered face-to-face in Swahili in a private tent under the supervision of the PI. Throughout the intervention's implementation, attendance records were kept to monitor retention and participation in the intervention. In week 14, participants completed a post-intervention survey administered by the Peer Facilitators. Of the 80 participants that completed pre-intervention surveys, 67 completed post-intervention surveys. At post-intervention 6 participants from each of the intervention groups were purposively invited to participate in focus group discussions (FGDs) about their experience

in the programme. Twenty-one participants returned to attend FGDs, which were conducted in Swahili by a trained Peer Facilitator and the PI. FGDs took 1 to 1.5 hours and occurred in a private tent.

6.3.8. Measures

Pre- and post-intervention standardized questionnaires were pre-tested for use with 5 male and 5 female SCY aged 16-24 who provided feedback regarding the clarity and acceptability of the questions. Minor changes to the Swahili wording of questions were made. The final questionnaire captured basic socio-demographic data including: age, school attendance, relationship status, orphan status, time typically spent on the streets, and time street-involved. The primary outcome of interest HIV knowledge was assessed using the 18-item (Cronbach's $\alpha=0.60$) HIV-KQ-18 questionnaire (Carey & Schroeder, 2002). HIV-KQ-18 answer options are 'true', 'false' or 'don't know', and each correct answer is given one point; scores are then summed. Higher scores represent greater HIV knowledge (Carey & Schroeder, 2002). Secondary outcomes included CUSE and sexual practices. CUSE was measured using the 9-item validated (Cronbach's $\alpha=0.73$) Condom Use Self-Efficacy Scale – Ethiopia (Shaweno & Tekletsadik, 2013). Responses for each item were scored as 0 = strongly disagree, 1 = disagree, 2 = undecided, 3=agree and 4=strongly agree. Items that were negatively worded were reverse coded. Higher scores indicate greater CUSE (Shaweno & Tekletsadik, 2013). Sexual practices were measured by asking participants the following questions: ever engaged in vaginal sex, age of first vaginal sex, was the first vaginal intercourse voluntary, last vaginal sex, last vaginal sex condom use, frequency of condom use, number of vaginal sex partners in the past month, ever exchange sex

for money, shelter, food, security or other material items, in the past month exchange sex, frequency of exchanging sex, ever tested for HIV, and when was the last HIV test.

FGDs used an interview guide that asked participants about their experience participating in the programme, what they learnt in relation to HIV, condom use, and sexual and reproductive health and how the programme changed or did not change their sexual practices.

6.3.9. Analyses

Statistical Analysis: Quantitative data collected on paper surveys was manually entered into Epi Info (version 7.2.1) and checked for errors and missing data. Data were exported into R Studio for analysis from Epi Info. All participants post-intervention were sought to complete questionnaires. Outcome analyses included all enrolled participants, irrespective of programme attendance or completion. Thirteen participants were not interviewed post-intervention: 8 were lost to follow-up, 1 dropped out of the programme, and 4 had moved and could not be located. Baseline scores were carried forward post-intervention for these participants. This provides a conservative estimate of the intervention effect when outcomes are not expected to decline (European Medicines Agency, 2011). In total, 4 single-items for 4 participants were missing from the HIV and CUSE scales. For these, scale items were imputed using the mode (HIV scale) and individual mean (CUSE) (Shrive et al., 2006). To test the accuracy of results using this missing data strategy, a complete case analysis was conducted. There were no differences in outcomes or statistical significance compared to the imputed analyses. We present both complete cases and last value carried forward outcomes in our findings.

Categorical variables were summarized using frequencies and percentages. Continuous variables were summarized using either median and interquartile range or mean and standard deviation. A Shapiro-Wilk test and visual analysis of histogram and Q-Q plots were used to test for normality of the outcome variables for HIV knowledge and CUSE scores. Due to the non-normality of the HIV knowledge scores, a Wilcoxon signed rank test was used to test whether participants had improved their HIV knowledge from pre- to post-intervention. CUSE scores were normally distributed and a paired t-test was employed to compare mean pre- and post-test scores. Difference scores were calculated by taking the post-intervention scores minus the pre-intervention scores. Multiple linear regression models were fit to predict HIV knowledge and condom use-self efficacy change scores. Models were adjusted for the covariates of age, gender, education level, attendance, time street-connected, relationship status, and ever tested for HIV. Pre-intervention scores were controlled for in the models, which ensured the net relationships of the difference score to the independent variables in the model are adjusted for the confounded effects of the pre-intervention score. When pre-intervention scores are incorporated into the equation, concerns and problems regarding difference scores are countered (Dalecki & Willits, 1991). Changes in sexual practices were compared using McNemar's test for paired nominal data.

Textual Analysis: Qualitative audio-recorded data were transcribed into Swahili and translated into English by a hired transcriptionist. Transcribed and translated data were imported into NVivo software for analysis. A codebook was developed to explore outcomes in relation to HIV and STI knowledge, CUSE, sexual practices and other health-related outcomes. Qualitative data were analyzed using thematic analysis driven by analytic interest (Braun & Clarke, 2006) to

explore concepts in relation to how participation in the intervention changed or did not change SCY's HIV knowledge, CUSE, sexual practices, and other health experiences.

Mixed Methods Integration: Qualitative and quantitative data were collected separately in a similar timeframe to explain and explore the primary and secondary outcomes of interest (Figure 11). Findings were merged for comparison after statistical and textual analyses of the data (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014). Data were then integrated through a weaving approach whereby qualitative and quantitative findings are presented together on a theme-by-theme basis, where integration confirms, expands on, uncovers discordant or silent findings (Fetters et al., 2013; O'Cathain et al., 2010).

6.4. Results

6.4.1. Socio-demographics and attendance

The median age of participants was 19.5 years (IQR 17-22) (Table 3). The majority of participants had ever attended school (96%); 86% had attended primary school and 14% secondary school. Over half of young women reported being in a relationship (60%), defined as being married or having a girlfriend or boyfriend. In contrast, the majority of young men reported being single (73%). Almost all (85%) participants had been street-connected for greater than 1 year. Less than half (35%) of participants reported that both of their parents were alive. Participants attended a median of 11 sessions (IQR 1-20) over 14 weeks. Young women attended a median of 10 sessions (IQR 1-18) and young men 15 sessions (IQR 1-23), with variation among age groups (Table 4).

Table 3 Socio-demographic characteristics of all participants, those lost to follow-up and those retained

SOCIODEMOGRAPHICS	All Participants			Lost to follow-up Participants	Retained Participants
	Total N=80 n (%)	Young Women N = 40 n (%)	Young Men N=40 n (%)	N=13 n (%)	N=67 n (%)
Age (median, IQR)	19.5 (17-22)	19.5 (17 – 23)	19.5 (17-21)	20 (17-20)	19 (17-22)
Ever Attended School					
Yes	77 (96.3)	38 (95.0)	39 (97.5)	12 (92.3)	65 (97.0)
No	3 (3.7)	2 (5.0)	1 (2.5)	1 (7.7)	2 (3.0)
Level of Education					
Primary	66 (82.5)	32 (80.0)	34 (85.0)	10 (77.0)	56 (83.6)
Secondary	11 (13.7)	6 (15.0)	5 (12.5)	2 (15.0)	9 (13.4)
None	3 (3.8)	2 (5.0)	1 (2.5)	1 (7.7)	2 (3.0)
Primary Level (Median, IQR)	7 (5-7)	6 (5-7)	7 (6-7)	7 (6-8)	7 (5-7)
Secondary level (Median, IQR)	2 (1-4)	3 (2-3)	2 (2-2)	2 (2-2)	3 (2-3)
Relationship Status					
Single	42 (52.4)	13 (32.5)	29 (72.5)	6 (46.2)	36 (53.7)
Have a girlfriend or boyfriend	23 (28.7)	12 (30.0)	11 (27.5)	6 (46.2)	17 (25.4)
Married	12 (15.0)	12 (30.0)	0 (0)	1 (7.7)	11 (16.4)
Divorced	2 (2.5)	2 (5.0)	0 (0)	0 (0)	2 (3.0)
Widowed	1 (1.2)	1 (2.5)	0 (0)	0 (0)	1 (1.5)
Time Street-connected					
6 months – 1 year	12 (15.0)	8 (20.0)	4 (10.0)	2 (14.9)	10 (15.4)
1-2 years	15 (18.8)	9 (22.5)	6 (15.0)	1 (20.9)	14 (7.7)
2 to 5 years	32 (40.0)	10 (25.0)	22 (55.0)	8 (35.8)	24 (61.5)
> 5 years	21 (26.2)	13 (32.5)	8 (20.0)	2 (28.4)	19 (28.4)
Time on streets					
Day & night	25 (31.25)	14 (35.0)	11 (27.5)	5 (38.5)	20 (29.9)
Day only	47 (58.7)	24 (60.0)	23 (67.5)	4 (30.8)	43 (64.2)
Varies	7 (8.75)	2 (5.0)	5 (12.5)	4 (30.8)	3 (4.5)
	1 (1.25)	-	1 (2.5)	-	1 (1.5)
Parents Vital Status					
Mother deceased / Vital status unknown	8 (10.0)	5 (12.5)	3 (7.5)	2 (15.4)	6 (9.0)
Father deceased / Vital status unknown	29 (36.25)	14 (35.0)	15 (37.5)	3 (23.1)	26 (38.8)
Both parents deceased / Vital status unknown	15 (18.75)	7 (17.5)	8 (20.0)	3 (23.1)	12 (17.9)
Both parents alive	28 (35.0)	14 (35.0)	14 (35.0)	5 (38.5)	23 (34.3)

Table 4 Attendance at pilot intervention stratified by gender and age groups

	N=80 Total n (%)	Young women N = 40			Young men N=40		
		Total	Aged 16-19 Years (n=20)	Aged 20-24 Years (n=20)	Total	Aged 16-19 Years (n=20)	Aged 20-24 Years (n=20)
Attendance							
Median # of Sessions (IQR) Range (0-24)	11 (1-20)	10 (1-18)	9 (1-20)	11 (3-16)	15 (1-23)	16 (3-23)	7 (0-19)
Attendance Level ⁺							
Low	33 (41.3)	15 (37.5)	9 (45.0)	6 (30.0)	18 (45.0)	7 (35.0)	11 (55.0)
Medium	20 (25.0)	14 (35.0)	4 (20.0)	10 (50.0)	6 (15.0)	3 (15.0)	3 (15.0)
High	27 (33.8)	11 (27.5)	7 (35.0)	4 (20.0)	16 (40.0)	10 (50.0)	6 (30.0)

⁺ Low 0-7 sessions, Medium 8- 16 sessions, High 17-24 sessions

6.4.2. HIV knowledge

Participants had a significant increase in HIV knowledge from pre- to post-intervention (Table 5). The median HIV knowledge score pre-intervention was 11 (IQR 8-13) and post-intervention 14 (IQR 12-16) ($p < 0.001$) out of a total possible score of 18. Therefore correct HIV knowledge shifted from 61% to 78% correct, representing a 27% increase in correct HIV knowledge from pre-intervention to post-intervention. Increases in HIV knowledge were confirmed in FGDs.

Table 5 Median HIV knowledge and mean condom use self-efficacy scores pre- and post- intervention for complete cases and all participants stratified by gender

Score	Pre-Intervention				Post-Intervention				p-value
	N=80	Young women n=40	Young men n=40	Baseline Retained ^a N=67	Complete Cases N=67	N=80	Young women N=40	Young Men N=40	
HIV-KQ-18 median (IQR)	11 (8-13)	11 (9-12)	11 (8-13)	11 (8-13)	15 (13-17)	14 (12-16)	14 (12-15)	16 (12-17)	<0.001
CUSES Mean (SD)	20.7 (4.6)	20.7 (5.1)	20.7 (4.0)	20.8 (4.9)	21.7 (4.5)	21.4 (4.3)	21.3 (4.9)	21.5 (3.7)	0.2476

^a Participants with both baseline and endline data representing complete cases

One young woman aged 16-19 stated that prior to the intervention she *'didn't know about HIV'*. While a young man aged 20-24 changed his perceptions about what HIV is: *'I realized that what I initially thought about HIV was wrong'*. This expanded to learning about STIs in the programme as discussed by a young man:

'We didn't know how diseases like STIs are spread and how we can prevent them but we learnt how to prevent and treat those diseases. So health wise it helped us because we learnt how to fight those diseases.'

(Young man, 20-24 years)

The impact of participant attendance on changes in HIV knowledge change scores was explored in a multiple linear regression model (Table 6). Participants with a medium level of attendance had a 2.8 point increase (95% CI: 1.17 – 4.37) in mean HIV knowledge change score relative to those with low attendance, while those with high attendance had a 4.2 point increase (95% CI: 2.80 – 5.50) in mean HIV knowledge change score relative to those with low

attendance while adjusting for age, gender, education, time street-connected, relationship status, ever being tested for HIV, and HIV knowledge score at baseline. This suggests that higher levels of attendance result in a larger magnitude of change in HIV knowledge from pre- to post-intervention.

Table 6 Multiple regression models to predict change in HIV knowledge score and condom use-self efficacy

Predictors	HIV KNOWLEDGE CHANGE SCORE β and 95% CI	CUSES CHANGE SCORE β and 95% CI
Intercept	6.1 (0.53 - 11.6)	16.2 (6.5-26.0)
Age (years)	-0.03 (-0.29 - 0.24)	0.2 (-0.3 – 0.6)
Gender		
Young woman	ref	ref
Young man	1.5 (0.18 - 2.74)	-0.7 (-2.8 - 1.45)
Education Level		
Primary / None	ref	ref
Secondary	1.0 (-0.71 - 2.71)	1.4 (-1.7 - 4.5)
Attendance (categorical)		
Low	ref	ref
Medium	2.8 (1.17 - 4.37)	-0.4 (-3.0 – 2.3)
High	4.2 (2.80 - 5.50)	0.7 (-1.6 – 2.9)
Time Street-connected		
6 months – 1 year	-0.5 (-2.53 - 1.53)	-2.2 (-5.7 – 1.3)
1-2 years	ref	ref
2 to 5 years	1.1 (-0.63 - 2.78)	0.7 (-2.2 – 3.6)
> 5 years	0.9 (-0.96 - 2.74)	-2.7 (-5.9 – 0.4)
Relationship Status		
Single / Divorced / Widowed	-0.5 (-1.80 - 0.85)	-0.05 (-2.2 – 2.1)
Married / Girlfriend / Boyfriend	ref	ref
Ever tested for HIV		
Yes	ref	ref
No	1.3 (-1.23 - 3.82)	0.9 (-3.4 – 5.2)
CUSES Score at baseline		-0.9 (-1.1 - -0.6)
HIV Score at baseline	-0.6 (-0.76 - -0.381)	
R2	0.53	0.51
Adjusted R2	0.45	0.43
P-value for model	<0.001	<0.001

Gender differences in changes in HIV knowledge scores occurred. Young women and young men both commenced with a baseline median score of 11 pre-intervention. For young women their median score increased to 14 (IQR 12-15) and young men to 16 (IQR: 12-17) (Table 5). Gender was a significant predictor of HIV knowledge change score (Table 6). Young men on average had a 1.5-point increase (95% CI: 0.18 – 2.74) in HIV knowledge change score in comparison to young women while controlling for age, education level, attendance level, time street-connected, relationship status, ever being tested for HIV, and pre-intervention HIV knowledge score.

Qualitative interviews with participants confirmed changes in HIV transmission knowledge. One young woman aged 20-24 years stated: *'I learnt that you can live with someone who has HIV. You can't get it from using cups and sharing a bed.'* While a young man aged 16-19 discussed learning about the ability to prevent transmission to children among couples living with HIV: *'Because even if either of you have HIV, you can have kids that don't have it.'*

Young men discussed gaining knowledge regarding the use of post- (PEP) and pre-exposure prophylaxis (PrEP) for HIV prevention:

'Let me add something. The experience I got from this programme is about PEP and PrEP. Before and after. Like if you go find a girl and have sex with her without protection, you go see the doctor within 72 hours. You rush there. You go very fast and get medicine to protect yourself.'

(Young man, 20-24 years)

This knowledge extended to young women understanding about the availability and use of PrEP for discordant couples:

'When I came here I learnt that if your husband has the disease [HIV], you can come and be given medicine [PrEP] to prevent that disease.'

(Young woman, 16-19 years)

Across age and gender strata, participants described that they learnt that condom use could prevent HIV and STI transmission:

'I learnt how to use a condom. How you can open the condom and know everyone is not the same. Others may have diseases like STIs or HIV so you have to protect yourself with a condom. That is what I learnt here. Honestly I didn't know, but now I know.'

(Young man, 16-19 years)

6.4.3. Condom use self-efficacy, condom use, and sexual practices

Learning about correctly using male and female condoms was a programme component, which aimed to improve CUSE and condom use among participants. At baseline, the mean CUSE score was 20.7 (SD: 4.6, Table 5). Post-intervention the mean CUSE score demonstrated a small non-significant increase (21.4, SD: 4.3) with similar scores across genders. A multiple linear

regression model was fit to predict CUSE score change (Table 6). Despite non-statistically significant changes, qualitative accounts among participants supported an increase in CUSE expanding on intervention outcomes. As one young man reported, the intervention increased his ability to use condoms:

'To me this programme has helped me and taught me a lot. In the past I wouldn't have used a condom. It was a burden. But it has helped me. It has taught me how to use a condom. Now I know there are diseases, something I ignored in the past...I can protect myself.'

(Young man, 20-24 years)

Young women also indicated they learnt about female condoms and how to use them:

'When we were in the streets we didn't even know there were female condoms. We heard there was a female condom, but didn't know how to use it. When we came here is when we were taught and if you find a fellow female in trouble you explain to her how she can protect herself.'

(Young woman, 16-19 years)

The correct use of condoms was another area in which participants' acquired knowledge through programme participation as discussed by a young man:

'We learnt that you shouldn't use two condoms. If you use two it may burst and if the person you were having sex with had HIV, you will be infected. So we learnt not to use two and how to put one on.'

(Young man, 16-19 years)

In spite of participants' qualitative accounts of increased knowledge of condoms and self-efficacy, condom use and other sexual practices remained generally unchanged among participants post-intervention (Table 7). Reported condom use at last vaginal sex was low among all participants pre- and post-intervention (35%). Post-intervention there was an increase in the proportion of young men reporting condom use at last sex (28% to 42%), although not statistically significant. Similarly, there was a small non-significant increase in the proportion of male participants reporting using condoms always or most of the time for vaginal sex (14% to 21%).

6.4.4. Health seeking practices

Almost all participants reported having ever been tested for HIV (94%) (Table 7). There was a small increase in the proportion of participants who reported being tested in the last 6 months from 71% pre- to 84% post-intervention. One young man discussed how the programme helped him to know his HIV status:

'This programme has helped me in many ways. First knowing my [HIV] status and about my health in general.'

(Young man, 20-24 years)

Table 7 Sexual and health-seeking practices pre- and post-intervention stratified by gender

Sexual Practices	Pre-Intervention				Post-Intervention		
	Total N=80 n (%)	Young women N = 40 n (%)	Young men N=40 n (%)	Baseline Retained ^a N=67 n (%)	Total N=67 n (%)	Young women N=33 n (%)	Young men N=34 n (%)
Participants who reported ever having vaginal sex							
	N=76	N=39	N=37	N=64	N=66	N=33	N=33
Last Vaginal Sex Condom Use							
Yes	27 (35.5)	16 (40.0)	11 (27.5)	23 (34.3)	23 (34.8)	9 (27.3)	14 (42.4)
No	49 (64.5)	23 (57.5)	26 (65.0)	41 (61.2)	43 (65.2)	24 (72.7)	19 (57.6)
How often do you use condoms for vaginal sex?							
Always / Most of the time	14 (18.4)	9 (23.1)	5 (13.5)	12 (18.8)	15 (22.7)	8 (24.2)	7 (21.2)
Sometimes	41 (53.9)	17 (43.6)	24 (64.9)	33 (51.6)	36 (54.5)	14 (42.4)	22 (66.7)
Never	20 (26.3)	13 (33.3)	7 (18.9)	18 (28.1)	15 (22.7)	11 (33.3)	4 (12.1)
Missing	1 (1.3)	-	1 (2.7)	1 (1.6)	-	-	-
How many different people have you had vaginal sex with in the last month?							
0	16 (21.1)	0 (0)	16 (43.2)	15 (23.4)	16 (24.2)	1 (3.0)	15 (45.5)
1	39 (51.3)	27 (69.2)	12 (32.4)	32 (50.0)	31 (47.0)	20 (60.6)	11 (33.3)
> 2	21 (27.6)	12 (30.8)	9 (24.3)	17 (26.6)	19 (28.8)	12 (36.4)	7 (21.2)
Have you ever exchanged sex for money, shelter?							
Yes	25 (32.9)	21 (53.8)	4 (10.8)	21 (31.3)	20 (30.3)	19 (57.6)	1 (3.0)
No	49 (64.5)	17 (43.6)	32 (86.5)	41 (61.2)	44 (66.7)	13 (39.4)	31 (94.0)
Refuse Answer	1 (1.3)	1 (2.6)	0 (0)	1 (1.5)	2 (3.0)	1 (3.0)	1 (3.0)
Missing	1 (1.3)	-	1 (2.7)	1 (1.6)	-	-	-
In the past month have you exchanged sex? <small>(Of those that have ever exchanged sex)</small>							
Yes	16 (64.0)	15 (71.4)	1 (25.0)	13 (61.9)	18 (90.0)	18 (94.7)	0 (0)
No	9 (36.0)	6 (28.6)	3 (75.0)	8 (38.1)	2 (10.0)	1 (5.3)	1 (100)
How often do you typically exchange sex? <small>(Of those that have ever exchanged sex)</small>							
Daily	9 (36.0)	9 (42.9)	0 (0)	8 (38.1)	13 (65.0)	13 (68.4)	0 (0)
Weekly	2 (8.0)	2 (9.5)	0 (0)	2 (9.5)	5 (25.0)	5 (26.3)	0 (0)
Once a month	4 (16.0)	3 (14.3)	1 (25.0)	2 (9.5)	0 (0)	0 (0)	0 (0)
In the past, but not in the past 6 months	7 (28.0)	4 (19.0)	3 (75.0)	6 (28.6)	1 (5.0)	0 (0)	1 (100)
Don't Know	3 (10.7)	3 (14.3)	0 (0)	3 (14.3)	0 (0)	0 (0)	0 (0)
Refuse answer	0 (0)	0 (0)	0 (0)	0 (0)	1 (5.0)	1 (5.3)	0 (0)
Health Seeking Practices							
Have you ever been tested for HIV? (N=80)							
Yes	75 (93.8)	37 (92.5)	38 (95.0)	64 (94.0)	65 (97.0)	32 (97.0)	33 (97.0)
Never	5 (6.3)	3 (7.5)	2 (5.0)	4 (6.0)	2 (3.0)	1 (3.0)	1 (3.0)
When was the last time you were tested? <small>(Of those ever tested, n=75)</small>							
< 1 month	31 (41.3)	21 (56.8)	10 (26.3)	25 (39.1)	25 (38.5)	17 (53.1)	8 (24.2)
1 to 3 months	18 (24.0)	2 (5.4)	16 (42.1)	14 (21.9)	23 (35.4)	6 (18.8)	17 (51.5)
3 to 6 months	8 (10.7)	5 (13.5)	3 (7.9)	7 (10.9)	8 (12.3)	3 (9.4)	5 (15.2)
> 6 months / Don't Know	18 (24.0)	9 (24.3)	9 (23.7)	17 (26.6)	8 (12.3)	6 (18.8)	4 (12.1)

Participants discussed learning to support their peers and to promote health-seeking practices. This extended to young women giving advice and accompanying their friends to get family planning as one young woman aged 16-19 explained: *“I can tell her to let me take her to the hospital to get family planning.”* Finally, both young men and women participants discussed increasing their knowledge in relation to family planning methods:

‘If it is me, say I don’t want another child; I will come because there are different types of family planning. There’s 3 years, three months and pills you can swallow. I can go get injections because that is what works for me.’

(Young woman, 16-19 years)

Overall, these qualitative accounts expanded on the intervention’s impact on participants’ health-seeking practices in relation to HIV testing, peer support, and family planning.

6.5. Discussion

This is the first known study of an evidence-based combination intervention for SCY in sub-Saharan Africa. Following the intervention, participants reported an increase in HIV knowledge, our primary outcome of interest. While participants did not have significant changes in secondary outcomes, qualitative accounts illustrated an improvement in condom knowledge and CUSE as well as in important sexual and reproductive health seeking practices. Our findings support the potential for further testing with a rigorous study design to investigate how best to

tailor the intervention, particularly by gender, and increase the overall effectiveness of the programme.

We previously documented a myriad of misconceptions regarding the transmission of HIV, STIs, and condom use among SCY in Eldoret, Kenya (Embleton, Wachira, et al., 2016, 2015). Given these previous findings and low baseline level of HIV knowledge, the positive change in HIV knowledge post-intervention among participants represents an important foundation for behaviour change. The relationship between level of attendance and increase in HIV knowledge change score supports that attendance at the intervention was a predictor of changing knowledge. These findings are in agreement with the body of evidence that Stepping Stones is effective in increasing HIV and STI knowledge (Skevington et al., 2013). Correct knowledge and perceived risk of acquiring HIV is an important component of reducing sexual risk practices, even if knowledge alone is insufficient (Bernardi, 2002; Sayles et al., 2006; Tenkorang & Maticka-Tyndale, 2014).

Gender had an impact on HIV knowledge scores, with young men having a greater score increase in comparison to young women when adjusting for covariates. Given that both young women and men had the same median score at baseline, this difference may be due to observed variances in facilitation and uptake of the intervention between groups of young men and women. Young men aged 16 to 19 had higher attendance than any other group and this may have contributed to significantly to their larger increase in HIV knowledge.

Our findings did reveal a small but non-significant increase in all participants' CUSE from pre- to post-intervention. Additionally, we did not find a difference in reported CUSE between young women and men pre- or post-intervention even though gender and social norms are

important components of CUSE and condom use among young people in sub-Saharan Africa (Closson et al., 2018). We found marginal changes in reported condom use among young men, albeit non-significant. In South Africa, participants in the Stepping Stones and Creating Futures interventions had no significant changes in condom use at last sex, but young women demonstrated a trend towards increasing use (Jewkes et al., 2014). Young women in the present intervention showed no change in the frequency of condom use and had a slight decrease in use at last vaginal sex from pre- to post-intervention. This may be due to the fact that condom use and sexual decision-making are typically under the control of men (Closson et al., 2018) and young women's sexual partners may not be the young men participating in the intervention. This may suggest the need for a couples-based intervention in this setting.

The sample size of our study was small and the power to detect significant changes was limited. Our results may also be prone to social desirability bias, as participants may have answered favourably or suppressed information on questionnaires. However, given the trusted relationship Peer Facilitators established with programme participants, it is likely they felt comfortable answering honestly. Lastly, this study took place in one geographic location in Kenya where the research team has a long-standing relationship with the study population, and therefore it's not generalizable to other settings.

This intervention occurred within an existing adolescent-friendly clinic and was implemented and facilitated by young people who grew up with street experiences. It reflects the ability of the programme to function within the existing infrastructure and setting, suggesting possible scale-up, sustainability and validity in 'real world' circumstances.

Overall, this study has demonstrated that *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme may be effective at increasing SCY's HIV and condom use knowledge, as well as health seeking behaviours.

Chapter 7 Improving livelihoods and gender equitable attitudes of street-connected young people in Eldoret, Kenya: results from a pilot evidence-based intervention

Embleton L¹, Di Ruggiero E², Logie C.H.³, Ayuku D^{4,5}, Braitstein P^{2,5,6}.

1. Institute of Medical Science, Faculty of Medicine, University of Toronto, Toronto, Canada
2. Dalla Lana School of Public Health, University of Toronto, Toronto, Canada
3. Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada
4. Moi University, College of Health Science, Department of Behavioural Science, Eldoret, Kenya
5. Academic Model Providing Access to Healthcare, Eldoret, Kenya
6. Moi University, College of Health Sciences, School of Medicine, Eldoret, Kenya

Corresponding Author:

Lonnie Embleton, MPH, PhD(c)
Institute of Medical Science
Faculty of Medicine
University of Toronto
lonnie.embleton@gmail.com

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7.1. Abstract

Objectives: This study sought to explain and explore how participation in a pilot adapted evidence-based intervention, Stepping Stones and Creating Futures, integrated with matched-savings, changed street-connected young people's economic resources, livelihoods, and gender equitable attitudes.

Methods: Eighty street-connected young people participated in a pre- and post-intervention convergent mixed methods design in Eldoret, Kenya. The primary outcome of interest was gender equitable attitudes and secondary outcomes included economic resources and livelihoods. Quantitative data was collected in a standardized questionnaire and qualitative data through focus group discussions. Mixed methods findings are presented together, to confirm, expand on, or uncover discordant findings.

Results: Participants had a significant change in gender equitable attitudes from pre- to post-intervention from 43 (IQR 38-48) to 47 (IQR 42-51) ($p < 0.001$). Attendance level was a significant predictor of gender equitable attitudes change. Quantitatively and qualitatively participants reported increases in daily earnings, changes in street-involvement, housing, and livelihood activities.

Conclusions: Overall, this study demonstrated that the adapted programme might be effective at changing gender equitable attitudes and improving livelihoods for street-connected young people in Kenya.

Keywords: gender equity; livelihoods; savings; street youth; intervention

7.2. Introduction

Structural drivers of HIV acquisition refer to the social, cultural, economic, legal, and political factors in a community context that facilitate or constrain an individual's ability to avoid acquiring HIV (Sumartojo et al., 2000). Street-connected young people (SCY) in Kenya, for whom the streets play a central role in their everyday lives and social identities (OHCHR, 2017), may be particularly vulnerable to acquiring HIV due to such structural factors. Numerous structural factors impact SCY including: being precariously housed; abject poverty; gender inequities; barriers to education, economic marginalization, and accessing healthcare; and an absence of sound policies and programmes for SCY (Coren et al., 2016; Embleton, Wachira, et al., 2018; Sorber et al., 2014; Woan et al., 2013). It is likely these structural drivers are influencing SCY's engagement in harmful sexual practices (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2015), resulting in their elevated HIV prevalence (Braitstein et al., 2019; Goldblatt et al., 2015; Shah et al., 2018; Winston et al., 2015), and impacting their ability implement HIV prevention practices.

Structural approaches to HIV prevention address broader issues that shape or constrain an individual's behaviour. For example, the provision of microfinance to vulnerable women, who may be excluded from accessing formal banking institutions and dependent on men, can help reduce their dependency and improve their access to financial capital thus reducing their HIV vulnerability (Gupta et al., 2008). For young people in sub-Saharan Africa, structural HIV prevention interventions have focused on changing gender and social norms, improving school attendance, livelihoods, and economic circumstances (Wamoyi et al., 2014). Given the disproportionate impact of HIV on young women in sub-Saharan Africa (UNAIDS, 2018a),

combined with high levels of poverty, many structural interventions in eastern and southern Africa have sought to address gender inequities while economically empowering young women (Wamoyi et al., 2014). While positive outcomes of structural interventions have been seen for adolescent girls and young women (Wamoyi et al., 2014), limited interventions have included young men (Gibbs et al., 2012). Yet, young men are an important part of changing gender norms, and reducing sexual and gender-based violence, all of which impact young people's vulnerability to acquiring HIV. When viewing these issues as interpersonal and spanning genders, it is evident that both young men and women need to be supported to embrace changes in gender equity and reduce HIV vulnerability (Gibbs et al., 2012). Therefore, including young men in combined gender and livelihood interventions may be a vital, albeit overlooked component of structural HIV prevention strategies.

Given the substantial gender inequities, economic marginalization, and elevated HIV prevalence among SCY in Eldoret, Kenya (Braitstein et al., 2019; Embleton, Wachira, et al., 2016, 2015, 2018; Shah et al., 2018; Sorber et al., 2014; Wachira et al., 2015; Winston et al., 2015), there is a crucial need to use multi-faceted approaches to reduce their vulnerability to acquiring HIV. Globally, very few effective interventions exist for SCY (Berckmans et al., 2012; Coren et al., 2016; Dybicz, 2005; Naranbhai et al., 2011). Interventions using economic and livelihood approaches with SCY have not been studied. Yet, livelihood strategies may represent a feasible method of improving their economic circumstance and reducing the harms associated with street-involvement (Berckmans et al., 2012). In response, we adapted the Stepping Stones and Creating Futures programmes for a new context, which address gender, livelihoods and sexual and reproductive health, with SCY in Eldoret, Kenya (Embleton, Di

Ruggiero, et al., 2019). The intervention was paired with a matched-savings programme conditional on attendance to further address structural drivers of HIV and gender inequity in our context (Embleton, Di Ruggiero, et al., 2019). It was posited that the integration of matched-savings with participation in the combined programme addressing gender and livelihoods, would reduce young women's economic dependency on young men, and potentially begin to reduce their reliance on transactional sex through building capital and working towards an income generating activity. For young men, it was hypothesized this combined intervention would also allow them to work towards an income generating goal and potentially reduce harmful expressions of masculinity associated with street-connected young men's economic marginalization and oppression and inability to achieve traditional masculine ideals in eastern and Southern Africa (Embleton, Wachira, et al., 2018; Gibbs, Sikweyiya, et al., 2015; Izugbara, 2015). The adapted intervention was shown to significantly improve knowledge of HIV and may have improved condom use knowledge and other health seeking behaviours (Embleton, Logie, Di Ruggiero, Ayuku, & Braitstein, 2019). The present analysis seeks to explain and explore how participation in the adapted *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme changed SCY's gender equitable attitudes, economic resources, and livelihoods.

7.3. Methods

7.3.1. Study design

This multi-stage mixed methods study was conducted from May 2017 to January 2018 to adapt and pilot a combined gender, livelihoods and HIV prevention for SCY in Eldoret, Kenya. The

Stepping Stones and Creating Futures (Jewkes et al., 2014; Jewkes, Nduna, et al., 2010a; Misselhorn et al., 2013) interventions were adapted in the first stage of this study from May 2017 to August 2017 (Embleton, Di Ruggiero, et al., 2019). In the second stage, we piloted our adapted intervention with 80 SCY using a convergent mixed methods design measuring outcomes pre- and post-intervention. Mixed methods were used to understand and explore how the intervention changed gender equitable attitudes, economic resources, and livelihoods by confirming, expanding on, or uncovering discordant findings (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014).

7.3.2. Study setting

This study occurred in Eldoret, Kenya, at the Moi Teaching and Referral Hospital (MTRH)-Rafiki Centre for Excellence in Adolescent Health. Moi University and MTRH are partners in the Academic Model Providing Access to Healthcare (AMPATH) consortium, which delivers HIV treatment and other primary healthcare across a swathe of western Kenya (Einterz et al., 2007; Ndege et al., 2016).

7.3.3. Intervention description

The intervention included three components: 1) matched-savings conditional on attendance 2) *Stepping Stones ya Mshefa* and 3) *Kujijenga Kimaisha*. The Stepping Stones and Creating Futures interventions are community-based interventions that seek to improve sexual health, gender equity in relationships among men and women, and increase young people's life skills to find pathways out of poverty (Gibbs, Washington, et al., 2017; Misselhorn et al., 2013;

Welbourn, 1995). In depth details about our adapted intervention and components are described elsewhere (Embleton, Di Ruggiero, et al., 2019; Embleton, Logie, et al., 2019). The savings programme was an informal savings account integrated with a conditional economic incentive of ‘matching’ provisional on attending twice-weekly sessions. Conditional economic incentives function on the basis of behavioural economics and are contingent on achievement of a behavioural goal (i.e. programme participation) (Heise et al., 2013). SCY lack identification and are unable to access formal financial institutions; therefore this microfinance approach sought to financially empower economically marginalized participants. In our programme, the matched-savings component began in the first week of the intervention and aimed to increase participation in the programme while providing participants an economic boost in their savings, which could be used to commence an income generating activity post-intervention. Participants contributed 25 to 200 Kenyan Shillings (Ksh) (~ 0.25 – 2.00 USD) per week and could make a financial contribution at each attended session. Savings were kept over the course of 14 weeks and participants received their matched-savings upon programme completion. In conjunction with the matched-savings programme, our adapted *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme ran sequentially over the course of 14 weeks, and included 24 sessions (Embleton, Di Ruggiero, et al., 2019).

Peer Facilitators who were respected and trusted members of the street community (Embleton, Di Ruggiero, et al., 2019), facilitated the intervention under the supervision of the Principal Investigator (PI) (LE). The Peer Facilitators underwent 1 month of extensive training on the intervention, facilitation skills, and on research conduct for this study. The intervention was conducted in a private tent outside of the adolescent-friendly clinic, and each session lasted

from 1.5 to 3 hours. Intervention sessions were conducted in single-gender age-stratified groups of 20 participants (ages: 16-19 years and 20-24 years).

7.3.4. Sample size

A sample size of 80 participants was determined based on calculations to detect significant mean difference in our primary outcome of gender equitable attitudes ($\alpha=0.05$ $\beta=0.20$ Power=0.8 SD=10) by estimating high, medium, and low baseline scores and hypothesized percentage increase in score (25%, 15%, or 10%). As this was a pilot and feasibility study it was not powered to detect changes in secondary outcomes.

7.3.5. Study participants, recruitment, and enrolment

Simple random sampling was used to select eligible participants who indicated their interest in participating in the intervention. SCY were eligible to participate in the pilot intervention if they were: 1) aged 16-24 years, 2) had spent a portion or majority of their time on the streets for the past 6 months, and 3) were not enrolled in or attending school. Selected participants were invited to enrol and provide consent at the MTRH adolescent-friendly clinic. If a selected participant did not come on the enrolment date or declined to participate, another participant from the sampling list was randomly selected until the desired sample size of 80 participants was reached, consisting of 20 participants for each age- and gender-stratified group.

7.3.6. Study procedures

Under the supervision of the PI (LE) enrolled and consented participants completed pre-intervention paper-based survey administered by the Peer Facilitators, in Swahili, in a private tent outside of the adolescent-friendly clinic. The PI kept participant attendance records and monitored and recorded participant matched-savings contributions. At the beginning of each session, all participants checked in with the PI to document attendance and deposit money into their savings account. In the final week of the intervention, sixty-seven of 80 participants completed a post-intervention survey administered by the Peer Facilitators and met with the PI to receive and sign for their matched-savings. Post-intervention six participants from each of the four intervention groups were purposively sampled across attendance levels and invited to participate in focus group discussions (FGDs) to discuss their experience participating in the intervention. Of the 24 participants invited, 21 individuals returned to participate in FGDs, conducted in Swahili by a trained Peer Facilitator and the PI. FGDs each took 1 to 1.5 hours and occurred in a private tent.

7.3.7. Data collection

A pre-tested standardized questionnaire captured basic socio-demographic data including: age, school attendance, relationship status, orphan status, time typically spent on the streets, and time street-involved. Livelihoods, economic resources, and personal assets were measured by asking participants how they earn money, money earned per day, personal assets owned, and where they typically slept at night. A category for housing status was created based on where participants slept at night: housed (in a shelter with friends, in my own rented house, at my

parent(s)/guardian(s)) and un-housed (in the barracks, on the streets, someplace different every night). The primary outcome of interest was gender equitable attitudes. Gender equitable attitudes were assessed using the 24-item (Cronbach's $\alpha=0.81$) Gender Equitable Men (GEM) scale, a validated instrument used in Kenya (Nanda, 2011). The scale measures attitudes towards gender norms in relationships and social expectations for men and women (Nanda, 2011). Answer options for questions on the GEM scale are 'agree', 'partially agree' or 'do not agree'. Responses for each item were scored as 1 = agree, 2 = partially agree, and 3 = do not agree. Higher scores represent higher support for gender equitable norms, with a highest possible score of 72 (Nanda, 2011).

FGDs used an interview guide that asked participants about what they learnt about how men and women live and relate to each other, their experiences participating in the matched-savings programme, how the programme changed or did not change their economic resources, livelihoods, and gender equitable attitudes.

7.3.8. Analyses

Statistical Analysis: Quantitative data collected on paper surveys was checked for errors and missing data, and manually entered into Epi Info (version 7.2.1). Data were exported from Epi Info into R Studio for analysis. Post-intervention all participants were sought to complete questionnaires, and analysis included all enrolled participants, irrespective of programme attendance or completion. Thirteen participants were not interviewed post-intervention: 8 were lost to follow-up, 1 dropped out of the programme, and 4 had moved during the programme and could not be located. Pre-intervention GEM scores were carried forward post-

intervention for these participants. When outcomes are not expected to decline post-intervention, this provides a conservative estimate of the intervention effect (European Medicines Agency, 2011). Two single items were missing from the GEM scale for two participants. For these, scale items were imputed using the individual mean (Shrive et al., 2006). To test the accuracy of results using this missing data strategy, a complete case analysis was also conducted. There were no differences in outcomes or statistical significance compared to the imputed analyses. We present both last value carried forward and complete cases outcomes in our findings.

A Wilcoxon signed rank test was used to test whether participants had improved their gender equitable attitudes from pre- to post-intervention. Difference scores were calculated by taking the post-intervention GEM scores minus the pre-intervention GEM scores. A multiple regression model was fit to predict GEM change scores adjusting for the covariates of age, gender, education level, attendance, time street-connected, relationship status, money earned per day, orphan status, housing status, and engaging in casual labor at baseline. Pre-intervention scores were controlled for in the model, to adjust for the confounded effects of the pre-intervention score. Including pre-intervention scores in the model counteracts problems regarding the use of difference scores (Dalecki & Willits, 1991).

Textual Analysis: Qualitative audio-recorded data were transcribed into Swahili and translated into English by a hired transcriptionist. Data were imported into NVivo software for analysis. A codebook was developed to explore gender equitable attitudes, economic resources, and livelihoods related outcomes. Qualitative data were analyzed using thematic analysis driven by analytic interest (Braun & Clarke, 2006) to explore concepts in relation to how participation in

the intervention changed or did not change SCY's gender equitable attitudes, economic resources, and livelihoods.

Mixed Methods Integration: Qualitative and quantitative data were collected separately during a similar time period from September 2017 to January 2018. Both types of data sought to explain and explore changes in gender equitable attitudes, economic resources, and livelihoods. Data were analysed separately and findings were then merged for comparison (Fetters et al., 2013; Zhang & Watanabe-Galloway, 2014). Using a weaving approach data were integrated, where integration confirms, expands on, uncovers discordant or silent findings (Fetters et al., 2013; O'Cathain et al., 2010). Qualitative and quantitative findings are presented together on a theme-by-theme basis.

7.4. Results

7.4.1. Socio-demographics

The median age of participants was 19.5 years (IQR 17-22). The majority of participants reported ever attending school (96%); 86% had attended primary level school and 14% secondary school. Over a quarter of participants (26.2%) had been street-connected for greater than 5 years and almost a third reported spending both days and nights on the street. Full details of participant socio-demographics have been reported elsewhere (Embleton, Logie, et al., 2019).

7.4.2. Attendance and matched-savings

Table 8 Attendance and savings in pilot intervention stratified by gender and age groups

	N=80 Total n (%)	Young women			Young men		
		Total N = 40	Aged 16-19 Years (n=20)	Aged 20-24 Years (n=20)	Total N=40	Aged 16-19 Years (n=20)	Aged 20-24 Years (n=20)
Attendance							
Median # of Sessions (IQR) Range (0-24)	11 (1-20)	10 (1-18)	9 (1-20)	11 (3-16)	15 (1-23)	16 (3-23)	7 (0-19)
Attendance Level[†]							
Low	33 (41.3)	15 (37.5)	9 (45.0)	6 (30.0)	18 (45.0)	7 (35.0)	11 (55.0)
Medium	20 (25.0)	14 (35.0)	4 (20.0)	10 (50.0)	6 (15.0)	3 (15.0)	3 (15.0)
High	27 (33.8)	11 (27.5)	7 (35.0)	4 (20.0)	16 (40.0)	10 (50.0)	6 (30.0)
Savings							
Total saved without matching Ksh (USD)	71100 (704)	33930 (336)	14405 (143)	19425 (193)	37170 (368)	24840 (246)	12330 (122)
Total saved with matching Ksh (USD)	133075 (1318)	62895 (623)	27240 (270)	35655 (353)	70180 (695)	47170 (467)	23010 (228)

After matching conditional on attendance, participants saved a total of 133075 Ksh (~1318 USD; Table 8). Participants discussed at length the benefits of the matched-savings programme including how it assisted them with learning about money and how to save while meeting their needs as explained by one young woman:

'I learnt that if I get money, I would be using a bit and keeping a bit because it can help me when I don't have money.'

(Young woman, 16-19 years)

Some participants were inspired to continue saving and joined savings groups in the community after intervention completion:

'The experience I got from double saving was this. First, I didn't save before. I was hand-to-mouth. I find and spend. But when I heard we were saving 200 per week in the middle of the week, it gave me experience of saving even if it was a little and I got used to it. By the time the programme ended, I had gotten used to it. It affected me a bit but what I did is get another savings group. Even if it is not double saving, you save.'

(Young man, 20-24 years)

These findings show that the programme introduced SCY to the concept of savings and gave them experience saving, which may have been sustained post-intervention.

7.4.3. Economic resources and livelihoods

Participants reported a significant change in their daily earnings from pre- to post-intervention from 66% of participants reported earning greater than 100 Ksh (~1.00 USD) per day to 81% of participants post-intervention ($p=0.03$) (Table 9). The proportion of young women reported earning more than 100 Ksh per day increased substantially for young women from 45% pre- to 76% post-intervention.

Table 9 Livelihoods, economic resources, and personal assets pre- and post-intervention stratified by gender

	Pre-Intervention				Post-Intervention		
	Total N=80 n (%)	Young Women N = 40 n (%)	Young Men N=40 n (%)	Baseline Retained ^a N=67 n(%)	Total N=67 n (%)	Young Women N=33 n (%)	Young Men N=34 n (%)
How do you get money							
Begging	46 (57.5)	28 (70.0)	18 (45.0)	40 (59.7)	27 (40.3)	21 (63.6)	6 (17.6)
Stealing	1 (1.25)	1 (2.5)	0 (0)	1 (1.5)	0 (0)	0 (0)	0 (0)
Collecting Recycling	16 (20.0)	4 (10.0)	12 (30.0)	12 (17.9)	11 (16.4)	1 (3.0)	10 (29.4)
Selling plastic bags	10 (12.5)	3 (7.5)	7 (17.5)	7 (10.4)	3 (4.5)	0 (0)	3 (8.8)
Selling Drugs	10 (12.5)	1 (2.5)	9 (22.5)	8 (11.9)	7 (10.4)	0 (0)	7 (20.6)
Watching / Parking Cars	27 (33.75)	4 (10.0)	23 (57.5)	24 (35.8)	12 (17.9)	1 (3.0)	11 (32.4)
Carrying Luggage	23 (28.75)	3 (7.5)	20 (50.0)	19 (28.4)	12 (17.9)	0 (0)	12 (35.3)
Commercial Sex	3 (3.75)	3 (7.5)	0 (0)	2 (3.0)	2 (3.0)	2 (6.1)	0 (0)
Casual labour / IGA	17 (21.3)	12 (30.0)	5 (12.5)	11 (16.4)	28 (41.8)	13 (39.4)	15 (44.1)
Amount earned / day							
< 100 Ksh	27 (33.8)	22 (55)	5 (12.5)	22 (32.8)	12 (17.9)	8 (24.2)	4 (11.7)
> 100 Ksh	53 (66.3)	18 (45)	35 (87.5)	45 (67.2)	54 (80.6)	25 (75.8)	29 (85.3)
Don't know	-	-	-	-	1 (1.5)	0 (0)	1 (2.9)
Personal Assets							
Slippers	40 (50.0)	27 (67.5)	13 (32.5)	34 (50.7)	42 (62.7)	26 (78.8)	16 (88.2)
Shoes	66 (82.5)	27 (67.5)	39 (97.5)	57 (85.1)	56 (83.6)	26 (78.8)	30 (88.2)
Jacket/Jumper	76 (95.0)	36 (90.0)	40 (100.0)	63 (94.0)	57 (85.1)	26 (78.8)	31 (91.2)
Mattress	37 (46.25)	19 (47.5)	18 (45.0)	33 (49.3)	34 (50.7)	18 (54.5)	16 (47.1)
Blanket	44 (55.0)	20 (50.0)	24 (60.0)	38 (56.7)	41 (61.2)	20 (60.6)	21 (61.8)
A second pair of clothing	66 (82.5)	34 (85.0)	32 (80.0)	55 (82.1)	56 (83.6)	31 (94.0)	25 (73.5)
Jiko	37 (46.25)	18 (45.0)	19 (47.5)	31 (46.3)	31 (46.3)	20 (60.6)	11 (32.4)
Cellular Phone	18 (22.5)	11 (27.5)	7 (17.50)	17 (25.4)	13 (19.4)	9 (27.3)	4 (11.8)
Radio	11 (13.75)	5 (12.5)	6 (15.0)	9 (13.4)	17 (25.4)	10 (30.3)	7 (20.6)
TV	4 (5.0)	3 (7.5)	1 (2.5)	4 (6.0)	5 (7.5)	5 (15.2)	0 (0)
Typically Sleep at Night							
Housed	61 (76.25)	32 (80.0)	29 (72.5)	52 (77.6)	58 (86.6)	29 (87.9)	29 (85.3)
Un-housed	18 (22.5)	7 (17.5)	11 (27.5)	15 (22.4)	9 (13.4)	4 (12.1)	5 (8.8)
Missing	1 (1.25)	1 (2.5)	(0)	-	-	-	-

Expanding on outcomes of the matched-savings programme, a number of participants reported using the money they accrued to assist family, which included involving family in income generating activities as explained by two young woman:

'I gave it to my mum. I paid her rent and the rest I bought food for her... I bought my sibling a uniform then with the rest we started a business''

(Young woman, 16-19 years)

'My dad said he would give me a bit more money to start a business selling vegetables so that I can stop going to town.'

(Young woman, 16-19 years)

While young women aged 16-19 years appeared to involve their families in their plans with their savings and livelihood activities, young women aged 20-24 years only discussed not being able to reach their desired income generating goal. Young women often have additional financial responsibilities in relation to child rearing, which may have prevented them from achieving their income generating goals. They described that they were able to buy supplies, and get started as one young woman explains:

'Even I didn't reach my goal because there are some things I bought. My goal was to start a salon. But I bought tools like combs; hair oil and the rest I bought a school uniform for my child.'

(Young woman 20-24 years)

For some participants, commencing income generating activities represented a shift in SCY's livelihood activities. Begging was the most common source of income pre-intervention (58%). Participants reported a significant reduction in begging post-intervention (40%, $p=0.006$; Table 9). Similarly, participants reported changes in performing casual labour from 21% pre- to 42% post-intervention ($p=0.006$). Participants discussed buying supplies for and commencing numerous income generating activities including: selling charcoal, vegetables, chapati, eggs, beading, salon supplies, and used clothing sales. As explained by one young woman aged 16 to 19 years: *'The money I got enabled me to pay rent and some I bought charcoal with, which I want to start selling.'*

The proportion of young men reporting engaging in casual labour increased substantially from 13% pre- to 44% post-intervention (Table 9). This was confirmed qualitatively as many young men reported starting income generating activities. Two groups of young men aged 16-19 reported pooling their money and resources together to start income generating activities, and as explained by another young man the programme helped him to sell tomatoes, changed his living circumstances, and led him to stop selling glue:

'The money we got from double saving helped me in some way. I was living in some house and I didn't have things. I slept on a California. A California is a sack that is sewn with papers inside. But it has helped me, grown me a bit. I now have a business and good clothes. My life is just right. I am now at ease. The business I started, I sell tomatoes in Langa. I sell three tomatoes at 10 bob or sometimes I go to the market and

sell at 10 shillings each. I have several businesses... And it has profit. But I can't sell glue.'

(Young man 16-19 years)

However, commencing income generating activities was not without structural barriers. Participants reported that County level government and policy prevented them from fully actualizing their plans. These included problems with identification, business permits, location to work from, as one young man aged 16-19 explained: *'The problem is we don't have things like ID, business permit and a place to sell from.'*

SCY expressed that participation in the programme reduced their street-involvement. As one young woman aged 16-19 stated *'It helped us since we were not going to the street.'* While some young men expressed a shift in identity from 'street youth' to 'business men':

'The difference is they [referring to street youth] are still where they were and we took one or two steps forward... Like how we used to struggle looking for scraps in parking lots, we don't do that anymore. We now do business. You get your salary, use a bit and get more at the end of the month...We are different from those in the streets. We are not street youth. We are business people.'

(Young men 16-19 years)

This identity shift was tied to the ability to look clean, and changes in housing and clothing after programme participation as a group of young men discuss:

'If you stand in town, the municipal people cannot arrest us here. They will arrest the others because they are dirty. Also, they still sleep on the verandah and we got houses after coming here...From how we are dressed. They still have dirty street clothes.'

(Young man, 16-19 years)

Housing and the ability to pay rent may be an important component of reducing street-involvement and HIV vulnerabilities. Differences in housing status (housed vs. un-housed) from pre- to post-intervention were marginally significant ($p=0.08$). Pre-intervention 23% participants reported being un-housed and post-intervention this reduced to 13% (Table 9). This was confirmed qualitatively, as many participants discussed an ability to pay rent and changes in their housing status post-intervention as one young woman and one young man explain:

'When I got the money it helped me buy clothes and to pay rent. The rest I spent slowly.'

(Young woman, 16-19 years)

'It helped me with rent. I used to sleep in town but I now have a house. I looked for a house for 400 bob (~ 4 USD) and paid three months in advance with that money so I don't sleep on the street.'

(Young man, 20-24)

7.4.4. Gender equitable attitudes

Table 10 Median gender equitable attitudes scores pre- and post- intervention for complete cases and all participants stratified by gender

Score	Pre-Intervention				Post-Intervention				p-value
	Total N=80	Young Women N=40	Young Men N=40	Baseline Retained ^a N=67	Complete Cases N=67	Total N=80	Young Women N=40	Young Men N=40	
GEM median, (IQR)	43 (38-48)	41 (38-47)	45 (40-49)	42 (38-47)	46 (43-53)	47 (42-51)	46 (42-49)	48 (42-64)	<.0001

^a Participants with both baseline and endline data representing complete cases

Participants had a significant increase in gender equitable attitudes from a median score of 43 (IQR 38-48) pre-intervention to 47 (IQR 42-51-16) post-intervention ($p < 0.001$); Table 10).

Changes in young men's gender equitable attitudes were confirmed in FGDs where young men discussed a shift with respect to gender roles:

'I used to think some jobs are just for men and others are just for women. But when I came [to the intervention] I realized we need to help each other. You shouldn't say, "Ah! That is her job. Let her do it." No. Now I know we are equal. We are the same.'

(Young man, 20-24 years)

Young men's discussion of changing their attitudes towards gender roles and norms was limited, and no young women brought this up in focus group discussions. However, across focus groups with young women, there was insufficient probing in the focus group discussions in relation to how young men and women act and their gender roles, and therefore their lack of discussion should be interpreted cautiously. However, quantitatively young women increased

their median gender equitable attitudes score from 41 (IQR 38-47) pre-intervention to 46 (IQR 42-51) post-intervention. In comparison, young men increased their gender equitable attitudes score from 45 (IQR 38-49) to 48 (IQR: 42-64). In multiple linear regression, in comparison to young women, young men on average had a 7.7-point increase (95% CI: 2.6 – 12.7) in GEM change score, after adjusting for age, education, attendance, money earned per day, relationship status, orphan status, housing, engaging in casual labour at baseline, and GEM score at baseline (Table 11). Attendance also contributed to changes in GEM scores. Participants with a medium level of attendance had a 5.6-point increase (95% CI: 0.13 – 11.0) in mean GEM change score relative to those with low attendance, while controlling for other variables.

Table 11 Multiple regression model to predict gender equitable attitudes change score

Predictors	GEM CHANGE SCORE β and 95% CI
Intercept	37.1 (13.7-60.5)
Age (years)	-0.8 (-1.7 – 0.08)
Sex	
Female	ref
Male	7.6 (2.6 – 12.7)
Education Level	
Primary / None	ref
Secondary	1.4 (-5.7 – 8.4)
Attendance (categorical)	
Low	ref
Medium	5.6 (0.13 – 11.0)
High	0.7 (-4.2 – 5.5)
Money Earned per day	
< 100 Ksh	1.3 (-4.3 – 7.0)
> 100 Ksh	ref
Relationship Status	
Single / Divorced / Widowed	-2.9 (-7.6 – 1.8)
Married / Girlfriend / Boyfriend	ref
Orphan Status (vs. all others)	
Maternal Orphan	6.0 (-1.5 -13.5)
Paternal Orphan	-0.4 (-5.5 – 4.8)
Double Orphan	-2.7 (-8.7 – 3.4)
Housing Status	
Housed	ref
Un-housed	-4.7 (-10.4 – 1.0)
Engaging in Casual Informal labour	
Yes	6.0 (0.4 – 11.6)
No	ref
GEM Score at baseline	-0.6 (-0.9 - -0.3)
R2	0.39
Adjusted R2	0.26
P-value for model	0.001

7.5. Discussion

This is the first known study piloting a structural and livelihoods intervention with SCY in sub-Saharan Africa. Following the intervention participants had a positive increase in gender equitable attitudes, our primary outcome of interest. Moreover, qualitative and quantitative findings support that participants had a significant increase in daily earnings, commenced income generating activities, had a change in their housing circumstances, and in some instances reduced their street-involvement.

We previously documented substantial gender inequities and sexual and gender-based violence in the street subculture which contributes to SCY's HIV vulnerability (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2016, 2015). Therefore, the positive change in gender equitable attitudes post-intervention represents an important finding. However, gender differences across measured gender equitable attitude scores merit discussion. At baseline, young women had a lower median GEM score in comparison to young men, potentially reflecting their deeply entrenched gender attitudes that are socially constructed in a patriarchal society, and this gender difference persisted post-intervention. This gender difference, whereby men have higher gender equitable attitudes than women, may not be solely an artefact of the street subculture. In a study of adult men and women in Kenya, men reported significantly higher scores on the gender equitable attitude scale than women (Stephenson, Bartel, & Rubardt, 2012), suggesting that this is potentially a product of the broader social and cultural context in Kenya and social construction of gender attitudes. Gender inequity is pronounced in Kenya. Out of 16 eastern and southern African countries, Kenya scored the second highest in the gender inequality index developed by the United Nations Development Programme, where

a higher score indicates that gender inequality is more prominent in a country (MacPherson et al., 2015), thus pointing to a profoundly inequitable context for young women. While street-connected young women who participated in the intervention increased their median score from 41 (IQR 38-47) to 46 (IQR 42-51), and street-connected young men from 45 (38-49) to 48 (IQR 42-64), identifying as a young man predicted a greater absolute change score in our multiple linear regression model in comparison to young women. When examining our data, young men who experienced a change in gender equitable attitudes had a larger absolute difference between their pre- and post-intervention scores contributing to this phenomenon; whereas there was a more nuanced and consistent absolute difference across young woman participants. Our qualitative data on gender equitable attitudes should be interpreted cautiously as young women were not adequately probed in relation to the gender outcome, and therefore we can only say that young men discussed some limited shifts in gender equitable attitudes to confirm their quantitative outcomes. Finally, a medium level of attendance predicted an increase in GEM change score, suggesting that attendance at the intervention was a predictor of change. An increase in gender equitable attitudes from pre- to post-intervention is in alignment with the South African Stepping Stones and Creating Futures intervention (Jewkes et al., 2014). However, in South Africa, young women had a higher gender equitable attitudes score than young men, suggesting contextual differences in the social construction of gender equitable attitudes between these settings. Young men's higher median score in comparison to young women in our setting, may support the inclusion of men in combined gender and economic strengthening intervention to work towards achieving a more gender equitable street subculture (Dworkin et al., 2013; Gibbs et al., 2012). Despite young

women's increase in gender equitable attitudes score, it is clear that young women require more support to shift gender attitudes. Shifting deeply engrained social and gender norms is challenging and will require multiple interventions from the macro-level to the micro-level with both street-connected young women and young men to facilitate a radical change in gender equity in the street subculture (Jewkes et al., 2015).

Overall our results point to the combined programme having a significant and positive impact on participants' livelihoods. Our matched-savings programme approach aimed to mitigate concerns regarding microfinance increasing sexual risk practices with vulnerable adolescents (Gibbs et al., 2012; Wamoyi et al., 2014). SCY were supportive of the inclusion of the matched-savings programme and worked with the study team to ensure it was feasible and suitable prior to commencing the pilot (Embleton, Di Ruggiero, et al., 2019). Overall participants reported improved earnings and successful changes to their livelihoods, including assisting family. Given that poverty in sub-Saharan Africa is a structural determinant of young people's street-involvement (Embleton, Lee, et al., 2016) and HIV acquisition (Wamoyi et al., 2014), interventions addressing economic marginalization and strengthening livelihoods for SCY are fundamental.

Lastly, being precariously housed is likely a significant structural driver of HIV acquisition for SCY in Kenya. Without stable and secure housing, SCY in our setting are exchanging sex for security and shelter at night, and may experience increased violence, exploitation and abuse (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2015). Our intervention resulted in a small marginally significant change in housing status, confirmed qualitatively. Stable housing has been associated with a decrease in sexual risk practices (Dickson-Gomez et al., 2011),

suggesting housing is an important structural component of HIV prevention. While ‘housing first’ strategies (Kozloff et al., 2016) may be unfeasible in resource-constrained countries, economic and livelihood approaches, such as our matched-savings programme and training, may allow SCY to secure housing thereby reducing their HIV vulnerability.

Our results may be prone to social desirability bias, and quantitative measure of gender equitable attitudes and qualitative discussion of shifts in gender attitudes should be interpreted cautiously. Measuring gender equitable attitudes with SCY may require a different tool in this context, and should be considered in future research. We were unable to assess the sustainability of changes in participants’ outcomes over time, and these may be prone to deterioration, which requires future investigation. Finally, we did not measure perpetration or experiences of sexual and gender-based violence, or emotional and economic violence. Yet, these forms of violence are important factors to consider in relation to HIV vulnerability and gender equity.

Strengths of this study include the use of standardized measures and the replication of some findings from South Africa. Moreover, our results suggest it is both feasible and highly acceptable to use livelihood and economic strengthening approaches with SCY, and that the inclusion of street-connected young men in economic strengthening when combined with gender and health components in this setting may be effective.

Overall, this study has demonstrated that *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme may be effective at contributing to changes in gender equitable attitudes and improving livelihoods for SCY in Kenya.

Chapter 8 General Discussion

For my dissertation, I established an independent area of research focused on designing, implementing, and evaluating interventions, with street-connected young people in Eldoret, Kenya. This study built upon the existing programme of research I have contributed to extensively with and for this marginalized population. In response to the hidden epidemic of HIV among street-connected young people in Eldoret, Kenya, the concerning gender inequities in the street subculture, and this population's economic marginalization, I sought to identify and test an evidence-based intervention to respond to these significant health, social, and economic inequities. Through this dissertation I sought to adapt and pilot the combined Stepping Stones and Creating Futures programmes, which were integrated with a matched-savings programme at the outset of intervention planning and development.

In the adaptation objective of this research, I wanted to determine what components of Stepping Stones, Creating Futures, and the proposed group-led matched-savings programmes were acceptable and appropriate and those that were not for street-connected young people in Eldoret. Using community-based research methods informed by a rights-based approach with street-connected young people (OHCHR, 2017) during the process of adaptation, we established that in general Stepping Stones and Creating Futures were acceptable and appropriate for street-connected young people, but required modifications to programme content and delivery for this particular context. In general, the Stepping Stones content was acceptable and appropriate for street-connected young people. Through the adaptation process we made modifications to the content to match the context of Kenya and street-connected young people. Additionally, we added content on substance use, given the extensive

use of volatile solvents and other substances among street-connected young people in Eldoret (Embleton, Atwoli, et al., 2013; Embleton et al., 2012). Creating Futures required more substantial modifications to programme content, including the creation of characters and stories to match the context of the streets, the removal of content in relation to preparing resumes, applying to scholarships, and formal employment, all of which were not applicable to street-connected young people's circumstances. Instead the *Kujijenga Kimaisha* version of programme focused on achieving a livelihood goal and working towards an income generating activity or commencing a training course in conjunction with the matched-savings programme component. For the combined whole programme, we adapted the delivery of the programme to be primarily dialogic. In addition, we identified several issues with our proposed group-led matched-savings programme, which required modifications in response to the population's concerns including: the frequency of contributions, the monetary amount, and the initially proposed method of matching conditional on the full group's attendance. This resulted in modifying the proposed group-led matched-savings programme in several ways. First, to change the mechanism of matching from group-based to individual-based conditional on attendance at twice-weekly sessions. Second, an increase in the monetary amount a participant could contribute in a week up to 200 Ksh. Finally, the ability for participants to contribute at each session in order to have a safe place to keep their money. Next, through adaptation, I sought explore how the programme components were adapted and integrated together into a comprehensive intervention. In this adaptation process, I demonstrated the feasibility of adapting an evidence-based intervention for street-connected young people and provided a framework for others to do so with the modified ADAPT-IT model process. Overall, the

adaptation objective resulted in a combined adapted intervention named '*Stepping Stones ya Mshefa na Kujijenga Kimaisha*'.

Following adaptation, this research project sought to pilot the adapted multi-faceted intervention and explain and explore how participation in the intervention changed HIV knowledge, gender equitable attitudes, condom use self-efficacy, sexual practices, economic resources, and livelihoods for participants using mixed methods. Our findings were encouraging across outcomes, as we demonstrated a significant and positive change in HIV knowledge and gender equitable attitudes, the project's primary outcomes of interest, from pre- to post-intervention for all participants. The novel use of matched-savings with street-connected young people in combination with participation in the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme improved daily earnings and housing status, and many participants reported achieving a livelihood goal and commencing an income generating activity, which may have reduced street-involvement.

8.1. Changing street-connected young people's vulnerability to acquiring HIV in Eldoret, Kenya: HIV, sexual health, and gender outcomes

The pilot sought to explain and explore how participation in the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention changed HIV knowledge, gender equitable attitudes, condom use self-efficacy, and sexual practices for street-connected young people. The research also aimed to understand the relationship between participant socio-demographic characteristics and changes in HIV knowledge and gender equitable attitudes, as well as how attendance rates were associated with changes. Table 12 summarizes the mixed methods HIV knowledge, sexual

health, and gender equitable attitudes outcomes side-by-side. Through the process of merging and integrating qualitative and quantitative findings, our mixed methods analysis confirmed, expanded on, uncovered discordance, and revealed 'silent' findings (Fetters et al., 2013; O'Cathain et al., 2010). Silence occurs when a theme or finding occurs in one data set and not another (O'Cathain et al., 2010). Overall, amongst all participants, our findings revealed significant improvements in HIV knowledge and gender equitable attitudes, and possible changes in condom use and family planning knowledge, condom use self-efficacy, and health seeking behaviours. The intervention did not result in changes to other sexual practices, such as transactional sex. Our findings did show gender differences across outcomes between participants who identified as young women and those who identified as young men. While the intervention resulted in quantitatively measured improvements in HIV knowledge and gender equitable attitudes across all participants, and within gender groups, it maintained differences in these outcomes between street-connected young women and young men, thus not creating equality. These differential improvements between street-connected young women and young men, suggest the intervention may not have the same level of effectiveness for young women as young men and requires further adaptations and modifications to improve outcomes for street-connected young women. Or it may be that street-connected young women require different interventions, which merits future research.

Table 12 Summary of mixed methods findings on HIV knowledge, sexual health, and gender outcomes

Outcomes	Level in the social-ecological model	Quantitative Findings	Qualitative Findings	Mixed Methods Triangulation
HIV knowledge	Individual	↑ Significantly increased HIV knowledge	• Participants described improved HIV knowledge regarding transmission, the use of PEP and PrEP	Confirmed
Gender Equitable Attitudes	Individual / Community/ interpersonal/ Structural	↑ Significantly increased gender equitable attitudes	• Street-connected young men described shifts in attitudes towards gender roles, norms, domestic, and financial equality	Confirmed for young men
Condom Use Self-Efficacy	Individual	• Non-significant increase in condom use self-efficacy across participants	• Participants described improved condom use knowledge, skills and self-efficacy	Expanded on
Condom use at last vaginal sex	Individual / Community norms	• Shift towards increasing street-connected young men 's condom use	• Some evidence that street-connected young men using condoms post-intervention whereas they report they would not have before	Confirm that some young men had changes in condom use for vaginal sex
Number of partners	Interpersonal / Network	No change	Not discussed	-
Transactional Sex	Interpersonal / Network	No change	Not discussed	-
HIV testing in the last 6 months	Individual	• Non-significant trend toward increasing HIV testing across all participants	• Some participants reported that they sought HIV testing and knowing their status as a result of participation	Confirmed
Health Seeking Behaviour	Individual / Interpersonal/ Network	Not measured	• Participants described that participation increased their health seeking behaviours	'Silence'
Knowledge of Family planning	Individual	Not measured	• Participants described that participation increased their knowledge of family planning methods	'Silence'

8.1.1. Improving HIV knowledge

Previous research has documented multiple myths and misconceptions regarding the transmission of HIV and STIs, among street-connected young people in Eldoret, Kenya, which suggested a low level of correct HIV knowledge (Embleton, Wachira, et al., 2016, 2015). This low level of knowledge was confirmed in this doctoral research, as participants had a median HIV knowledge score of 11 (IQR: 8-13) pre-intervention (out of a total possible score of 18 points). Participants in the intervention had a statistically significant increase in correct HIV knowledge post-intervention to 14 (IQR: 12-16) ($p < 0.001$). Therefore correct HIV knowledge shifted from 61% to 78%, representing a 27% increase in HIV knowledge from pre-intervention to post-intervention. This change was also confirmed through our qualitative findings as participants discussed learning about HIV transmission and demonstrated newfound knowledge in relation to the use of PEP and PrEP. Given that only 34% of young men and 28% of young women in sub-Saharan Africa have basic knowledge about how to protect themselves from acquiring HIV (UNAIDS, 2018b), this represents a significant increase in correct HIV knowledge for street-connected young people. Moreover, in Uasin Gishu county Kenya, only 67% of adult women and 68% of adult men reported having comprehensive knowledge of HIV and AIDS assessed through the Kenya Demographic and Health Survey (National AIDS Control Council, 2016). It may be that street-connected young people participating in the intervention didn't experience a radical change to completely correct HIV knowledge post-intervention due to their substance use and low levels of education,

which may have influenced their ability to retain new knowledge. Furthermore, varying levels of attendance were associated with HIV knowledge change scores.

Participants that had a medium or high level of attendance in the intervention had almost a 3- and 5-point increase in their mean HIV knowledge change score relative to those with low attendance, suggesting that the intervention had a dose-response effect on correct HIV knowledge. These findings are in agreement with the body of evidence that demonstrates that Stepping Stones is effective in increasing HIV and STI knowledge (Skevington et al., 2013). This positive change in HIV knowledge post-intervention among participants represents an important component of individual-level behaviour change, as correct knowledge and perceived risk of acquiring HIV, is a necessary albeit insufficient component of reducing sexual risk practices (Bernardi, 2002; Sayles et al., 2006; Tenkorang & Maticka-Tyndale, 2014). Without correct knowledge, street-connected young people may not be able to accurately assess their perceived susceptibility to acquiring HIV and thus are unable to appropriately take preventative measures such as condom use (Sayles et al., 2006).

Gender also had an influence on HIV knowledge scores. Young women participants experienced an increase in HIV knowledge score from 11 (IQR: 9-12) to 14 (IQR: 12-15). While young women's HIV knowledge did not decline from pre- to post-intervention, we did not see the same magnitude of change as young men. Young men had a greater increase in correct HIV knowledge from a median score of 11 (IQR 8-13) to 16 (IQR: 12-17), and identifying as a young man was associated with an increase in HIV knowledge change score in comparison to young women. Given that both young women

and men had the same median scores at baseline, this difference may be due to observed variances in facilitation and attendance in the intervention between groups of young men and women. Young men aged 16 to 19 had higher attendance than any other group and this may have attributed significantly to the larger change in HIV knowledge change score among young men. Moreover, through the process of observing each session and hosting weekly meetings with the Peer Facilitators, there were clear gender differences in facilitation approaches between the young women and young men. The Peer Facilitators themselves were an important component of the intervention, and therefore the variance in their skills may have had an impact on the different outcomes observed between young men and young women in the intervention. Gender inequities are prominent in the street subculture (Embleton, Wachira, et al., 2015, 2018; Sorber et al., 2014; Wachira et al., 2016, 2015), and the Peer Facilitators had all grown up with street experiences in the context of Kenya, which likely resulted in gender norms and differences that impacted facilitation skills and thereby potentially participant outcomes in relation to improving HIV knowledge. For example, in my weekly meeting with the Peer Facilitators I documented low levels of confidence, organization, and leadership among the young women Peer Facilitators in comparison to the young men. This is likely the result of socially constructed gender and social norms, and expectations that young women are conditioned to abide by, such as being 'quiet', not speaking up, letting men take a lead, and generally having fewer opportunities for education and skills advancement than boys and young men – particularly in the context of growing up in the street subculture in Kenya. This points to

the need to provide additional training for young women engaged in peer research or navigation roles in this setting to augment their confidence and leadership skills.

8.1.2. Changing gender equitable attitudes

As previously uncovered, substantial gender inequities and sexual and gender-based violence are functioning in the street subculture that contribute to street-connected young people's HIV vulnerability (Embleton, Wachira, et al., 2016, 2015, 2018; Wachira et al., 2016, 2015; Winston et al., 2015), which underscored the need to change gender inequitable attitudes of individuals who live and work in the street subculture. Across all participants there was a statistically significant change in gender equitable attitudes score from 43 (IQR: 38-48) pre-intervention to 47 (IQR: 42-51) post intervention ($p < .001$). A medium level of attendance was significantly associated with an increase in gender equitable attitudes change score for participants, indicating that participation in the intervention may have contributed to this change. These findings are in alignment with the South African Stepping Stones and Creating Futures interrupted time series results, which demonstrated changes in gender equitable attitudes across participants also using the Gender Equitable Men scale (Jewkes et al., 2014). In other contexts, the Stepping Stones programme has been effective at diffusing knowledge beyond participants into the community (Paine et al., 2010). Therefore, the change in gender equitable attitudes across participants may represent an important finding, as participants may begin to diffuse these new attitudes into the street subculture, which may have an influence on reducing sexual and gender-based violence and harmful street

initiation practices. However, our results demonstrate that this change was minimal, and there is much work to be done in relation to gender equitable attitudes in the street subculture, as the highest possible score on this scale is 72, whereby higher scores represent more equitable attitudes (Nanda, 2011). Moreover, street-connected young people in our setting, had lower gender equitable attitudes scores in comparison to young people living in informal settlements in the South Africa (Jewkes et al., 2014), and adults in Kenya (Stephenson et al., 2012) thus demonstrating street-connected young people's poorer gender equitable attitudes in Eldoret, Kenya.

Interestingly, our analysis found that reporting engaging in casual labour or income generating activities at baseline was associated with a significantly larger increase gender equitable attitude change score in comparison to those who did not. The intersection of poverty, gender inequities, and risk of HIV acquisition for young women has been established (Kim et al., 2008; MacPherson et al., 2015). This finding in our intervention underscores a potential relationship between livelihoods and gender equitable attitudes for street-connected young people, which require further investigation. It may be that participants who were less economically marginalized and engaging in livelihood activities at baseline had more liberal attitudes, and were therefore more amenable to change attitudes concerning gender norms in relation to violence, sexual relationships, reproductive health, and domestic chores. This has important implications for strengthening street-connected young people's livelihoods and engagement in income generating activities. If economic and livelihood security can result in larger changes to street-connected young people's gender equitable attitudes,

it may be an important factor in reducing sexual and gender based violence in the street subculture, which contributes to street-connected young women's HIV vulnerability.

Differences in gender equitable attitudes between street-connected young women and young men merit discussion. Young women participants increased their median gender equitable attitude score from 41 (IQR 38-47) to 46 (IQR 42-51). Our qualitative data on gender equitable attitudes were unable to confirm or deny this outcome, as young women were not adequately probed in relation to what they learnt about gender during focus group discussions. However, quantitatively, at baseline, young women had a lower median gender equitable attitude score in comparison to young men (41 vs. 45), potentially reflecting their deeply entrenched gender inequitable attitudes that are socially constructed in a patriarchal society. In contrast, in South Africa, young women had a higher gender equitable attitudes score than young men (Jewkes et al., 2014), suggesting contextual differences in the social construction of gender equitable attitudes between these settings. These gender differences, whereby men have higher gender equitable attitudes than women, may not be solely an artefact of the street subculture. In a study of adult men and women in Kenya, men reported significantly higher scores on the gender equitable attitude scale than women (Stephenson et al., 2012), suggesting that this is potentially a product of the broader social and cultural context in Kenya and social construction of gender attitudes. This may be a construct of social desirability bias, whereby men are more likely to respond that they hold more gender equitable attitudes, even when they do not. It may also be that women are so deeply entrenched in the patriarchy and disempowered, that they

uphold deeply held patriarchal norms, normalize them, and thus have poorer gender equitable attitudes. Gender inequity is pronounced in Kenya. Out of 16 eastern and southern African countries, Kenya scored the second highest in the gender inequality index developed by the United Nations Development Programme, where a higher score indicates that gender inequality is more prominent in a country (MacPherson et al., 2015), thus pointing to a profoundly inequitable context for young women. Additionally, young women's gender inequitable attitudes in eastern Africa are also reflected in studies qualitatively exploring young women's dependency on men for financial and material provisioning, particularly with respect to the normalization of engagement in transactional sex and age-disparate relationships (Wamoyi et al., 2018, 2019). Taken together, these studies and our present findings suggest that Kenya's street-connected young women may have particularly low gender equitable attitudes as a result of the highly gender inequitable context in Kenya, social, gender, and sexual norms in eastern Africa for young women, and their extreme marginalization in the street subculture. Therefore, despite young women's increase in gender equitable attitudes score in the present study, it is clear that young women require more support to shift gender attitudes. Shifting deeply engrained social and gender norms is challenging and will require multiple interventions from the macro-level to the micro-level with both street-connected young women and young men to facilitate a radical change in gender equity in the street subculture.

In contrast to young women, young men's gender equitable attitude score at baseline was 45 (38-49) and this increased to 48 (IQR 42-64) post-intervention.

Identifying as a young man was associated with a greater absolute change score in our multiple linear regression model in comparison to young women. When examining our data, young men who experienced a change in gender equitable attitudes had a larger absolute difference between their pre- and post-intervention scores contributing to this phenomenon, in comparison to young women who had a more nuanced and consistent increase. On average young men had almost an 8-point increase in gender equitable attitude change score after adjusting for covariates in comparison to young women. Correspondingly, young men in our study, albeit limitedly, qualitatively reported shifting their attitudes in relation to domestic and financial equality in the household and gender roles, and one young man made mention of equality in sexual pleasure. This possibly represents a similar shift as to what was documented in South Africa, where the combined Stepping Stones and Creating Futures intervention showed that young men who participated in the programme began to shift from harmful masculinities to more traditional masculinities, instead of a radical new form of gender equitable masculinity (Gibbs, Jewkes, Sikweyiya, et al., 2014). This shift and significant increase in street-connected young men's gender equitable attitudes, provides support for the inclusion of young men in combined gender transformative and structural interventions to achieve gender equity and reduce HIV risk (Dworkin et al., 2013; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012). This may be particularly important for street-connected young men in Eldoret, given the links between young men's economic marginalization, the social construction of harmful masculinities, and sexual and gender-based violence in sub-Saharan Africa (Dworkin et al., 2013; Fleming et al., 2015; Gibbs, Sikweyiya, et al.,

2015; Izugbara, 2015; Jewkes et al., 2015). When street-connected young men's economic marginalization is reduced and they are able to engage in sustainable livelihoods, they may be able to shift from harmful expressions of masculinity to more traditional expressions, which may result in a reduction in sexual and gender-based violence. Future research needs to explore whether a change in gender equitable attitudes translates to changes in practices, particularly in relation to young men's perpetration of and young women's experiences of physical, economic, psychological and sexual violence in the street subculture. Moreover, future research should explore how community-level interventions may be feasible, acceptable, appropriate and effective to shift harmful community-level social and sexual norms in the street-subculture.

In summary, differences in young women's and young men's gender equitable attitude changes from pre- to post-intervention were likely influenced by the profound social and gender inequalities in this setting. Moreover, changes may have also been influenced by gender differences in facilitation. The young women who facilitated the intervention likely had similar gender attitudes and experiences of sexual and gender-based violence as the participants given their street-involvement and upbringing in the street subculture, which may have limited their ability to promote and embrace more gender equitable attitudes themselves. As I previously discussed, young women Peer Facilitators showed lower levels of confidence, organization, and leadership during the research project. As a result, throughout the intervention, the facilitators received additional training as needed and weekly meetings were held to discuss challenges in an

attempt to rectify these differences and improve the confidence and skills of the young women Peer Facilitators. I spoke with the young women privately in our weekly meetings numerous times to ask them what they needed in terms of support, how I could assist them, and worked more closely with them to organize and prepare for sessions. However, despite my best efforts, I was frustrated in my attempts to motivate and empower the young women Peer Facilitators, and rally them to embrace their roles and achieve the same level of organization and confidence that the young men exhibited. At times I felt that they 'didn't care' or express the same motivations as young men and I felt disappointed, that as a young woman myself, I couldn't grasp how to lift young women up to rectify the inequalities I was witnessing.

Overall, our quantitative and qualitative findings and my meeting notes suggest that street-connected young women require additional support and training to empower them in circumstances when they have grown up extremely marginalized. In conclusion, both young women and young men had a significant increase in gender equitable attitudes from pre- to post-intervention. Changing deeply ingrained gender and social norms is challenging, and requires multiple interventions and time, however these results demonstrate that participation in the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention positively influenced street-connected young people's gender equitable attitudes in this setting. Overall, given that gender inequities and experiences of sexual and gender-based violence are known structural drivers of HIV acquisition (Gupta et al., 2008; Jewkes, Dunkle, et al., 2010; MacPherson et al., 2015), the positive and significant change in gender equitable attitudes post-intervention

among all participants represents an important finding, and may be an important factor in reducing street-connected young people's vulnerability to acquiring HIV in Eldoret.

8.1.3. Condom use self-efficacy and sexual practices

Gender and social norms influence condom use self-efficacy and condom use among young people in sub-Saharan Africa (Closson et al., 2018). Condom use self-efficacy refers to an individual's perceived belief in their ability to execute using condoms and thereby exert control over safe sex (Closson et al., 2018; Shaweno & Tekletsadik, 2013). Yet, an individual's self-efficacy alone is likely inadequate to be able to fully control or execute an outcome such as condom use, given social and structural factors, such as gender inequities, social norms, and poverty, which impact an individual's ability to enact change (Closson et al., 2018). Gender inequities often result in young women's inability to negotiate condom use, as men in many sub-Saharan African contexts generally control sexual decision-making and hold power in sexual relationships (Closson et al., 2018; MacPherson et al., 2015). The use of a gender and livelihoods programme in conjunction with sexual and reproductive health education in this research project sought to address these barriers and constraints. Gender differences in condom use self-efficacy among young people in sub-Saharan Africa have been documented, with young men generally reporting higher condom use self-efficacy than young women. Additionally, increasing young men's condom use self-efficacy predicts an improvement in condom use for young men but not for young women in sub-Saharan Africa (Closson

et al., 2018). Interestingly, our results did not find a difference in reported condom use self-efficacy between street-connected young women and young men pre- or post-intervention. Our findings did reveal a small but non-significant increase in all participants' condom use self-efficacy from pre- to post-intervention. Qualitative interviews confirmed changes in condom use self-efficacy for both young men and young women. Participants also expanded on these findings discussing the acquisition of new knowledge in relation to the use of male and female condoms, as well as improving their confidence and ability to use them, and teach their peers.

Our findings demonstrate low levels of condom use among all participants, with a third of young women reporting never using condoms for vaginal sex. Condoms are freely available at many public health facilities in Kenya, including AMPATH and at the Rafiki Centre for Excellence in Adolescent Health, where street-connected young people seek healthcare. During our intervention we also had condoms available for participants to take with them. These results show that street-connected young people have lower levels of condom use at last vaginal sex than other adolescents across Kenya, even after participating in the intervention (Kothari, Shanxiao, Head, & Abderrahim, 2012). We did find a marginal improvement in reported condom use at last vaginal sex and frequency of use among street-connected young men, albeit non-significant. In contrast, young women demonstrated a slight decrease in condom use at last vaginal sex post-intervention. In South Africa, participants in the Stepping Stones and Creating Futures interventions had no significant changes in condom use at last sex, but young women demonstrated a trend towards increasing use (Jewkes et al., 2014). In Kenya, low levels

of condom use among young people have been associated with poverty, low schooling, and the receipt of money and gifts from sexual partners (Davidoff-Gore, Luke, & Wawire, 2011), all factors that apply to street-connected young people in Eldoret. Furthermore, street-connected young women's ability to negotiate condom use may be highly constrained given their economic dependence on men and reliance on transactional and commercial sex for survival (Embleton, Wachira, et al., 2016, 2015, 2018; Sorber et al., 2014; Winston et al., 2015). This highlights the need to explore avenues for women controlled prevention, such as the use of PrEP. Exploring the potential use of PrEP with street-connected young women represents an avenue for future research.

The relationship between inconsistent condom use (not using a condom at every sexual encounter) and economic benefit (Davidoff-Gore et al., 2011), may be particularly important to consider in relation to street-connected adolescent girls' and young women's high levels of engagement in transactional and survival sex (Embleton, Wachira, et al., 2016, 2015, 2018; Winston et al., 2015). Comparable to results from South Africa (Jewkes et al., 2014), our adapted intervention showed no changes in relation to participants' engagement in transactional sex. While the integration of the matched-savings programme aimed to increase young people's ability to engage in alternative livelihoods, young women's reliance on transactional sex for survival remains a grave concern, given the association between transactional sex and HIV acquisition among young women in sub-Saharan Africa (Wamoyi et al., 2016). Our study did not allow for follow-up over time to see how the matched-savings programme or

commencement of income generating activities impacted medium and long-term changes in transactional and survival sex. Post-intervention measurements occurred on the last day when participants received their matched-savings, and we are therefore unable to tell how receipt of their savings or starting an income generating activity may or may not have changed participants' sexual risk practices in the short- to medium-term. However, a growing body of literature supports that both structural and economic interventions have a positive effect on reducing young people's sexual risk practices (Cluver et al., 2014, 2016; Heise et al., 2013; Pettifor et al., 2012). Moreover, combined savings and HIV prevention interventions have demonstrated a reduction in paying partners and an increase in consistent condom use for women engaged in commercial sex work (Odek et al., 2009; Witte et al., 2015). While it has been suggested that interventions using microcredit may induce risk practices for young women and thereby HIV vulnerability due to the need to make loan repayments (Dunbar et al., 2014; Gibbs et al., 2012; Wamoyi et al., 2014), our economic strengthening and livelihood approach did not require loan repayments and participants could choose how much to contribute on a weekly basis to their savings. Based on existing knowledge of street-connected young people's daily earnings in our setting (Sorber et al., 2014), it is unlikely that participation in the matched-savings programme increased sexual risk practices. Understanding the medium- and long-term impact of participation in the matched-savings programme on street-connected young people's sexual practices is an important avenue for future research.

8.2. Economic and livelihood-strengthening a novel approach to reduce street-connected young people's HIV vulnerability: positive outcomes, lessons learned, and future recommendations

Our pilot also sought to explain and explore how participation in the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention changed economic resources, housing status, and livelihoods for street-connected young people. Table 13 summarizes the outcomes across quantitative and qualitative data for savings, livelihood activities, assisting family, daily earnings, housing, personal assets, and reductions in street involvement side-by-side. Participation in the multi-faceted intervention resulted in encouraging outcomes for street-connected young people across quantitative and qualitative data in these areas. Our findings supported an increase in daily earnings across all participants, changes in livelihood activities, and housing status. However, similar to health and gender outcomes, there were gender differences in these outcomes that merit discussion. Furthermore, this work discovered additional structural barriers to street-connected young people realizing and actualizing their livelihood activities. To our knowledge, this is the first known study to test the use of both microfinance, a conditional economic incentive, and a livelihoods intervention with street-connected young people in a LMIC (Berckmans et al., 2012; Coren et al., 2016). In the next section, I situate our findings within the broader literature and discuss lessons learned and future recommendations.

Table 13 Summary of mixed methods findings on savings, livelihood activities and street-involvement

Outcomes	Level in the social-ecological model	Quantitative Findings	Qualitative Findings	Mixed Methods Triangulation
Savings	Individual / Structural	↑ Increased savings for all participants who made contributions	<ul style="list-style-type: none"> Participants described that participation increased their savings practices, balancing spending, allowed them to assist their family, commence IGAs, purchase items, rent houses and that they continued to save after the intervention in other savings groups 	Expanded on the impact of the matched-savings programme
Livelihood Activities	Structural / Individual	<ul style="list-style-type: none"> ↓ in participants' begging ↑ Increase in casual labour and IGAs 	<ul style="list-style-type: none"> Participants described that post-intervention they commenced a variety of IGAs, however young women reported challenges in actualizing and achieving their goals 	Confirmed changes to livelihoods and expanded on gender differences in achieving goals
Assisting Family	Interpersonal/Network	Not measured	<ul style="list-style-type: none"> Participants reported assisting their families post-intervention upon receipt of their savings 	'Silence'
Daily Earnings	Individual / Structural	↑ Increased reported daily earnings	<ul style="list-style-type: none"> Some participants explained how their daily earnings increased as a result of commencing IGAs 	Confirmed
Housing Status	Structural	↑ Marginally significant increase in being housed from pre to post-intervention	<ul style="list-style-type: none"> Across genders and age groups participants reported that the programme allowed them to pay rent, secure housing, assist family with rent, and improve their living circumstances 	Expanded on
Personal Assets	Individual	No change	<ul style="list-style-type: none"> Participants reported purchasing new clothing and household items with their matched-savings post-intervention 	Discordance
Reduction in street-involvement	Structural / Individual	Not measured	<ul style="list-style-type: none"> Participants described a reduction in street-involvement as a result of participation and a shift in social identity from 'street youth' to 'business men' and improvements in their life circumstances 	'Silence'

8.2.1. Conditional economic incentives and attendance

A core component of our economic and livelihood-strengthening programme was the use of a conditional economic incentive, whereby participants' savings contributions were matched (1:1) conditional on attending twice-weekly intervention sessions.

Despite a lack of previous studies using microfinance or economic incentives with street-connected young people (Berckmans et al., 2012), our results demonstrate that our matched-savings approach with street-connected young people was feasible. The goal of the matched-savings programme was to increase participation and retention while addressing the structural drivers of street-connected young people's HIV vulnerability. However, despite this economic incentive, which was highly supported by participants, attendance was not consistent across age and gender-strata.

Overall, over half of all participants (n=47, 59%) had medium or high attendance. A third (n=27) of participants had what we categorized as 'high' attendance, defined as attending between 17 to 24 sessions, and of those seven participants (4 young men, 3 young women) attended all 24 sessions. Attendance differed by gender and within age groups. Young men aged 16 to 19 had the highest level of attendance, whereas those aged 20-24 had the lowest levels of attendance, followed by young women aged 16-19. Young women aged 20-24 fell within the overall median attendance level. During the post-intervention focus group discussions when inquiring about participants who did not attend, street-connected young people reported that issues of trust with finances may have arisen among those with low attendance; however, that did not explain the

gender and age differences. It is likely that socially constructed gender norms, roles, and age influenced the attendance and savings differences seen across the age and gender strata. We can posit that for young men aged 20-24 years, whom had the lowest levels of attendance, it may have been that their priority was income generation and the incentive of matching a fairly low monetary amount (25 Ksh to 200 Ksh per week) was not a sufficient incentive to offset their potential earnings that would be lost during attendance. Whereas young women aged 16-19 years, may be facing additional challenges in their daily lives, which influenced their attendance and savings levels including: undergoing a difficult period of adolescence coupled with their street-connections, substance use, low levels of education, and pregnancy and childbearing at a young age (Embleton, Atwoli, et al., 2013; Sorber et al., 2014; Wachira et al., 2016). While young women aged 20-24 had slightly higher attendance than those 16-19, they likely faced additional challenges with childcare, children's school fees, and domestic duties that influenced their level participation and savings given the gender inequitable attitudes at play in Kenya (MacPherson et al., 2015), and expectations of women's roles in child rearing and domestic duties (Neitzert, 1994). As Sorber et al (2014) previously found, young women on average earn less than young men, and therefore have less financial resources at their disposal to save, especially when balancing the needs of their children. In contrast, young men aged 16-19 may lack additional responsibilities as they are generally not yet fathers, and engage in a wider range of income generating activities likely due to gender norms and roles, which may have allowed them to both participate more regularly and contribute more to their savings (Embleton, Wachira, et

al., 2018; Sorber et al., 2014; Wachira et al., 2016). The gender differences in savings and attendance suggest that the intervention requires further modifications to address these inequities in order to reduce the differences between outcomes for street-connected young women and young men, and promote gender and economic equity.

8.2.2. Matched-savings

Participants reported a significant increase in the amount of money earned per day, with a substantial number of these participants being young women. As in South Africa, where both young men and young women in the combined Stepping Stones and Creating Futures intervention reported increases in their earnings in the past month (Jewkes et al., 2014), it is likely that street-connected young people's participation in *Stepping Stones ya Mshefa na Kujijenga Kimaisha* contributed to this change.

In Uganda, a matched-savings intervention with orphaned adolescents found that age, future orientation, and family demographics influenced savings habits and that only 66% of participants in the intervention opened savings accounts (Karimli, Ssewamala, Neilands, & McKernan McKay, 2015). In our study, 75% of participants made at least one contribution to their informal savings accounts, and those who did not make a contribution had a low level of attendance or did not attend sessions after enrolment. The relatively high levels of participation in the savings component that exceeded orphaned adolescents in Uganda (Karimli et al., 2015), and encouraging findings in relation to savings, livelihoods, housing, and street-involvement in our study, suggest that informal savings activities are a highly feasible mechanism for economically

empowering street-connected young people, despite age and gender differences in attendance and savings levels.

Our matched-savings programme in combination with the *Kujijenga Kimasiha* sessions sought to empower street-connected young people to set a clear and achievable personal goal in relation to commencing an income generating activity or training course. This approach aimed to mitigate concerns regarding microfinance with vulnerable adolescents (Dunbar et al., 2014; Gibbs et al., 2012; Wamoyi et al., 2014). Street-connected young people were supportive of the inclusion of the matched-savings programme and worked with the study team to ensure it was feasible and suitable prior to commencing the pilot (Embleton, Di Ruggiero, et al., 2019), and our findings support that its implementation assisted street-connected young people in securing livelihoods with many of them reaching their goals. Moreover, participants also qualitatively reported reducing their street-involvement, suggesting that sustainable livelihoods approaches may in fact be a viable avenue for interventions with street-connected young people as suggested by Berckmans et al (2012), and allow young people to transition from the streets and into the community as young adults over time. This is supported by street-connected young men's described shift in their social identity from '*Mshefa*' to '*business man*'. This finding also suggests that participation in the multi-faceted intervention may have improved the future outlook of some street-connected young men in regards to a life beyond the streets as '*business men*'. Links between participation in a matched-savings intervention and future outlook were found among orphaned adolescents in the Uganda Suubi-Maka trial (Karimli & Ssewamala, 2015).

Positive changes in future outlook, aspirations, and hope and optimism for the future are crucial to adolescent well-being and studies have demonstrated that positive future orientation reduces substance use and sexual risk practices (Robbins & Bryan, 2004). Moreover, adolescents in Kenya with savings have reported lower levels of depression (Kagotho, Patak-Pietrafesa, Ssewamala, & Kirkbride, 2018). The importance of potentially improving street-connected young people's future outlook, reducing street-involvement, and improving other mental health outcomes through participating in the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention with matched-savings requires further investigation. Nonetheless, our present findings suggest that intervention participation could potentially reduce street-involvement, and shifted some participants' outlook regarding their future street-connections, which is a novel finding.

8.2.3. Achieving livelihood goals

Post-intervention fewer participants reported begging as a source of income, and more participants reported engaging in casual labour, commencing income generating activities, and economically assisting family. It has been suggested that strengthening livelihoods for street-connected young people may be a viable approach to reduce street-involvement (Berckmans et al., 2012), and our findings support this assertion. Given that poverty is a structural factor driving both young people's street-involvement (Embleton, Lee, et al., 2016) and HIV acquisition (Wamoyi et al., 2014) in sub-Saharan

Africa, addressing economic marginalization and focusing on strengthening livelihoods for street-connected young people is fundamental.

Despite many participants achieving their livelihood goal, the majority of young women aged 20-24 years were unable to actualize and achieve their income generating goal. In contrast, a few of the young women aged 16-19 years did. Young women aged 16-19 years discussed more involvement with their parent(s)/families in their plans in relation to their income generating goals and use of their savings, which may have provided them the additional economic and social support required. While all young women were supportive of the matched-savings approach during our adaptation process, it is evident that young women, regardless of age, still require additional support due to gender norms, social roles, and other challenges they face as mothers and caregivers. Unlike young women in South Africa receiving a conditional cash-transfer who primarily spent their money on toiletries, clothing, school supplies, and mobile phones and accessories (MacPhail et al., 2017), street-connected young women in our study primarily reported spending their money on provisions for their children and household needs to facilitate their survival. Young women aged 20-24 years reported spending their savings on their children's school fees and uniforms, and household needs, and those aged 16-19 years reported assisting family, supporting children, buying clothes, and securing housing, all of which may have prevented young women from achieving their income generating activity goals. In contrast, the majority of street-connected young men who participated reported commencing income generating activities and small businesses with their peers. When asked about how to

overcome the challenges in relation to achieving their income generating activity goal during the post-intervention focus group discussions, street-connected young women aged 20-24 suggested that they would like to include microloans in future iterations of the intervention, and suggested that this may enable them to achieve their income generating activity goals while also meeting their needs of supporting their children. The use of loans with other vulnerable young women has been discouraged due to the inability to repay loans and fears of inducing sexual risk practices to secure money (Dunbar et al., 2010; Wamoyi et al., 2014). In contrast, a graduated programme, whereby participants commence with support, livelihood skills, and savings and then advance to small grants that do not require repayment may mitigate concerns regarding the use of other microfinance with vulnerable street-connected young women, while allowing them to achieve their livelihood goals. This graduated approach was used in Zimbabwe, where young women could apply for a micro-grant upon completion of vocational training and development of a business plan in the SHAZ! Trial (Dunbar et al., 2014). Of participants in the intervention arm, 58% received a micro-grant upon completion of the requirements. This approach may have influenced young women's sexual risk practices, as young women within the SHAZ! intervention arm demonstrated a reduction in transactional sex and a higher likelihood of condom use with their current partner (Dunbar et al., 2014). Given that street-connected young women reported high levels of transactional sex and low levels of condom use both pre- and post-intervention in our setting, a graduated programme including a micro-grant may be a viable approach to augmenting support for street-connected young women, which may reduce

concerning sexual risk practices. It has been proposed that augmenting adolescent girls and young women's economic and livelihood circumstances works to reduce HIV acquisition through allowing young women to secure their own basic needs, thereby resulting in a reduction in transactional sex to secure material, social, and economic provisions (Wamoyi et al., 2014). However, the use of economic and livelihood-strengthening approaches with young women in sub-Saharan Africa has had mixed results in reducing sexual risk practices to date (Bandiera et al., 2012; Dunbar et al., 2014, 2010; Pronyk et al., 2006; Rotheram-Borus et al., 2012; Wamoyi et al., 2014), and there remains a need for additional evidence and understanding the long-term effects and potential sustainability of these programmes. It remains unclear how our multi-faceted intervention may influence street-connected young women's sexual risk practices or HIV acquisition over time, as we were unable to interview participants after receipt of their savings. To ascertain the impact of the economic and livelihood-strengthening components of the intervention on street-connected young women's sexual risk practices and HIV acquisition requires additional research that includes follow-up over time post-intervention.

8.2.4. Economic-strengthening approaches with young men

The inclusion of street-connected young men in our intervention was novel, as very few economic strengthening programmes in sub-Saharan Africa have included young men (Arrivillaga & Salcedo, 2014; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012; Kennedy et al., 2014). Including street-connected young men in our economic intervention sought

to enable them to secure their livelihoods while increasing gender equitable attitudes and shifting gender norms through the *Stepping Stones ya Mshefa* component of the intervention. Although the intervention did not appear to have any negative consequences of using economic-strengthening approaches with both young men and women, we cannot say for sure what consequences arose post-intervention that were unmeasured or that occurred over time. However, we posit that because street-connected young men in Eldoret are extremely oppressed and economically marginalized (Embleton, Wachira, et al., 2018; Sorber et al., 2014), that economically empowering them may contribute to reducing harmful expressions of masculinity that have been associated with the inability to achieve traditional masculine norms in sub-Saharan Africa and HIV risk practices (Dworkin et al., 2013; Fleming et al., 2015; Gibbs, Sikweyiya, et al., 2015; Izugbara, 2015; Jewkes et al., 2015). It is likely, that street-connected young men's economic empowerment resulted in subtle shifts in masculinities from harmful to more traditional, as seen in the combined South Africa Stepping Stones and Creating Futures intervention (Gibbs, Jewkes, Sikweyiya, et al., 2014). However, some street-connected young men did express more gender equitable attitudes in relation to gender roles, norms, and domestic and financial equality, suggesting a shift towards more gender equitable masculinity among some participants. Finally, young men did demonstrate a shift towards increasing condom use and qualitative accounts supported this, signifying that the adapted multi-faceted intervention potentially had an influence on street-connected young men's sexual risk practices. This research is extremely valuable as it adds to the sparse body of literature

on the inclusion of young men in combined gender transformative and economic strengthening interventions in sub-Saharan Africa (Arrivillaga & Salcedo, 2014; Dworkin et al., 2013; Gibbs, Jacobson, et al., 2017; Gibbs et al., 2012; Kennedy et al., 2014). Our study demonstrated that for young men who are extremely economically marginalized, such as street-connected young men in Kenya (Sorber et al., 2014), their participation in a combined gender, economic, and livelihood intervention may be feasible and could potentially result in positive outcomes for gender equity and sexual practices, both of which influence HIV vulnerability.

8.2.5. Structural barriers and contextual challenges to achieving livelihood goals

For all participants, additional structural barriers came to light in the process of achieving their goals and implementing income generating activities. These included: a lack of government issued identification, the need for business permits, and changes in the political context and policy surrounding informal income generating activities in Eldoret, Kenya during the study, all of which may have impacted participants' livelihood activities. This is similar to how the political and economic context in South Africa undermined Stepping Stones and Creating Futures participants' attempts to secure employment and generate income, and thereby despite the intervention, contextual issues limited young men's ability to change (Gibbs et al., 2018). Notwithstanding these contextual challenges in our setting, both street-connected young men and young women reported improving their livelihoods, and in contrast to the South African Stepping Stones and Creating Futures intervention, our multi-faceted intervention

included an additional economic strengthening component of matched-savings to further address economic marginalization. However, it is likely that these structural barriers limited the magnitude of change observed in our study, and influenced the sustainability of livelihood activities for street-connected young people. As Gibbs (2018) suggests, if economic marginalization is a significant factor in influencing young men's perpetration of violence against women, and HIV risk behaviours, then challenging the broader political and economic structures that are constraining meaningful change are vital for reducing violence and HIV acquisition (Gibbs et al., 2018). This underscores the importance of assessing and considering all aspects of the social, political and economic context when planning and implementing interventions (Edwards & Barker, 2014; Gupta et al., 2008). While some of these political contextual changes were unforeseen and occurred during the pilot phase of the study, others such as lack of government issued identification and business permits were beyond the scope of the intervention and not considered during the adaptation process, yet became important barriers to participants' ability to fully actualize and sustain their livelihood goals. To support street-connected young people in achieving their livelihood goals and reducing economic marginalization, it may be that the programme needs to be delivered by a community-based organization, which can also facilitate procuring identification and business permits, or these aspects need to be integrated into the *Kujijenga Kimaisha* programme materials.

8.2.6. Housing

A final finding was that participants reported a marginally significant change in housing status, and qualitatively confirmed that they secured housing or paid rent as a result of participating in the matched-savings programme. This represents a vital outcome for reducing street-connected young people's HIV vulnerability. It is likely that being precariously housed is a significant structural driver of HIV acquisition for street-connected young people in Kenya. Without stable and secure housing, street-connected young people in our setting are exchanging sex for security and shelter at night (Embleton, Wachira, et al., 2015, 2018), and are at increased risk of experiencing physical and sexual violence at night (Embleton, Wachira, et al., 2016, 2015; Wachira et al., 2015). Housing instability has been associated with high-risk sexual practices in high-income countries (Aidala et al., 2016; Grieb et al., 2013), whereas stable housing has been associated with a decrease in sexual risk practices (Dickson-Gomez et al., 2011). Furthermore, the provision of housing has been associated with undetectable viral loads among homeless people living with HIV (Hawk & Davis, 2012). This suggests that structural interventions that assist street-connected young people to secure housing are an important component of HIV prevention. While 'housing first' strategies (Kozloff et al., 2016) may be unfeasible in many LMICs, other social policy interventions such as cash transfers (Cluver et al., 2013; Heise et al., 2013), and economic and livelihood approaches such as our intervention with matched-savings may allow street-connected young people to secure housing, and thereby reduce their HIV vulnerability.

8.2.7. Summary of livelihood programme findings

In conclusion, our study demonstrated that the novel use of the economic and livelihood-strengthening programme was feasible and appropriate with both street-connected young women and young men. While our findings indicate the need for further tailoring of the programme to account for gender differences and contextual issues, our results support that it may be possible to scale-up a further adapted multi-faceted intervention that builds off these current findings, and rigorously test it to determine if and how it may be effective at improving livelihoods, and reducing street-connected young people's sexual risk taking practices, HIV and STI acquisition, and street-involvement over time.

8.3. Strengths and Limitations

8.3.1. Strengths

First, from the outset, this project used community-based research methods informed by a rights-based approach (OHCHR, 2017) with street-connected young people in Eldoret and built a strong and trusting relationship with the street community. The adaptation process respected street-connected young people's right to participate in the research process and led to a high level of programme acceptability in our context. Throughout the intervention the Peer Facilitators were able to communicate with participants using language from the street subculture and share their lived experience in relation to the topics covered in the adapted *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme. In many respects, the Peer Facilitators became respected

mentors and role models for participants, while also learning and building their own skill sets that would be transferable to other areas of their lives. Overall, street-connected young people's participation and meaningful engagement in this research project fostered a trusting relationship between the research team and participants, where street-connected young people felt respected and valued, all of which likely had an impact on the success of an intervention (Berckmans et al., 2012; Coren et al., 2016; Panter-Brick, 2002). Second, this research started to fill a major gap in the lack of evidence-based interventions for street-connected young people in LMICs. The use of an existing evidence-based intervention, in lieu of creating a new intervention specifically for street-connected young people, ensured that the intervention was proven effective at changing our outcomes of interest with young people in sub-Saharan Africa. Moreover, the intervention was able to address multiple levels of street-connected young people's HIV vulnerabilities and was situated in the social-ecological model framework. Third, the research project occurred within an existing adolescent-friendly clinic setting. This reflects the ability of the intervention to function within the existing infrastructure and setting in Eldoret, suggesting the possibility for its scale-up, sustainability, and validity in 'real world' circumstances. Fourth, our results suggest it is feasible and highly acceptable to use livelihood and economic strengthening approaches with both young men and young women in connected to the street in Eldoret, but requires further adaptation based on participant feedback and it will also require further research to explore the medium and long-term sustainability and impacts associated with these strategies. Fifth, importantly, this study used standardized outcome

measures and replicated some findings from the Stepping Stones and Creating Futures intervention in South Africa, signifying the effects of the Stepping Stones and Creating Futures intervention can be replicated in new settings. Lastly, we took gender into consideration in the study design and measured gender differences across outcomes.

8.3.2. Limitations

First, our adaptation process occurred in one geographic region of Kenya, and therefore the programme materials may not be completely contextually relevant to other street-connected young people in Kenya and would require further adaptation before its use in other settings. Second, despite our best attempts we were unable to completely involve street-connected young people in all aspects of the full research process, such as choosing outcome measures. Nonetheless, we do believe the degree of their active and meaningful participation was at the core of the success of this project. Third, the pilot study was small and therefore the power to detect significant changes in secondary outcomes and across age and gender strata was limited. Fourth, post-intervention quantitative interviews occurred on the final day of the intervention and therefore were unable to assess changes over mid- to long-term, nor the impact of participants receiving their matched-savings on sexual risk practices, livelihood activities, economic resources, and personal assets over time. Post-intervention qualitative interviews occurred one month after the end of the intervention and therefore provide some insight into how the receipt of matched-savings influenced participant outcomes with respect to housing, personal assets, and livelihood activities. However, our qualitative

data with respect to gender equitable attitudes outcomes should be interpreted with caution, as young women were not adequately probed in this domain. Fifth, our results may also be prone to social desirability and reporting bias, as participants may have answered favourably or suppressed information on questionnaires, particularly with respect to sexual practices and gender equitable attitudes. However, given the trusted relationship that Peer Facilitators established with intervention participants, it is likely they felt comfortable answering honestly. Sixth, this study did not measure biological outcomes for HIV or STIs, and therefore it is unable to assess its potential effectiveness of reducing incident cases of HIV and STIs, thus preventing HIV. Seventh, we did not measure perpetration or experiences of sexual, physical, emotional, and economic violence. Yet, these forms of violence are important factors to consider in relation to HIV vulnerability, particularly given the sexual and gender-based violence in the street subculture. Lastly, this study took place in one geographic location in western Kenya where the research team has a long-standing relationship with the study population, and therefore its generalizability to other LMIC settings with street-connected young people is unknown and requires further investigation.

8.4. Conclusions

This multi-stage mixed methods research project demonstrated that it was feasible to adapt an existing evidence-based intervention with street-connected young people. It provided a model for other researchers and organizations in LMICs to use, which may assist in addressing the knowledge gap in effective interventions to ameliorate the

health and well-being of this highly marginalized and vulnerable population (Berckmans et al., 2012; Coren et al., 2016; Naranbhai et al., 2011). Paramount to this process was the meaningful engagement of street-connected young people in the adaptation process. Our rigorous adaptation process using community-based research methods informed by a rights-based approach and a modified ADAPT-ITT framework respected street-connected young people's right to participate in the research process, and became the foundation for piloting the adapted intervention successfully. This process ensured that the adapted intervention was acceptable and responsive to the needs of street-connected young people, and relevant to the local social, cultural, and economic context of the streets in Eldoret. Through the adaptation process, we showed which content from the Stepping Stones and Creating Futures programmes was appropriate and acceptable for street-connected young people in the context of Eldoret Kenya, and established that the adapted multi-faceted intervention was suitable. Additionally, this project demonstrated that the use of novel microfinance and livelihood strategies with street-connected young people was highly acceptable, suitable, and feasible when street-connected young people were involved in the planning and decision-making processes to reduce potential harmful and unintended consequences.

Overall, this study has demonstrated that the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention may be effective at improving street-connected young people's HIV knowledge, gender equitable attitudes, daily earnings, and livelihoods. Moreover, the intervention may increase condom use self-efficacy, knowledge of family planning, health-seeking behaviours, and improve housing status while reducing street-

involvement for street-connected young people. Our findings were encouraging, but demonstrate the need for further adaptation to address gender differences, street-connected young women's need for additional support, and contextual issues that came to light during this project. In addition, our findings suggest that the intervention may be suitable for scale up and testing with a rigorous study design to assess its overall effectiveness at improving gender equitable attitudes and livelihoods, while reducing sexual risk practices, and HIV and STI acquisition. Street-connected young people in Kenya and other LMICs urgently need effective evidence-based interventions to address their HIV vulnerability across multiple levels of the social-ecological model while providing them an avenue to safely transition into adulthood and off the streets, and the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme may be a viable intervention to do so.

Chapter 9 Future Directions

9.1. Knowledge translation and dissemination

Sharing the research project's findings with stakeholders, researchers, government, and community-based organizations in a timely manner is essential. The innovative use of livelihood and economic strengthening approaches with street-connected young people merits promotion, as our findings are the first to demonstrate that it is feasible and advantageous to use both with street-connected young people in a LMIC setting.

Likewise, the overall significance of this project's encouraging findings cannot be overlooked, given the lack of evidence-based interventions for street-connected young people in LMICs. In the next six months, I will commence knowledge translation activities and disseminate the project's findings in Eldoret and Kenya more broadly.

Working with one of the Peer Facilitators, we will disseminate findings locally in Eldoret to the street community through community meetings, and presentations at AMPATH, in the Uasin Gishu Children's Forum, to the County government, and other community-based organizations working with the street community. Nationally, we will disseminate our findings through presentations and policy briefs to NASCOP, the National Children's Coordinator, and the Ministry of Gender, Children and Social Development. As well, I will ensure our findings are disseminating to international organizations working with street-connected children and youth, such as the Consortium for Street Children. Finally, I will ensure our adapted manuals and findings are available online in layperson briefings in addition to the peer-reviewed manuscripts.

9.2. Additional analyses and adaptations

Simultaneously, the starting point for future research is to complete additional analyses from the rich data available from this project. First, additional data available will be analysed to explore the complexities of implementation and operational challenges of piloting a multi-faceted intervention with street-connected young people. This analysis is the starting point for understanding how to further tailor and adapt the intervention with street-connected young people to overcome challenges or limitations with programme content or delivery that became apparent during implementation or that were discussed post-intervention. Central to this process is identifying key components of the adapted *Stepping Stones ya Mshefa na Kujijenga Kimaisha* programme that participants discussed they would like to change, remove, or further adapt, while keeping those that they reported enjoying and were acceptable and appropriate. Participants and Peer Facilitators made recommendations and suggestions, which included new innovations, such as grants, to possibly ameliorate both the programme content as well as the programme delivery. Second, additional data that is available explores the experiences of the Peer Facilitators needs to be analysed to understand how being a Peer Facilitator for the project broadly impacted their lives, what the benefits and challenges were, and any unintended consequences that arose from participating in this project as Peer Facilitators. This analysis will provide further evidence and support for interventions using participatory approaches and engaging peers when working with street-connected young people. Together these two analyses

are the fundamental first step in identifying areas for amelioration and challenges that need to be rectified through additional tailoring and adaptations before scale-up.

9.3. Further tailoring, adapting, and investigating the effectiveness of the *Stepping Stones ya Mshefa na Kujijenga Kimaisha* intervention

Following this analysis, in the next year the intervention can be adapted to respond to the project's findings. Specifically, it is evident that the intervention needs to be tailored further. First, the intervention needs to better account for gender norms and differences in facilitation. Second, it is clear the intervention needs to be strengthened to address differences in gender equitable attitudes, how young men and young women participated in the matched-savings programme, and achieved or did not achieve their livelihood goals. Adaptations may seek to improve the matched-savings programme, to consider how small grants may be integrated into a graduated livelihood programme, as well as to address gender equity and the additional structural barriers (e.g. business permits, identification) to achieving goals. Importantly during this process, we can continue to use community-based research methods informed by a rights-based approach, thereby including street-connected young people in this process as members of the research team.

Upon completion of tailoring and adapting the intervention based on this pilot project's findings and follow-up work, in the next two to three years the goal would be to test the further adapted intervention's effectiveness in a cluster randomized control trial using a stepped wedged design. This study design is suitable to use with street-

connected young people to overcome potential challenges with treatment group contamination and other problems that would likely arise with individual level randomization in the tight-knit street community. Moreover, using a stepped wedge design we could ensure that all control clusters receive the intervention, which would alleviate ethical concerns of not offering the intervention to all street-connected young people. The trial could be designed to partner with community-based organizations and/or adolescent-friendly healthcare facilities across Kenya in cities with a significant number of street-connected young people, and could train a number of Peer Facilitators using the same strategies that worked well in this pilot project. This trial would allow us to understand the effectiveness of the multi-faceted intervention on reducing sexual risk practices, gender inequities, multiple forms of violence, street-involvement, and HIV and STI acquisition, while improving livelihoods and housing status over time. It would also allow for measurement of biological outcomes to assess potential reductions in HIV and STI incidence, which would demonstrate if the intervention is indeed effective at preventing HIV. Moreover, this study would allow us to investigate the possible pathways and mechanisms of action at work that reduce HIV acquisition as a result of participation in economic-strengthening interventions for both young men and women, which is currently not well documented in the literature.

9.4. Tackling housing as a structural driver of HIV

With the established association between unstable housing and sexual risk practices (Aidala et al., 2016; Grieb et al., 2013), securing safe housing for street-connected young

people may be a significant structural intervention to reduce HIV acquisition, violence, and street-involvement for this population. Social housing and 'housing first' strategies in North America have been tested with homeless populations, and proven successful at reducing street-involvement, allowing homeless persons to find stability and transition from the street while improving health and well-being (Aubry, Nelson, & Tsemberis, 2015; Kozloff et al., 2016; O'Campo et al., 2016). Housing strategies for street-connected young people in LMICs cannot be disregarded as a potential avenue to reduce street-involvement and improve the health and well-being of this marginalized population. Despite obvious challenges in providing safe and secure housing to a subset of the population when many persons live in substandard informal settlements and have inadequate housing, working towards an innovative 'housing first' strategy that is feasible, sustainable, cost-effective and environmentally friendly for street-connected young people in LMICs will be an imperative long-term research direction. This research direction could have far-reaching implications for housing and urban health policy and impact for all vulnerable persons living in informal settlements. Given my background in architecture and work with this population, devising sustainable and secure urban housing solutions in LMICs and testing the outcomes of such an intervention on the health and well-being of street-connected young people is a long-term innovative direction of my future programme of research.

9.5. Social protection for street-connected children and youth

Finally, it is apparent that street-connected young people may not be benefiting from social protection programmes such as the cash-transfer to orphaned and vulnerable children programme in Kenya (Handa et al., 2014), as very few young people connected to the street in our setting reside with parent(s)/guardian(s) (Braitstein et al., 2019). However, these programmes are an essential upstream intervention to prevent children and youth finding themselves in street situations due to poverty at home. The extension of such social policy interventions to vulnerable adolescents and young people not living with an adult caregiver, may be an avenue to reduce street-involvement and thereby HIV vulnerability. Research and policy action over the next five to ten years, should work towards supporting the government to expand the cash-transfer for orphaned and vulnerable children programme to reach street-connected young people or to design/adapt, implement, and evaluate a unique social protection programme for this marginalized population. Given the extensive research that demonstrates the positive benefits that cash-transfers and social protection programmes have in reducing sexual risk practices and poverty, working with the government to evaluate the effects of such a programme tailored to street-connected young people will be essential.

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APPENDICES

Appendix I: Economic and livelihood strengthening interventions tested with young people in sub-Saharan Africa

Author, Year	Country	Study Population	Intervention Description	Structural and HIV-related outcomes
Unconditional cash-transfers				
(Cho et al., 2011)	Kenya	Adolescent orphans aged 12-14 years N=105	Name: none Study Design: Randomized controlled trial Description: Unconditional cash-transfer for school fees and uniforms to intervention participants	<ul style="list-style-type: none"> • Intervention participants were less likely to drop out, commence sexual intercourse or report attitudes supporting early sex or intimate partner violence.
(Cluver et al., 2014)	South Africa	Children and adolescents 10-18 years N=3515	Name: none Study Design: Prospective observational study with random sampling Description: Participants receiving the South Africa – Child Support Grant, Foster Care Grant and other Social Services support programs. Compared to programs offering cash plus care (food, social support).	<ul style="list-style-type: none"> • Cash reduced HIV risk for girls, but not for boys. • Cash plus care halved HIV-risk behaviour incidence for both sexes.
(Cluver et al., 2013)	South Africa	Children and adolescents 10-18 years N=3515	Name: none Study Design: Case-control study Description: Receipt of the South African Child Support Grant or Foster Care Grant	<ul style="list-style-type: none"> • Receipt of a cash transfer was associated with reduced incidence of transactional sex and age-disparate sex for adolescent girls. • No significant effects were shown for other risk behaviours. • Boys showed no consistent effects for any of the behaviours

(Duflo et al., 2007)	Kenya	Males in females in Grades 5-8 74,000 students	Name: none Study Design: randomized controlled trial Description: School intervention to reduce costs for school by providing free uniforms	<ul style="list-style-type: none"> • Girls provided free uniforms less likely to start childbearing. • Decrease in teen childbearing. • Decrease in child marriage.
(Hallfors et al., 2011)	Zimbabwe	Orphan girls in Grade 6 N=329	Name: none Study design: randomized controlled trial Description: All primary schools received a universal daily feeding program; intervention participants received fees, uniforms, and a school-based helper to monitor attendance and resolve problems	<ul style="list-style-type: none"> • The intervention reduced school dropout and marriage after 2 years. • Intervention participants had more gender equitable attitudes.
(Handa et al., 2014)	Kenya	15-25 males / females N=1443	Name: Kenya's Cash transfer to orphaned and vulnerable children (CT-OVC) Study Design: Impact evaluation Description: Registered households in the program received KSH. 1500/month	<ul style="list-style-type: none"> • Reduced the odds of sexual debut with a larger impact on females relative to males • No statistically significant effects on secondary outcomes of behavioral risk such as condom use, number of partners and transactional sex.
(Handa et al., 2015)	Kenya	15-24 young women N=1549	Name: Kenya's Cash transfer to orphaned and vulnerable children (CT-OVC) Study Design: Impact evaluation Description: Registered households in the program received KSH. 1500/month	<ul style="list-style-type: none"> • Young women in treatment households were less likely to have ever been pregnant compared to controls. • No impact on marriage.
(Rosenberg , Pettifor, Thirumurthy, Halpern, & Handa, 2014)	Kenya	15-25 males/ females N=2212	Name: Kenya's Cash transfer to orphaned and vulnerable children (CT-OVC) Study Design: Impact evaluation Description: Registered households in the program received KSH. 1500/month	<ul style="list-style-type: none"> • No impact on partner age, partner school status or transactional sex.

Conditional Cash-Transfers				
(Baird et al., 2012)	Malawi	Young women aged 13-22 N=827 (control) N=501 (intervention)	Name: Zomba Cash-Transfer Program Study Design: Cluster randomized controlled trial Description: Monthly payments of 1-5 USD for adolescents and 4-10 USD for parents. Conditional on school attendance vs. unconditional vs. control (no incentive)	<ul style="list-style-type: none"> • Lower HIV and HSV-2 prevalence in the combined intervention group in comparison to control. • Reduced reported sexual activity and age-disparate relationships in intervention groups. • Intervention participants more likely to remain in school. • No change in sexual debut or unprotected sex.
(Karim et al., 2015)	South Africa	Grade 9 and 10 Students in KwaZulu- Natal N=3,217 (n=1,517,male) (n=1,700, female)	Name: CAPRISA 007 Study Design: Randomized controlled trial Description: Cash incentives (maximum of \$175 over 2 years). Conditional on fulfilling any combination of 4 conditions; annual HIV testing, performance in school tests, participation in "My Life! My Future!" and a written report on their community involvement project	<ul style="list-style-type: none"> • Students who received larger cash incentives had lower HSV-2 incidence rates.
(Pettifor et al., 2016)	South Africa	Adolescent girls and young women aged 13-20 enrolled in grades 8 to 11 N=1225 (Intervention), N=1223 (control)	Name: HPTN 068 Study Design: Randomized controlled trial Description: Intervention group received 10 USD and guardian 20 USD per month conditional on attending 80% of school days per month.	<ul style="list-style-type: none"> • The intervention did not result in a reduction in HIV incidence over three years of follow-up. • Girls receiving the cash transfer were less likely to experience physical violence from a partner or to have had a sex partner in the past 12 months. • Girls receiving the cash transfer were less likely to have had unprotected sex in the past 3 months.
Microfinance				
(Erulkar & Chong,	Kenya	Out of school adolescent	Name: Tap and Reposition Youth (TRY) Savings and Microcredit for Adolescent Girls	<ul style="list-style-type: none"> • Intervention participants had a significantly higher level of income.

2005)		girls aged 16 to 22 in low income and slum areas of Nairobi N=326 matched-pairs	<p>Study Design: Pre-post- test with matched-controls</p> <p>Description: Group-based microfinance, business support and mentoring</p>	<ul style="list-style-type: none"> • Intervention participants had increased economic assets and savings. • Intervention participants had more liberal gender attitudes. • Trends towards increased condom use and refusal of sex in intervention group.
Combined Savings and Life skills				
(Austrian & Muthengi, 2014)	Uganda	Adolescent girls 10-19 in low income areas of Kampala, Uganda	<p>Name: none</p> <p>Study Design: Pilot with 3 groups (savings plus, savings only, control)</p> <p>Description: The intervention had 4 components: safe spaces where girls meet with a mentor, reproductive health training program Tuko Pamoja, financial education, and individual savings accounts</p>	<ul style="list-style-type: none"> • Increase in indecent touching in savings only group. • Girls in savings groups were more likely to have a budget than the control group. • Girls in the savings plus group had a greater improvement in savings than savings only. • Girls in the savings plus group had increased HIV knowledge and contraception knowledge.
(Austrian & Muthengi, 2013)	Kenya / Uganda	Adolescent girls aged 10-19 N=899 (Kenya) N=1062 (Uganda)	<p>Name: Safe and Smart Savings Products for Vulnerable Adolescent Girls project</p> <p>Study Design: Pilot with control groups</p> <p>Description: The program consisted for group meetings with a female mentor, financial education, and individual savings accounts</p>	<ul style="list-style-type: none"> • Some evidence that Ugandan girls who saved were less likely to exchange sex for gifts or money in comparison to girls who saved irregularly. • Increase in sexual and reproductive health knowledge. • Increase in savings among intervention participants.
(Jennings et al., 2016)	Uganda	Orphaned Adolescents aged 10-17 N=346, n=167 (control), n=179	<p>Name: Suubi-Maka</p> <p>Study Design: Randomized controlled trial</p> <p>Description: Participants were randomized to receive orphan care plus mentoring, or orphan care, mentoring, financial education and matched-savings accounts</p>	<ul style="list-style-type: none"> • Intervention participants increased their savings. • Intervention participants had improved HIV prevention attitudinal scores. • Intervention participants had improved HIV risk perception.

		(intervention)		
(Ssewamala, Han, Neilands, Ismayilova, & Sperber, 2010a)	Uganda	Children in Grade7-8 who had lost a parent to AIDS n=133 (control), n=127 (intervention)	Name: SUUBI program Study Design: Randomized Controlled Trial Description: Children in the program received 12 1-2 hour workshops on asset building and financial planning, mentorship, and a child savings account for secondary school or a family business. Savings accounts were matched 2:1 conditional on attending all 12-workshop sessions.	<ul style="list-style-type: none"> • Adolescents in the economic intervention reported a significant reduction in sexual risk-taking intentions.
Combined HIV and life skills education, livelihood strengthening and/or microfinance				
(Bandiera et al., 2012)	Uganda	Adolescent girls aged 14-20 N=4800	Name: Empowerment and Livelihood for Adolescents (ELA) Study Design: Randomized controlled trial Description: Life skills, HIV and sexual and reproductive health training, vocational skills training, microfinance offered	<ul style="list-style-type: none"> • Improved HIV and pregnancy knowledge, condom use, and entrepreneurial skills among intervention participants. • Reduction in unwilling sex in intervention group. • Adolescent girls in the intervention were more likely to be engaged in income-generating activities and have higher earnings.
(Dunbar et al., 2010)	Zimbabwe	Orphaned and out-of-school adolescent girls aged 16-19, N=49	Name: Shaping the health of adolescent girls in Zimbabwe (SHAZ!) Study Design: Pre-/post-test pilot Description: The SHAZ! Program included materials from 'Talk Time' and Stepping Stones and was delivered in 10 interactive sessions with groups of 25 participants. Participants received business training and mentoring occurred. Microcredit loans were issued from 51USD to 87USD.	<ul style="list-style-type: none"> • Post-intervention participants were significantly more likely to report having their own income and savings. • Increased HIV knowledge. • Increased relationship power. • No change in future plans, aspirations, current sexual activity or condom use.
(Dunbar et al., 2014)	Zimbabwe	Orphaned and out-of-school	Name: Shaping the health of adolescent girls in Zimbabwe (SHAZ!)	<ul style="list-style-type: none"> • Within the Intervention arm lower risk of transactional sex and a higher likelihood of

		adolescent girls aged 16-19 N=315 (n=158, intervention, n=157 control)	Study design: Randomized controlled trial Description: All participants received reproductive health services, life skills education (Stepping Stones and Talk time). Intervention participants additionally received livelihoods training consisting of financial literacy and vocational training of choice. Those who successfully completed training were offered micro-grants. Lastly the intervention group received integrated social support through mentorship.	using a condom with their current partner from baseline to endline. <ul style="list-style-type: none"> • Intervention participants were more likely to have their own income and reduced food insecurity. • Reduction in physical/sexual violence or rape. • Trend toward fewer unintended pregnancies among intervention participants.
(Jewkes et al., 2014)	South Africa	Out-of-school youth aged 18-30 living in informal settlements in Durban N=232	Name: Stepping Stones and Creating Futures Study Design: Shortened interrupted time series with 12 month follow-up Description: Participants attended 10 Stepping Stones sessions and 11 sessions of the livelihoods intervention Creating Futures over the course of 12 weeks in sequence. Sessions were 3 hours long and delivered 2 times per week.	<ul style="list-style-type: none"> • Reduction in sexual violence experienced by women. • No impact on sexual or physical violence perpetrated by men. • Increase in men reporting last person they had sex with was main partner. • Increase in men and women's earnings in the past month. • Men and women improved their gender equitable attitudes. • Men reduced their controlling practices in relationships. • Trend towards increasing condom use at least sex among women. • No changes in transactional sex.
(Pronyk et al., 2006, 2008)	South Africa	Young women 15-35 cohort 2 n=1835	Name: Microfinance for AIDS and Gender Equity (IMAGE) Project Study design: Group randomized controlled	<ul style="list-style-type: none"> • Intervention participants had a higher level of HIV-related communication, were more likely to access HIV counselling and testing.

		Cohort 3, n=3881	trial. Description: Participants received microfinance loans for income generating activities with a group-lending model. Intervention participants also were in the 12-15 month participatory Sisters for Life program, which included life skills, HIV education, gender, and community mobilization.	<ul style="list-style-type: none"> • Intervention participants were less likely to have unprotected sex with a non-spousal partner.
(Rotheram-Borus et al., 2012)	Uganda	Youth aged 13-23 from slums of Kampala Uganda (n=100)	Name: Street Smart Study design: Pre-post test with immediate intervention or delay Description: 10 sessions on HIV prevention and vocational training to strengthen livelihoods.	<ul style="list-style-type: none"> • Increase in employment. • Decreases in the number of sexual partners, mental health symptoms, delinquent acts, and drug use.

Appendix II. Adapted from Wingood (2008), the modified ADAPT-ITT model framework that guided the community-based participatory adaptation process with street-connected young people.

PHASE	QUESTIONS	ORIGINAL ADAPT-ITT MODEL METHODOLOGY	MODIFIED ADAPT-IT METHODOLOGY AND EXAMPLE OF PROCESS
1. Assessment	Who is the new target population and why are they at risk of HIV?	<ul style="list-style-type: none"> • Conduct focus groups/needs assessment with the new target population • Conduct focus group/elicitation interviews with the key stakeholders • Analyze results of formative evaluations^{[1][2][3][4][5][6][7][8][9][10]} 	<ul style="list-style-type: none"> • Drew on existing research in our setting that demonstrated that HIV, gender inequities and livelihood issues were prominent.
2. Decision	What evidence-based intervention is going to be selected and is it going to be adopted as is or adapted?	<ul style="list-style-type: none"> • Review HIV interventions defined as EBIs^{[1][2][3][4][5][6][7][8][9][10]} • Decide on the EBI to be selected • Decide on whether to adopt as is or adapt the EBI^{[1][2][3][4][5][6][7][8][9][10]} 	<ul style="list-style-type: none"> • Completed a scoping review of HIV prevention interventions for adolescents and homeless youth • Held research and stakeholder team meeting to come to a consensus on intervention selected • Decided to adapt the EBI for the new context • Identified underlying theoretical components of program delivery and core content of the original EBI
3. Administration	What program features (e.g. content, delivery) in the original evidenced-based intervention need to be adapted, and how should they be adapted?	<ul style="list-style-type: none"> • Administer theater test with members of the new target population • Involve key stakeholders as observers of the theater test. • Administer a brief survey with open-ended and close-ended items to elicit participants' and stakeholders' reactions to the theater test^{[1][2][3][4][5][6][7][8][9][10]} 	<ul style="list-style-type: none"> • Peers Facilitators' experience full original program as part of their training and provide reactions, feedback, and initial program adaptations • Hosted mock facilitation sessions with guest participants akin to theater test • Extensive documentation of feedback through both processes result in preliminary adaptations.

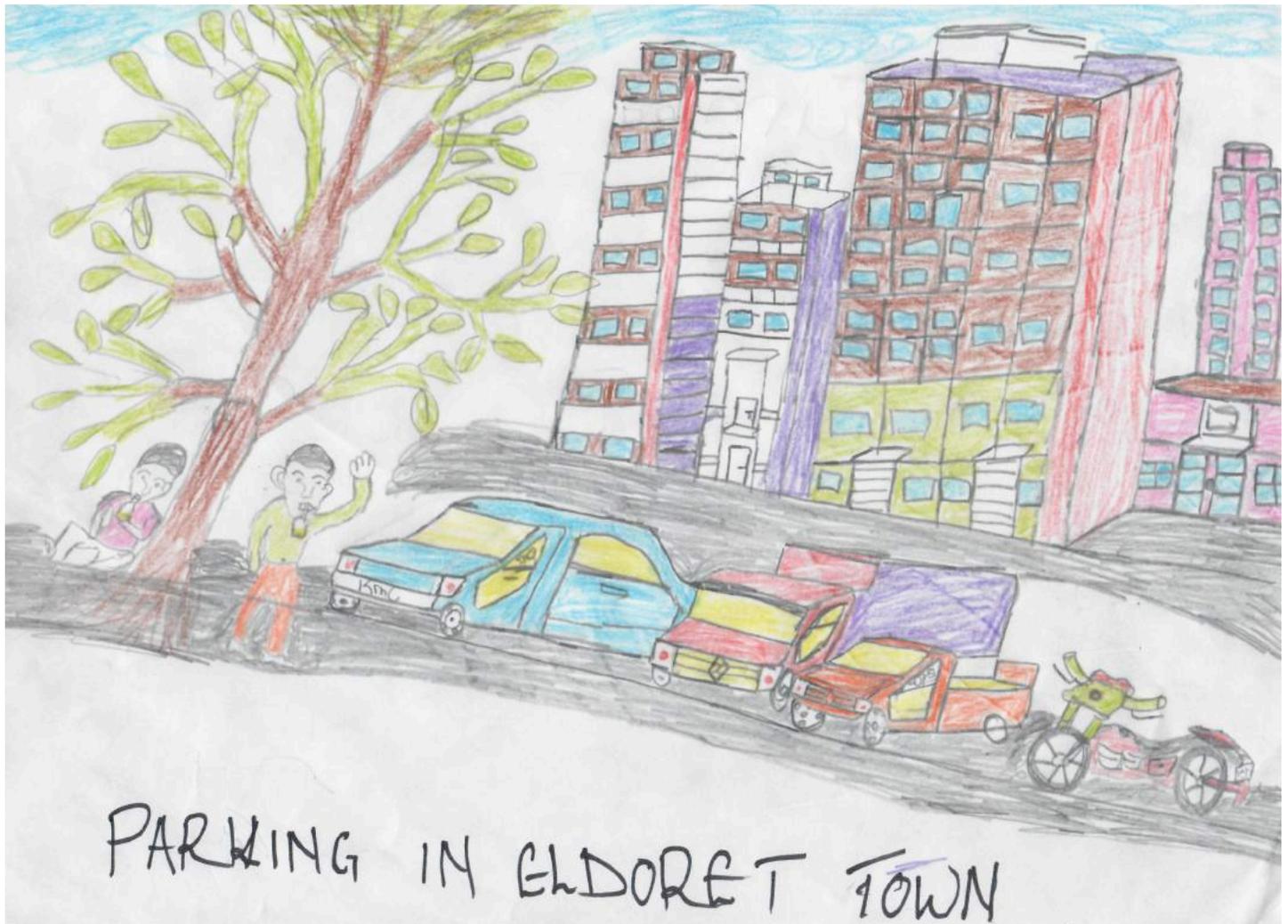
		<ul style="list-style-type: none"> Analyze results of the theater test^{[1][2][SEP]} 	
4. Production	How do you produce draft 1 and document adaptations to the evidenced-based intervention?	<ul style="list-style-type: none"> Produce draft 1 of the adapted EBI^{[1][2][SEP]} Balance priorities while maintaining fidelity to the core elements and underlying theoretic framework of the original EBI^{[1][2][SEP]} Develop an adaptation plan^{[1][2][SEP]} Develop quality assurance and process measures^{[1][2][SEP]} 	<ul style="list-style-type: none"> Produced draft 1 of the adapted EBI in an iterative process
5. Topical Experts	Who can help adapt the evidenced-based intervention?	<ul style="list-style-type: none"> Identify topical experts^{[1][2][SEP]} Actively involve topical experts in adapting the EBI^{[1][2][SEP]} 	<ul style="list-style-type: none"> Street-connected young people aged 16-24 became our topical experts Hosted community meetings with street community and representatives invited to participate in FGDs and working groups FGDs and working groups further adapt program based on feedback Street-connected young people illustrate new manual.
6. Integration	What is going to be included in the adapted evidenced-based intervention to be piloted?	<ul style="list-style-type: none"> Integrate content from topical experts based on the capacity of the agency, and create draft 2 of the adapted EBI^{[1][2][SEP]} Integrate scales that assess new intervention content in study survey^{[1][2][SEP]} 	<ul style="list-style-type: none"> We assessed our resources and ability to integrate content from topical experts Created draft 2 of the adapted evidenced-based intervention.
7. Training	Who needs to be	<ul style="list-style-type: none"> Train staff to implement draft #3 of the 	<ul style="list-style-type: none"> We integrated training into Step 3

	trained?	adapted EBI, including recruiters, facilitators, and assessment and data management staff	Administration over the course of 4 weeks with the Peer Facilitators
8. Testing	Was the adaptation successful and did it enhance short-term outcomes?	<ul style="list-style-type: none"> • Test draft 3 of the adapted EBI as part of a pilot study • Analyze results of the pilot study and use results in phase 2 study • Analyze results of the phase 2b study to determine efficacy 	<ul style="list-style-type: none"> • We tested the adapted evidenced-based intervention as part of a pilot study with 80 street-connected young people from September 2017-January 2018. • On-going analysis to determine the effectiveness of the pilot with street-connected young people • On-going analysis to evaluate the pilot and impacts on Peer Facilitators and participants.

Appendix III: The *Stepping Stones* ya *Mshefa na Kujijenga Kimaisha* Manuals

Stepping Stones ya Mshefa & Kujijenga Kimaisha

A training manual for sexual and reproductive health, communication, relationships, livelihoods and economic strengthening for street-connected young people



Stepping Stones on the Streets and Strengthening Livelihoods for Street-Connected Young People

Kenyan Streets Edition By:

Lonnie Embleton, Sharon Naliaka, Winnie 'Eunice' Nafula, Evans Odep Okal & Duncan Ronga

Cover Illustration By: Edwin Juma

Adapted from the South African Stepping Stones And Creating Futures manuals

Stepping Stones by: Alice Welbourn

Edition III South Africa: Rachel Jewkes, Mzikazi Nduna and Nwabisa Jama

Creating Futures: Andrew Gibbs, Nwabisa Jama- Shai, Laura Washington

OVERVIEW

This training manual has been adapted from Stepping Stones (Edition III South Africa), a sexual health, gender, and HIV prevention program, and Creating Futures, a livelihood program designed to build on Stepping Stones, for young people living in urban informal settlements in South Africa. "Stepping Stones ya Mshefa na Kujijenga Kimaisha / Stepping Stones on the Streets and Strengthening Livelihoods for Street-connected Young People " was adapted using community-based participatory methods with healthcare workers, stakeholders, and current and former street-connected young people in Kenya. The program was altered and re-developed for use with street-connected young people in the social, cultural and economic context of Kenya. The program integrates situations and scenarios common to the street community and local context. The manual has extensively been integrated with Sheng and Swahili to reflect the mixed use of English, Sheng, and Swahili in Kenya, particularly among street-connected young people. The majority of exercises have been adapted to solely utilize dialogue and drawing, given the extremely low literacy among this population. As part of the participatory approach to creating this adapted program, street-connected young people illustrated this manual to reflect their lives on the streets and to include imagery they identify with. While the focus of this manual is street-connected young people, the manual could be also used with other groups of marginalized young people in Kenya, so long as they are prepared to meet together for the workshops and share aspects of their lives. The combined manual is meant to run over 14 weeks in the sequence of exercises and sessions presented here. Part 1 of the manual covers 'Stepping Stones ya Mshefa' and Part 2 'Kujijenga Kimaisha'.



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INTRODUCTION

This adapted manual combines the Stepping Stones and Creating Futures programs into a comprehensive program for street-connected young people named '*Stepping Stones ya Mshefa & Kujijenga Kimaisha*'. Part 1 commences with the *Stepping Stones ya Mshefa* program, followed by *Kujijenga Kimaisha* in Part 2. The combined manual is meant to run over 14 weeks in the sequence of exercises and sessions presented here. Each session is intended to build on the previous ones. It is important to follow the sequence of exercises in the sessions and not to use the manual like a recipe book, picking and choosing exercises. The earlier exercises build up to working through some difficult issues. Missing out those earlier exercises might make it difficult for participants to cope well with the harder, later exercises. Missing the later exercises would mean that participants would miss out on key skills to help them to put their knowledge and ideas into practice. The whole program aims to enable individuals, their peers, and their communities to change their behaviour and build themselves up (*Kujijenga Kimaisha*), individually and together, through the '*Stepping Stones*' or '*building blocks*' (*Kujenga* means to build in English) that each session provides.

The manual is based on the assumption that community-wide change is best achieved through a personal commitment to change from each of its members. This demands some effort from each participant involved in the workshop and, as we explain below, participants are strongly encouraged to make a commitment to attend all the sessions.

This manual integrates a matched-savings '*chama*' (group) program called '*Kudouble Savings*' that is meant to run concurrently in conjunction with attendance at the full program. Participants join a matched-savings *chama* in their first session (A.9). An individual's savings are matched, based on weekly attendance at all sessions. In Kenya, group-led savings approaches at the community-level provide a means of accruing savings, investing, and lending without the formality of institutional banking that may not be accessible to marginalized proportions of the population. Matched-savings *chamas* are intended to have a positive impact on street-connected young people's HIV risk behaviours through three pathways. First, group-led savings will enhance social cohesion among group members and promote positive peer support. Second, savings will be matched for each individual in the group based on their individual weekly attendance at both sessions (a participant *must* attend the intervention sessions to be eligible for matching). This will motivate everyone to attend each session, which will enhance their HIV knowledge, attitudes and give them the tools to change their behaviours. Lastly, group-led matched-savings will help street-connected young people build capacity to accrue savings over the course of the intervention. This will provide them a significant boost to kick-start their group-savings that can be used by group members to start small businesses and work towards their livelihood strengthening goals in the *Kujijenga Kimaisha* program.

A key aim of the *Stepping Stones ya Mshefa and Kujijenga Kimaisha* intervention is to address gender inequality and livelihood insecurity as a foundation for reducing HIV related risks. The differences between street-connected young men and women in the opportunities afforded to them, their levels of health and wellbeing, and street community, societal, and family expectations, not only affect gender equality but also have a great impact on the responses of men and women to the intervention. It is important that facilitators carry this awareness with them while running the intervention.

What is Stepping Stones?

Stepping Stones is a workshop series designed as a tool to help promote sexual health, improve psychological well-being and prevent HIV. The workshops address questions of gender, sexuality, HIV/AIDS, gender violence, communication and relationship skills. In doing so they recognize that our sexual lives are embedded in a broader context of our relationships with our partners, families and the community or society in which we live – particularly for young people living and working on the streets. The context in which we find ourselves in, strongly influences how we act, the possibilities open to us, and our ability to make safe and healthy choices. Knowledge is important, but to make changes in our lives we need more than knowledge, for example if we do not communicate well with our partner, or we fear being beaten or abandoned, or feel constrained by our culture or religion, we may not be able to use condoms. Sometimes we try to say what we want but are not listened to. There are many programs that are aimed at helping participants practice safer sex and protect themselves from HIV, but Stepping Stones is different in its approach. Other programs often emphasise building knowledge and changing attitudes, in the belief that if these change, behaviour change will follow. But behaviour change is often more complicated than this. We may have knowledge and a desire to do certain things, such as use condoms, that we cannot or do not implement this in practice. Sometimes the first change to occur is in practices, and then attitude change comes afterwards. For example, if we use a condom successfully we may become less hostile to condom use. Similarly if we provide care for a relative with HIV, we can change our ideas about HIV and stigma.

Stepping Stones workshops provide opportunities for participants to examine their values and attitudes towards gender and relationships, to build on their knowledge on aspects of sexuality and HIV/AIDS and to develop skills to help them communicate with others and ensure that other people know exactly what they want. The workshops are based on participatory learning approaches, as we all know that we learn better when we have our knowledge affirmed and are able to discuss and decide things for ourselves, rather than just receiving lectures.



What is 'Kujijenga Kimaisha'?

Kujijenga Kimaisha was adapted from Creating Futures, a livelihood-strengthening program developed in South Africa and implemented with young people (18-24 years) living in urban informal settlements. Creating Futures is a programme designed to enhance the ability of young people to think more critically in appraising opportunities and challenges related to their lives and livelihoods. Creating Futures is designed to be facilitated by trained peer facilitators in a participatory style, encouraging participants to seek and develop relevant livelihoods for themselves through their own learning. Creating Futures was explicitly developed for implementation together with the South Africa Stepping Stones intervention, a rigorously tested HIV prevention intervention aimed at improving sexual health through building stronger, communicative and more gender equitable relationships.

Kujijenga Kimaisha was adapted from Creating Futures over the course of 4 months with street-connected young people in Kenya. Working with Peer Facilitators, mobilizing and engaging the street community, and conducting working groups with street-connected young people, we adapted the program for the context of the streets and street-connected young people's lives in Kenya. This is reflected through the stories, scenarios, language, and imagery adapted for use with street youth. The program was adapted to be primarily dialogical, given the extremely low literacy levels among street-connected young people in this setting. Given the need for survival on the streets, the program was altered to encourage participants to work towards an income generating activity goal in conjunction with the matched-savings *chamas* that are structured to commence at the outset of *Stepping Stones ya Mshefa*.

The Creating Futures manual is not tailored for male and female groups, yet there are often gender differences in the priorities of women and men in their decision-making, in the opportunities afforded to them as well as education and work and therefore how they will respond to the manual during sessions. In *Kujijenga Kimaisha*, separate male and female groups established at the outset of the program in the *Stepping Stones ya Mshefa* sessions are meant to continue for the duration of the program. Historically it has been difficult for women to lead independent lives and gain access to education, work or self-reliance, and this still applies in some contexts. Moreover, societal expectations and assumptions related to women getting married and depending on their husbands for material and physical wellbeing remain. Men are often expected to be providers despite facing socio-economic and political challenges. These expectations shape not only young peoples' opportunities, but also their own aspirations and choices. Encouraging young people to think critically about these should be facilitated where appropriate throughout Creating Futures.



How is this program different?

Focus on skills building: The program provides knowledge and enables participants to explore and question their attitudes, but the focus of the program is not on these, but on skills building. The skills built during the program are: critical reflection, communication, relationship, negotiation, condom use skills, savings, realistic goal setting, and using ones talents to secure livelihoods.

Use of participatory learning approaches: there is no didactic teaching (classroom style) in the program. We explore, affirm and supplement existing knowledge of participants. The program is primarily conducted through dialogue, role-play, games, and drawing exercises. Participants explore their existing knowledge and facilitators help guide them along the way to explore new ideas and concepts.

Flexibility: Stepping Stones has been used successfully in all global regions and with all age groups. The secret lies in the participatory methods because these mean that the participants themselves determine what is the focus of the discussion in each exercise and can tailor it to their lives and culture.

Focus on gender: Stepping Stones is a gender transformative intervention. It enables participants to reflect on who they are as men and women, what ideas they have about how men and women should be, how they relate to the other gender, and how fair this is. The Stepping Stones program promotes gender equity and helps participants explore in their lives how their relations could be more fair and equitable.

Focus on communication: communication about sex is often difficult. If we learn to talk about sex among our peers, it's easier to do so with our partners or when advising others in our families. Stepping Stones also provides skills for helping us express what we want to say, even on difficult subjects, in a way that is assertive and should be effective but not threatening to another person.

Emphasis on empowerment: real power doesn't come from being told what to do but being enabled to analyse a situation and work out the best choices for oneself. Stepping Stones shows participants how to discuss and decide for themselves what they can do to improve their relationships and their lives. In that way it provides benefits for participants that can be applied in areas of life far beyond the scope of the material discussed in the programme.

Focus on achievable goals: Kujijenga Kimaisha provides participants the framework and guidance to focus on an achievable goal to strengthen their livelihood opportunities. Street-connected young people have a variety of talents and skills to draw. This program gives them the opportunity to focus on a small achievable goal and work towards lifting themselves up and transitioning off the streets.

Supported by research evidence: the effectiveness of Stepping Stones has been shown in many different settings in different parts of the world. The biggest study was in rural South Africa and involved 2800 young men and women. Benefits of reduced sexually transmitted infections and less perpetration of intimate partner violence were demonstrated two years after the intervention. Most recently, Stepping Stones and Creating Futures was tested with out-of-school young people living in informal settlements in South Africa. The combined program had a positive impact on gender relations, livelihoods and saw changes in sexual health practices.

FACILITATING STEPPING STONES YA MSHEFA & KUJIGENA KIMAISHA

For *this streets version*, it is highly recommended that facilitators have experience working with street-connected young people, and that they themselves have experience with street life. We recommend Peer Facilitators from the streets be paired with a Young-Adult Facilitator of the same gender and similar age, but different socio-economic status (completed of secondary school) to facilitate the program with street-connected young people. In our experience adapting and piloting the combined program, we had four young people (19-23 years) all with extensive street experience facilitate the program; two of the facilitators had completed their secondary school education, but had grown up with experience on the streets in Kenya, and the other two had a stopped their schooling in primary and secondary respectively, and were still connected to the streets. Together these four facilitators supported each other in facilitating the program, drawing on each of their strengths and knowledge of street circumstances.

Facilitating this program demands a number of skills. These include: experience in participatory learning approaches, facilitation, communication and counselling skills, gender and sexuality awareness, livelihoods, savings groups, open-mindedness, creativity, imagination - and humour. This manual was written for people who have these skills, who work with local groups. If you have these skills and approaches, then this manual may be suitable for you. But running *Stepping Stones ya Mshefa and Kujijenga Kimaisha* is about more than just having the right skills to make the training work. It is also crucial that you have the time - and institutional support - to run the workshop over about 14 weeks.

Active facilitation of the program is vital. As a facilitator you must summarise and draw conclusions from each exercise and enable participants to summarise what they learn from each session. You also must be able to challenge participants. The key to building participants' knowledge through participatory processes is being able to challenge what is said in the groups in a way that makes participants think, rather than just saying "you are wrong". It is very important to do this as a facilitator as otherwise the group environment can potentially reinforce unhelpful attitudes or popular myths. The order of exercises in the programme is designed to help facilitators do this. It is best to draw on ideas and principles discussed in earlier sessions, to help a group question things, which are raised in later sessions.

Ideally before you begin working with this manual you should attend a training course. Otherwise, it is important that you work through the material even if it seems familiar to you. Begin by reading the whole manual, together with the colleagues you will work with to run workshops. Then try out the exercises on each other, going through in the sequence the manual suggests. This will enable you to get to know the material, to be confident in using it and think about how you may use ideas from earlier exercises in discussion of later ones.

This program is designed to challenge people's (including our own) attitudes and behaviour towards themselves and others. You are likely to find this rather frightening. You may also feel rather nervous about things going wrong, or not going according to plan. Going through it beforehand will help you work through some of your worries and identify areas that might be difficult in the community. Practising the material as if you were a participant gives you a chance to find out how it would feel to experience it at first hand. This will make you more effective as a trainer of others.

PARTICIPANTS AND GROUPS

Working with street-connected young people

Working with street-connected young people in difficult circumstances requires building trust, being non-judgemental, and flexible. We strongly recommend that this program be implemented through an organization that has an existing strong relationship with street-connected young people in the local context and that the facilitators themselves have experience with street life. Street-connected young people are often extremely marginalized and stigmatized within their communities. It is of the utmost importance to establish and build trusting relationships with this group before running the program. We recommend conducting extensive community engagement, prior to commencing the program, and carefully considering the primary concerns among street-connected young people in the local context, such as substance and alcohol use, security and safety concerns, gender issues, transportation, and other livelihood concerns. Lastly, literacy levels among street-connected young people are often low; therefore strong facilitation skills are paramount to run this program using primarily oral traditions and dialogic methods.

Groups

Stepping Stones ya Mshefa & Kujijenga Kimaisha is designed for use with people in small groups who commit to coming to the programme - **not for open meetings**. This is because it has been shown repeatedly that people share and learn best from talking first with those who are similar to them and understand their circumstances. If I am a young man living on the street (*Mshefa*¹), I am most likely to talk openly with other young men living on the streets. They are my “peer group”. Similarly if I am a young woman, my “peer group” will be other young women connected to the streets. Talking about sex is often difficult and would be much more so in large, mixed groups. Peer groups provide a safer space to express views and feelings that might be really hard to talk about to people of other generations or the opposite sex. It is also easier to build trust and confidentiality in a small group of this kind, once people have got used to working together. So we recommend strongly that you use this training material with small, single sex peer groups only, and not in open meetings.



Numbers

The ideal size for a peer group is between fifteen and twenty people. This is large enough to work with and small enough to encourage everyone’s individual involvement in the group.

Within each group of 15-20, participants should form two matched-savings chamas, forming two groups of 8-10 people. Within these groups, they will self-select to to work with peers they know, trust, and consider individuals whom they would continue to run a chama or business with after the program is complete.

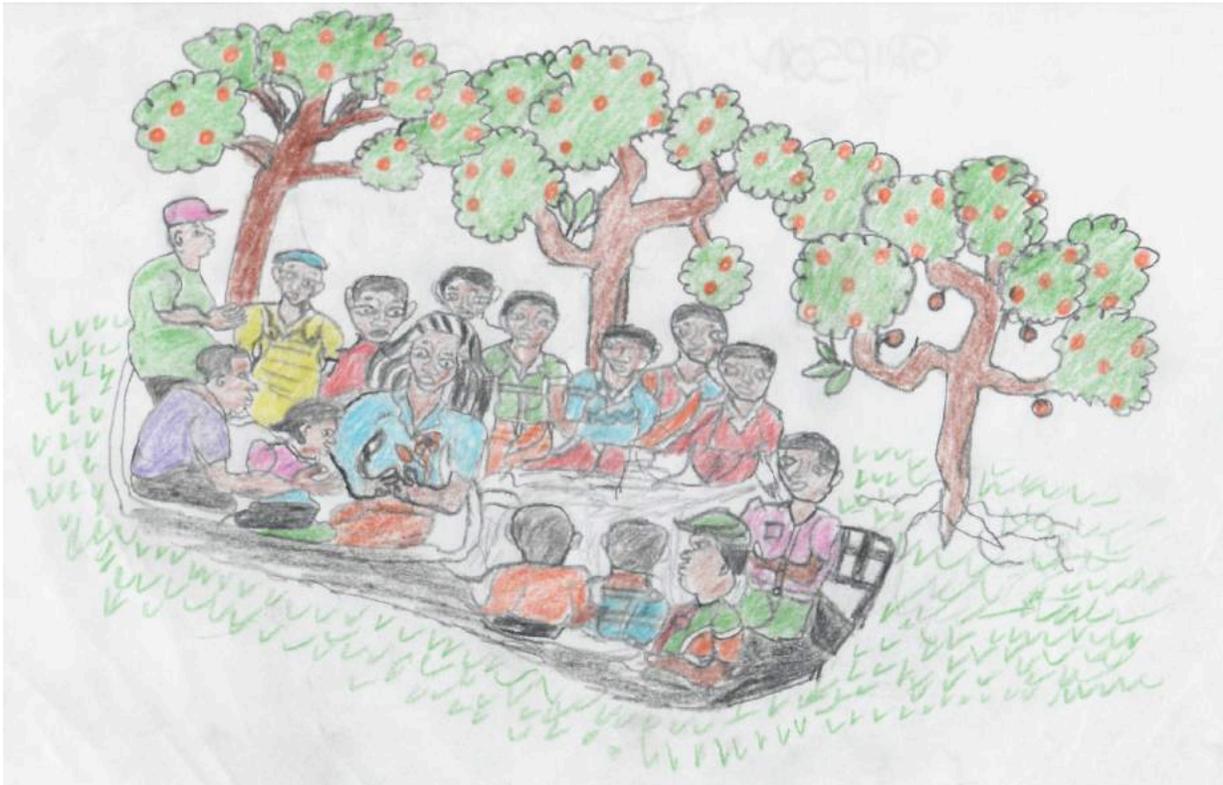
¹ *Mshefa* is a slang word that means a hustler (one who works hard to survive). It is a label used by street-connected young people themselves in Kenya.

Selection of Participants

There are no rules for selecting groups, but remember that people generally talk more freely with people like themselves. We strongly recommend that if you are running this with street-connected young people, to limit the programme to street-connected young people given their extreme marginalization and stigmatization within the community at large. Additionally, groups **must be single sex** and generally its best to keep age ranges limited. If there are great differences in your setting between e.g. married and unmarried women, then separate these in groups too. Sometimes it's hard for people who have never had sex or a boyfriend to speak out in groups with those who are sexually active, so depending on your local setting you may want to separate those as well. It is well worth taking care in choosing the peer groups and ensuring that the groups are comfortable together. Groups can be part of the power of this program because if peers as a group make a decision (or pledge) to change their behaviour in a particular way, they can help each other adhere to this commitment. Sometimes behaviour change is most difficult when we try and do it ourselves, as feel it is 'only us' who are losing out on the pleasures or benefits of the risky practice. If we do make a decision to change with our peers, it can feel a whole lot easier.

Meetings of peer groups

Ideally *Stepping Stones ya Mshefa & Kujijenga Kimaisha* will be provided to different peer groups (age and sex) in a community and these will be run approximately in parallel so that the different groups are doing the sessions at about the same time. If this is possible then it is ideal to schedule meetings where the peer groups are brought together and given an opportunity to communicate with each other about their feelings and perspectives on matters that have been explored in the workshops. This promotes communication between the different peer groups, gives a chance for group practice of assertively communication with the other sex or another age group, and provides an opportunity to build understanding across sex or age divides. We suggest holding all three peer group meetings if this is possible, and it may be useful to host a broader open final meeting more broadly to members of the street community.



WHERE

Privacy

It is a good idea to find a safe and private place to conduct the workshop. For street-connected young people it is important to find a space that they are comfortable coming to in order to be able to attend the sessions. This is very important, since street-connected young people are often discriminated against when trying to access healthcare and social services. It is unlikely that young men and women connected to the streets will attend the program if the space selected isn't safe, private, and accepting of them. You will need enough space for people to move around during the sessions.



Size

You also need to choose a location that is small enough for groups to feel comfortable during workshops but at the same time with enough space for people to move around.

WHEN

Time of Year

The timing of the workshop should bear the seasons in mind and holiday periods or migration patterns of street-connected young people. Certain times of the year, street-connected young people migrate and shift between towns and cities. If a workshop clashes with other activities in the community attendance is likely to be very low. So plan ahead to avoid this happening! Unexpected happenings, like funerals, or transport breakdown, can interrupt your schedule. So it is always a good idea to allow extra time in your schedule just in case, so that you don't find that you have run out of time.



Time of day

At what time of day you train can be just as important as where you train. The best idea is to ask different groups in the community what would be the best times for them to meet with you. You can then arrange a number of different session times, to fit in with each peer group.

Workshop Duration

We suggest that you run the full program over the course of about 14-16 weeks, on a twice-weekly basis. We recommend that you do it over this length of time, rather than as an intensive course, so that people can put what they are learning into practice in their day-to-

day lives between each session.

Duration of each session

Each session will probably last around three hours, depending on the participants. It may be the case that participants want to explore issues in more depth or that people work through the material more quickly. For this reason, we have not put time limits on the exercises. We have, however, designed the sessions so that they should take on average about three hours.

In each session we suggest you spend around:

- 20 minutes on the introduction
- 10 minutes on each of the quick warm-up and wind-down exercises
- 40-60 minutes on the longer exercises

We also suggest that, if any of the groups feel they need more time, they should be allowed the flexibility to spend more than one meeting on each session.

Pace

Each group will have its own starting point and perspective. It is important that they are given the time and space to work through the sessions and develop their understanding of all the issues at their own pace. If a group needs more time, you may need to arrange extra sessions.

HOW THE SESSIONS ARE STRUCTURED

The rest of this manual presents the sequence of sessions. Below, we run through a few basic principles upon which all the workshop sessions are designed.

Aims

The aims of each session are presented for facilitators. At the start of an exercise facilitators should not say what the aims are as they may provide constraints on discussions in the session. You can explain what the aims were when you sum up at the end of a session.

Sitting Together in a Circle and using the Maasai Talking Stick

As this program has been adapted to be primarily oral and conducted through group dialogue, it has been adapted to use a Talking Circle approach in many of the sessions. For centuries indigenous communities in North America have been coming together in a circle to solve problems within their communities, to heal spiritually, and to share their thoughts in a non-reactive



and non-hierarchical setting. The Talking Circle originated in indigenous communities in North America as a method to ensure all tribal council members were able to voice their concerns and be equally heard. Today, the Talking Circle is used in Aboriginal and non-Aboriginal communities as a method to bring people together to share, listen, gain knowledge, and foster a deeper understanding and respect for other

individuals in the Circle.

We drew on the broad principles of the traditional Talking Circle to foster dialogue, sharing, understanding, and active listening in many of the exercises in this manual. Typically, an object of importance, traditionally an eagle feather, talking stick, or stone, is held by the person speaking, and is circulated clockwise around the Circle, person-by-person. In our setting we used a beaded 'Maasai Stick' or 'Rungu', which signifies respect (*heshima*) in Kenyan culture. Only one person at a time can speak when the sacred object, is in their possession. The use of the Circle, creates a safe space, cultivates equality, active listening, suspends judgement, and fosters respect while in the Circle. Participants are made aware that all information shared in the Circle remains in the Circle. The Talking Circle can enable individuals to gain a newfound collective knowledge, as participants have an opportunity to understand and respect their peers in a safe setting, while reflecting on what they've heard without reacting, which may bring about a transformative change.

Emphasis on we and us, not they and them

Throughout the text we have used the words "we", "us" and "our" and have tried to avoid "they", "them" and "their" in talking about concerns and dilemmas to make the point that we all benefit from listening and understanding ourselves and others. If you use the words "we", "us" and "our" during your sessions, you will find that your participants will quickly develop confidence in you as someone who is willing to reflect and to share.

No note-taking

Please discourage note-taking during the sessions very strongly. Nobody needs any pen or paper, except when you provide it for particular drawing sessions. Note-taking can be very unsettling for other members of the group, particularly when people are talking about sensitive or private things. Also, a person who takes notes is not involving him or herself fully in the group's activities.

Using games and exercises

Many of the sessions include games and exercises, which some participants might object to as childish. Sometimes facilitators who are unfamiliar with participatory techniques prefer to have a discussion instead and find running a game or other interactive exercise a bit daunting. But a discussion is rarely as productive as an analysis of a game or an exercise. Most of the time, once people have had a go and seen how useful these techniques can be, they feel readier to continue with them in further sessions.

Role-play

The program includes a number of exercises in which participants are asked to do a role-play. Role-plays are an incredibly powerful learning tool because they require the actors to process, that is really think through, their ideas and not just repeat them. Participants remember lessons they learn through role-play long after they would have forgotten facts they taught in lectures. Acting can feel daunting for people who are not used to it, but it's amazing how quickly participants can settle into different roles. We do not provide scripts for role-plays, but have given suggestions for scenarios relevant to the context of the street community. However, you can encourage participants to come up with their own role-play scenario. Participants are always asked to draw on their own experiences for both of these. For exercises where role-play is suggested, participants should be encouraged to think of a situation of their choice, relevant to the particular exercise. Each participant should adopt a different character, so that together they can act out the situation they have chosen. What they say to each other should be agreed only roughly beforehand - it needs no written script. What is important is the spontaneity of the performance and the clarity for everyone of what is being communicated between the actors. Body language can often be as important as words in these

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scenes. A role-play really only needs to last a maximum of 4 minutes. In truth the shorter and more simple the role-play, the more effective it is in presenting a situation clearly. Longer role-plays start to ramble and the audience quickly gets lost.

Acting and role-play need no literacy skills at all. People who can't read can be just as good - or even better - at acting as can those who have had a formal education. However, they often lack confidence. So make sure that non-literate participants are given a lot of encouragement to involve themselves throughout and do not just watch quietly from the sidelines. Finally, remember to remind peer groups that when they present their role-plays or tableaux to one another, they should not think that they are having a competition! Some groups may feel nervous about performing in front of others. So each peer group should receive as much encouragement and praise as possible from the other peer groups. Everyone will be surprised by what they find they can achieve.

### **Counselling and giving advice**

Many people may wish to come and ask your advice about their own situation. You either need to refer them to someone who can give them the right help, in confidence; or you need to decide what role - if any - you want to play in personal counselling. On the whole, as a facilitator it is better not to become involved in giving personal advice to participants. This is because your relationship with the person and with the rest of the group will change as soon as you become personally drawn into individual participants' personal issues. Also, the role of a counsellor is a skilled one. Trained counsellors, for instance, do not, in general, give advice. Instead they enable their clients to decide what to do for themselves, through asking relevant questions and giving them appropriate information. You need to make the best decision on this for yourselves and your participants, depending on your own community and situation.

### **Working with the street community: initial community contact**

Before you start planning to conduct the program, we would recommend that you first meet with people who might regard themselves as community leaders to explain what you want to do. In the case of the street context, this would be "base or barracks leaders" in Kenya; other settings may have a similar social hierarchy on the streets. It is important to reach out and engage the street community and explain what you want to do. In the context of Kenya we recommend hosting a series of *mabaraza* with different groups in the street community. Additionally, we recommend reaching out to stakeholders working with street community, political leaders who may work with street-connected young people, and other groups that may be relevant. You may need to conduct several small preparatory meetings, to ensure that you have contacted everyone concerned. The more you have the leaders on your side from the beginning, the more chance you have of conducting a successful workshop. We do not recommend using this program if this is your first involvement with the street community. Establishing relationships and trust, when working with street-connected young people takes time and engagement and working with the community is paramount. So don't under-estimate the importance of this first step! Make sure you do not promise what you will not be able to deliver.

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# TRAINING FACILITATORS

Training facilitators to run the *Stepping Stones ya Mshefa and Kujijenga Kimaisha* program over the course of four to five weeks is recommended. This intensive training program ensures that facilitators have experienced the full program themselves, have gained key facilitation skills, and undergone content related training for the relevant background and expertise in a variety of topics. It is essential that facilitators have experience working with street-connected young people when running this program.

The recommended training program would be structured as follows:

**Week one:** Facilitators experience the whole ‘*Stepping Stones ya Mshefa*’ programme as participants.

**Week two:** this is structured to provide a depth of background information on the core areas covered by the programme so that the facilitators have expertise that is essential for authoritatively facilitating and answering questions arising in the session. This week should include: a discussion of gender inequity and relations, understanding of gender-based violence, laws related to this and services and sources of help; detailed understanding of HIV transmission, of the progression to AIDS, stigma, signs of opportunistic infections, anti-retroviral and other treatment and availability of testing; all about contraception, conception, pregnancy confirmation and termination, menstruation, reproductive anatomy and basic physiology; male and female condoms; sexually transmitted infections; understanding motivations for sex – alcohol and transactional sex. This week can also be used to help build non-judgemental attitudes among facilitators. Depending on your setting it may be useful to invite guest speakers in to talk about issues such as having HIV, being gay or lesbian, having an abortion, or being a sex worker.

**Week three:** Facilitators experience the whole strengthening livelihoods program, ‘*Kujijenga Kimaisha*’

**Week four:** Facilitators conduct mock facilitation sessions for the program. Two sessions from each program should be selected, and facilitators invite guests/colleagues to experience facilitating sessions. They should be given feedback and guidance on their facilitation skills as well as using this as a chance to discuss how the work will be organized and sources of information to support problem solving in the groups.

**Facilitator support:** Ideally facilitators should receive support sessions once a week to allow for challenges to be shared, materials refreshed and debriefing where necessary.

**Facilitator preparation:** It will be necessary for facilitators to read and familiarise themselves with each session before running it as the notes are quite detailed and are intended to cover a specific set of topics.

**Facilitators supporting participants:** Supporting people to think more critically is the core aim of the intervention, and therefore an understanding of contextual challenges facing participants is of great value for facilitators. Further, where possible and/or when funding permits, it would be ideal for facilitators to provide additional communication and support outside the sessions and after the end of the intervention. This could be in the form of, for example, telephone calls or one-on-one discussions. This is of course more easily accomplished in situations where facilitators live in the same community as participants.

## SESSION A: LET'S COMMUNICATE / TUBONGE

**PURPOSE:** To help a peer group form itself. To help participants develop skills of listening and analysis of communication and cooperation. There are a lot of exercises in this session, but most are very short. We recommend that you spend about 1 hour and 45 mins on A1-A6 and then have a short break before A7, A8, and A.9 which will take 1 hour.

**MATERIALS NEEDED:** Flip chart, markers, bag of sweets, beaded Maasai stick - Rungu

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## Exercise A.1: INTRODUCING OURSELVES / KUJITAMBULISHA KIBINAFSI

**AIMS:** For the facilitator to learn the names of participants. For everyone to speak early and to laugh. To explain that participants will form a Savings Chama in this session that requires a commitment to attending all sessions.

**MATERIALS NEEDED:** Maasai Stick, Sweets

### **DIRECTIONS:**

1. Welcome everyone and coordinate having the group sit in a circle. Everyone should be at the same level, including yourself. Introduce yourself, thank everyone for coming and explain that joining the workshop requires a commitment - ask the participants again to make a commitment to coming to every meeting of their group. Explain that new things will be discussed at each meeting, which build on what has been discussed before. So it is very difficult for the group to have members missing meetings or only coming for one or two. Explain that today we are going to ask you to form a *Savings Chama* with your peers that are present, who you would like to work with in a group of 10 throughout the programme. This *Savings Chama* will have the opportunity to have its savings matched based on your weekly attendance at the workshop. In order for you to have your savings matched, it is required that you attend all sessions scheduled that week.

**Facilitator note:** Groups will form one or two matched-savings groups depending on the number of participants in the session. Each session has approximately 20 participants and will have two matched-savings *chamas* of 10 participants

2. Introduce the idea of the '*talking Maasai stick*'. The person who has the stick is able to speak, and everyone else listens and may not speak until the stick reaches them. The Maasai stick is a sign of leadership and when someone is holding it, we listen to him or her with respect.
3. Explain that you would like to learn everyone's names or street name, because you are going to be working together for several sessions and need to get to know one another. You would also like to learn something special about each participant. Start by asking each participant to think of something they like about themselves. Explain that you are going to pass a bowl of sweets around with the Maasai Stick and each person should take one sweet and say their name and something about themselves. Then pass the sweet bowl on and the stick to the next person who will speak.
4. Begin the game by holding the Maasai stick, introducing yourself and taking one sweet: e.g. I am Ngoroge and I like dancing / Mimi ni Ngoroge na napenda kudance.
5. Go round the circle, where each group member in turn introduces her/ himself to the rest of the group in this way, saying something they like about themselves and taking a sweet, while everyone else listens with respect.
6. Continue going round until the sweets are finished. It's good to make sure there are enough for about two or three sweets each.



**Facilitator Note:** If someone really can't think of anything to say about him or herself, it may be because they are shy. Bear this in mind, because they may need some help in other exercises. Help now by suggesting something and encourage others to help too. Some participants may also find it embarrassing to say something they like about themselves. Give a lot of praise and encouragement to those who are more shy, throughout the workshop.

## **Exercise A.2: EXPECTATIONS / MATARAJIO**

**AIMS:** A chance for each participant to voice their feelings about the workshop. This enables you to gauge their understanding of explanations so far, and to adjust any misunderstandings.

**DESCRIPTION:** Each participant in turn voices one hope and concern about the workshop.

**MATERIALS NEEDED:** Flip chart and markers, Maasai Stick

### **DIRECTIONS:**

1. Explain to the group that it is always a good idea for a facilitator to find out what a group is thinking and it would be nice to keep a record of this to look back on at the end.
2. Going round the circle using the Maasai stick, ask each group member in turn to express one thing they want and one they do not want from the workshop. They should be encouraged to say "I want ...." "Ninataka...or Ninatumaini" and then "I don't want..."... "Sitaki or Ninajali". Finish with your own statements as the facilitator. Do not make any comments about their wants and concerns as you go round the circle, but **record them on the flip chart.**
3. Once everyone has stated a hope (tumaini / ombi) and a fear (ngori/ogopa), you should make some comments. If any hopes are quite beyond the scope of the workshop, you should explain this now. You could also try to reassure people about their fears.
4. Ask everyone to remember what he or she has said, so that at the end of the workshop, you can review the hopes and fears all together.



## Exercise A.3: GROUND RULES / SHERIA

**AIMS:** To agree on a set of rules for the group during its time working together

**MATERIALS NEEDED:** Flip chart and markers, Maasai Stick

### DIRECTIONS:

1. Explain to the group that this is their time together and that so they can make the best of this time, it is useful for everyone to agree to some group rules.
2. **Ask the group: What should the ground rules be? / Je mashariti ya hapa yakawe aje?** - Using the Maasai stick ask everyone to go around one at a time and say one idea for a ground rule (sheria) and to explain it to the group. Write the rules suggested on a flip chart. After everyone has had a chance to suggest a rule as the full group - **Does everyone else agree? / Kila msee amekubali?** Come to a consensus as a group on the rules.
3. If there are any obvious gaps or are silences, suggest certain topics, which they may like to include:
  - Masaa – Punctuality (sign an African song if you are late)
  - Heshima - Respect for other people's views
  - Hakuna kujudge - Being non-judgmental
  - Siri – Confidentiality
  - Trusti – Trust
  - Kusikiliza – Listen
  - Active – Participate
  - Hakuna Biere hapa - No glue in the sessions
  - Do not come drunk - Usikuja kulewa
  - Give everyone a chance to talk – Pea Kila mtu fursa aonge
4. Once all the rules that the group want have been written on the flip chart, go through them again together, so that everyone is clear about them all.
5. Encourage group members to try to stick to these rules and ask them to remind you and one another if you or any of them err from them.
6. As the facilitator, you will keep the flip chart page outlining the agreed upon ground rules / sheria. You will bring it to each of your meetings, so that you always have it on hand to refer to.



## Exercise A.4: TRUST, CONFIDENTIALITY and BEING JUDGMENTAL / TRUSTI, SIRI, & HAKUNA KUJUDGE

**AIMS:** To understand what we mean by the words 'trust/trusti' and 'confidentiality/siri'. To increase awareness of the value of trust, confidentiality and being non-judgmental / hukuna kujudge. To think about how we can keep ourselves and others safe when we discuss personal things in the workshop and in our relationships

**MATERIALS NEEDED:** None – Group Discussion

### DIRECTIONS:

1. Ask the group to divide into four. Give each group one of the following health problems:
  - a) You are a 19 year old street girl who wants to have an abortion / Ni mschichana wa miaka 19 na unataka kufanya abortion / kutaa mimba.
  - b) You are a 23 year old who had unprotected sex and needs an HIV test / Uko na miaka 23 na ulifanya ngono bila kutumia kinga na unahitaji kufanya HIV test
  - c) Something is itchy in your private parts/ Kuna kitu kusichu cha kawaida na kindkwawshakwa sehemu za siri
  - d) You are being forced to work for someone doing something you don't want to do that puts your health at risk / Unalizimishwa na mtu kufanya kitu ambacho kinwezakufanya ujiweke kwenya shida
2. Tell the group that they are going to think about what they would do if they had this problem. First, discuss about who you would want to seek advice from, for example, a friend, a social worker, a family member or a health worker. Talk together about the following questions:
  - a) Who you are going to tell? / Ni nana utaambia?
  - b) Why it is that you would tell that person and not someone else? / Ni kwa nini utamwambia vyo mtu na fio mtu mwingine yeyote?
3. Call everyone back into the full circle and ask them to describe what they have discussed. Discuss the different responses and emphasize the similarities. Say that we all have secrets or embarrassing feelings in life that we would like to share with someone else, whom we feel could reassure or help us. Mention that trust (trusti), confidentiality (siri) and being non-judgmental (hakuna kujudge) are very important. This exercise shows that people take different problems to different people. We all have problems but may not have discussed them with someone yet. Ask the group to think about themselves: **do you behave in a way that helps people trust you?** (you will not have time to actually discuss this).
4. **Ask the group:** *What are the good things about telling personal stories in the group? / Ni nini kizuri?*
  - Explain that we learn a lot from talking together about our own real life experiences. It can help us understand our lives, to solve problems, to feel better and to gain strength from one another.
5. **Ask the group:** *What are the risks from telling personal stories? / Ni nini unafikiri ni risk kwa kusema stori za kibinafsi?*
  - Explain that we cannot be sure that none of us will talk to other people about our stories. If one of us tells someone a secret outside the group, someone might be angry or hurt; and a member of the group may get into trouble with a friend or spouse.

6. **Ask the group:** *How can we work in the group so that we enjoy the benefits and reduce the risks? / Tuta fanya aje kazi kwa kikundi ili kufaulu na kupunguza hatari?*
- Explain that we have heard about trust (*trusti*), confidentiality (*siri*) and non-judgement (*hakuna kujudge*) and now understand the benefits of sharing. Be that as it may, people still feel uncomfortable sharing certain things. We must care for each other and not tell private stories outside the group. We should always talk about problems in a caring way without judging or joking.
7. **Ask the group:** *What they thought the aim of the exercise was and discuss this.*



## **Exercise A.5: LISTENING PAIRS / KUSIKIA KIMOJA**

**AIMS:** *To help people realise the importance of listening skills to good communication in all life situations including relationships.*

**DESCRIPTION:** *Participants work in pairs, taking it in turns to speak. As one speaks, the other first listens carefully to what they say, then stops listening. A group session with discussion and summary follows.*

**MATERIALS NEEDED:** None

### **DIRECTIONS:**

1. Tell participants we will need to do a lot of listening to one another in this workshop. In this exercise we are going to look together at the skills of good listening.
2. Ask participants to divide into pairs, and one of them should start by describing to the other an event in their life. The listener should say nothing, but should just concentrate hard on hearing what is being said. After a couple of minutes, you will ask the listeners to stop listening by calling out "Simama". At this stage, the speaker should continue to describe their experience, but the listener should stop listening completely. The person could yawn, look elsewhere, turn round, whistle, do whatever they like: the important thing is that they should no longer listen, although the speaker should continue to tell the story.
3. After a couple of minutes again, you will call "Simama". At this stage, the speaker and listener should change roles. The two stages of the exercise should then be repeated, with the former listener now becoming the speaker and the former speaker now becoming the listener.
4. Once you are sure that everyone has understood the instructions, call out "Anza", and time each section of the exercise for two minutes. Thus the whole exercise should take eight minutes.
5. Finally call the group together and ask them to share examples of when bad communication has occurred in their lives.
6. Ask participants how they felt first as speakers, encouraging them to compare telling their story to a willing listener and telling it to a bad listener. Then ask participants to describe and compare how they felt as good and bad listeners.
7. Ask participants to describe some of the attributes of good listening, which they experienced and then some of the attributes of bad listening. Ask participants how else we communicate with one another, apart from through language. When someone mentions body language, explain that by being aware of our own body language, we can often change it, in order to communicate a different mood to others around us. This is what we are going to look at next.



## Exercise A.6: BODY LANGUAGE / KUBONGA KWA KUTUMIA VIUNGO VYO MWILI

**AIMS:** To help participants understand further the role of body language in our relationships.

**DESCRIPTION:** Through silent role-play, participants are asked to demonstrate how body language can help onlookers understand what is happening, without their hearing any words.

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Ask participants to divide into pairs, working with someone with whom they have not worked before. Each pair should think of a situation that one of them has had in a relationship, which they can act out without talking. The pair should first establish the two characters and their relationship and describe what happened. Without saying anything aloud, they should act out the situation between them, only using their bodies and faces, and with no words.
2. Give the pairs a few minutes to work on this. Then ask everyone to return to the circle. Pick out two pairs, whose scenes looked particularly clear. Ask the first chosen pair to show the others their scene by coming forward into the middle of the circle, so that everyone can see.
3. Ask members of the audience to tell the story of this pair's situation. It doesn't matter if the audience doesn't know the details, but point out how easy it can be for us to know what is going on in general through what we do with our bodies.
4. Repeat this viewing exercise with the second pair whom you have picked out.
5. Brainstorm with the participants on the kinds of emotion we can communicate with our bodies: such as pleasure, dejection, anger, submission, strength, weakness, power and so on. Ask them to add to this list, encouraging them to show different body stances to illustrate each emotion.
6. Finish by asking participants to start to think about the way that they use their own bodies to say things to one another over the next few days and weeks. Encourage them to think how they might use their bodies differently in different contexts, in order to convey different messages to people.

### **Feedback and Discussion:**

Encourage participants to be aware that we communicate and listen as much with our bodies as with our words. Explain how some body language can appear very powerful and aggressive, some can appear friendly and warm, whilst other body language can appear very weak and submissive. We say a lot with our bodies!



## Exercise A.7: LOVING ME, LOVING YOU / KUNIPENDA MIMI KUKUPENDA WEWE

**AIMS:** To build self-esteem through helping participants understand that they are all special people and have aspects of their lives that are important to them. Some parts of their lives make them happy and it is important to remember these if we are to improve their relationships.

**DESCRIPTION:** Undertaken as a group discussion

**MATERIALS NEEDED:** Maasai Stick, Flipchart, markers

### DIRECTIONS:

1. Have the group sit in a circle. Explain that using the Maasai talking stick we are going to go around one by one and tell the group **one thing they like about themselves/kitu moja unapenda kijihusu mwenyewa**. Mention that these can be their personality, appearance, or achievements.
  - As the facilitator record each participants' response on the flipchart under the heading **"Things we like about ourselves" / "Vitu ambazo tunapenda kujihusu"**
2. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group **one thing that is important to them / kitu moja ambacho ni mhimu kwao**. Mention that these can be people, relationships, values, ways they are treated or things, but do not make suggestions.
  - As the facilitator record each participants' response on the flipchart under the heading **"Things that are important to us" / "Vitu ambazo ni mhimu kwetu"**
3. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group **one thing that makes them happy / kitu moja ambacho kuna wafanya wawe na furaha**. Again, mention that these can be people, values, relationships, things etc.
  - As the facilitator record each participants' response on the flipchart under the heading **"Things that make us happy" / "Vitu ambavyo vinafanya kuwa wachangamtu"**
4. **Facilitator Discussion:**
  - Mention that it is very important for us to think about what is important to us and what makes us happy.
  - We often accept situations that we are unhappy in. In Stepping Stones we will explore ways and develop skills for communicating that can help us change situations in which we are unhappy to happier ones.
  - The path to happiness and having better relationships with people around us has to start with understanding that we are all special people and recognizing what makes us happy, then we can determine the route we should follow to make our lives happier.



## Exercise A.8: MY GOALS IN LIFE / LENGO LANGU LA MAISHA

**AIMS:** For participants to think about what they want from life and what they will need to do to achieve these goals

**DESCRIPTION:** Exercise undertaken by participants as a group discussion

**MATERIALS NEEDED:** Maasai Stick, Flipchart, Markers

### DIRECTIONS:

1. Prepare a flipchart page with four quarters. Give the quarters headings "*Familia/Family*", "*Kazi/Work*", "*Training/Mafunzo*", and "*Social/Kijamii*"
2. Have the group sit in a circle. Explain that using the Maasai talking stick we are going to go around one by one and tell the group *one goal in relation to their family/lengo moja lina lohisioana na familia yako*.
  - As the facilitator record each participants' response on the flipchart under the heading "*Familia*"
3. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group *one goal in relation to kazi/work – moja kwa moja unambie kundi lengo moja lina lengo na kazi*.
  - As the facilitator record each participants' response on the flipchart under the heading "*Kazi*"
4. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group *one goal in relation to training / moja kwa moja uambie kundi lengo moja lina lohosiana na mafunzo*.
  - As the facilitator record each participants' response on the flipchart under the heading "*training*"
5. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group *one goal in relation to social life / moja kwa moja uambie kundi lengo moja lina lohosiana na rasilimali ya maisha*.
  - As the facilitator record each participants' response on the flipchart under the heading "*Social Life / Kijamii*"
6. Place the flipchart on the wall. Take another piece and title it "*What will enable me to achieve my goals*" / "*Ni kinaweza nisaidia nifikie lego langu?*"
7. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group *what will enable them to achieve their goals*.
  - As the facilitator record each participants' response on the flipchart under the heading "*What will enable me to achieve my goals*" / "*Ni nini kinaweza nisaidia nifikie lego langu*"
8. Place the flipchart on the wall. Take another piece and title it "*What will prevent me from achieving my*

goals"/ "Ni nini kinanizuia mimi nisiweze kufikia lengo langu"

9. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group *what will prevent me from achieving my goals*.
  - As the facilitator record each participants' response on the flipchart under the heading "*What will prevent me from achieving my goals*" / "*Ni nini kinaweza nizuia mimi ili nisiweze kufikia lengo langu*"
10. Place the flipchart on the wall. Take another piece and title it "Overcoming obstacles to achieve goals" / "Kushinda vizuizi ili kufikia lengo"
11. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group how can these obstacles be prevented or overcome.
  - As the facilitator record each participants' response on the flipchart under the heading "Overcoming obstacles to achieve goals" / "Kushinda vizuizi ili kufikia lego letu"

**FACILITATOR DISCUSSION:** As the facilitator you will now lead a summary discussion.

- Explain that it is very important for us all to have goals in life and to think about how we can achieve them and what may prevent us from doing this. This is essential if we are to work out how we can best achieve our goals.
- Mention that good health is important for achieving our goals. Also mention that people with poor health also have goals in life and its important for them also to try and achieve these. We hope that this program will provide skills that will help everyone achieve their goals.





## EXERCISE A.9: FORMING A MATCHED-SAVINGS CHAMA / KUDOUBLE SAVINGS

**AIMS:** To form a chama for the duration of the program with people that you think you would like to continue having a chama with after the program ends.

**MATERIALS NEEDED:** None

### DIRECTIONS:

1. Explain that now we will form one or two chamas within our group. Explain that these chamas will work as a savings plan for the duration of the program and will function a bit differently than the chamas they may be used to.
2. Each group will have to nominate a representative. Tell the groups they have to come to a consensus about who will be their nominated representative for the duration of the program. The representative will communicate with the "program banker" and coordinate the group. The "program banker" will keep track of each participant's weekly contributions. Explain that participants can contribute between 25 to 200 Kenyan Shillings each week, but should decide as a group how much they will all try to contribute.
3. Explain that a participant's savings will be matched, when that individual attends all sessions that week. Attendance will be recorded on arrival.
4. For example if you attend Monday and Wednesday and you contribute 50 Shillings that week, the program banker will match your 50 Shillings for a total savings of 100 Shillings.
5. This can happen every week until the end of the program. If you do not participate or attend the sessions that week, your savings will not be matched.
6. At the end of the program each individual will receive their savings to invest in an income-generating activity or the group can decide to make a group investment or loan to an individual and continue with the Chama after the end of the program.
7. Ask participants to line up with the "Program banker" in their groups to register their group and indicate the amount they are aiming to contribute on a weekly basis.



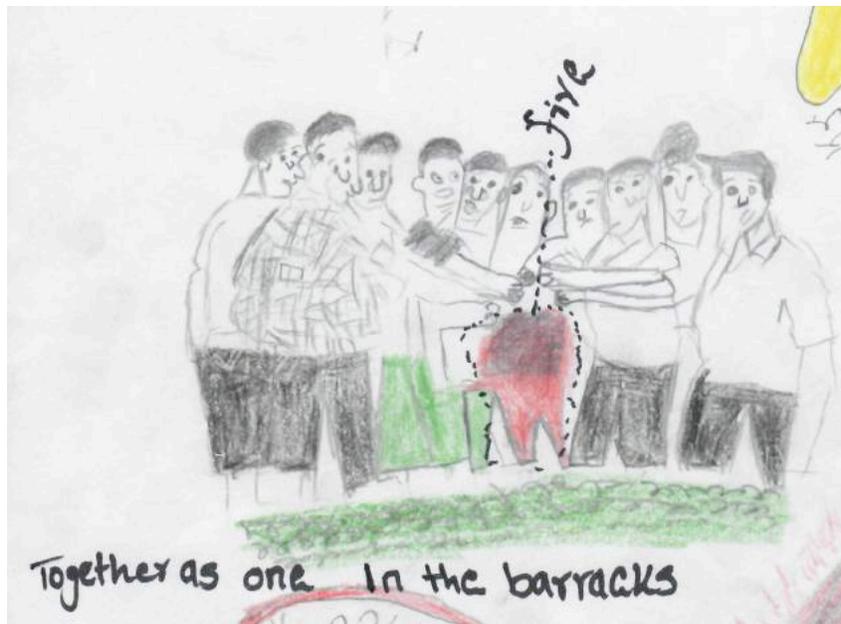
## Exercise A.10: HAND IN HAND / MKONO KWA MKONO

**AIMS:** Winding down exercise.

**MATERIALS NEEDED:** None

### DIRECTIONS:

1. Explain that the time for this session has now run out and that we are going to finish with a closing circle to review this session.
2. Everyone stands in a tight circle. Ask the first person to your left to put their right outstretched arm into the middle of the circle and say something they have found difficult about the session and then something that they have found good about the session. Ask her/ him to use the phrases: "I didn't like it when.....", "Sipendi wakati...." followed by "I liked it when...." "Napenda wakati..."
3. Ask the person two to your left to also do this, placing their right hand on top of the hand already in the middle, and also saying one thing they found difficult and one thing they found good about the session and one thing they will share.
4. Continue round until all the participants have their right hands placed in a tower on top of one another in the circle, and everyone has said something, which they found difficult, followed by something which they found good about the group.
5. Finish by saying that this tower of hands can represent our strength together as a group.
6. Thank everyone for coming. Fix with them a time and place for the next session, which they can all manage. Ask them to remind one other to come on time.



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## SESSION B: HOW WE ACT / JINSIA

**PURPOSE:** To help participants explore images and realities of the ideal man and woman and how these are shaped by the actions of all of us and what implications this can have for the individuals concerned.

**MATERIALS NEEDED:** Flip chart and pens

### CONTENTS:

#### INTRODUCTION

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### INTRODUCTION

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Using the Maasai stick, have everyone go around once and recount quickly one good thing that has happened to them since the last session.
4. Review the last session. Ask participants to recall what we learnt together at the last session – that we are all special people, about what makes us happy, what our goals are in life and some of the things that may stop us achieving them... Remind them if they have forgotten.
5. Explain that we are going on to discuss other things in this session, but will start with a game.



## Exercise B.1: MIME THE LIE / MCHEZO UNAUSEMA KITU AMBACHO HUFANYI KWA SAHIZO

**AIMS:** Warm-up game. Shows that what people say they are doing is not necessarily what they are really doing!

**DESCRIPTION:** Each person (one at a time) mimes an action without speaking and, when asked, says they are doing something else.

**MATERIALS NEEDED:** None

### DIRECTIONS:

1. Stand in a circle. As the facilitator go into the middle of the circle and mime an action, such as eating. Ask the person who was next to you in the circle to ask you aloud "what you are doing?/Ni nini unafanya?". You reply by saying out loud, for example, "I am digging the ground!/Nalima shamba!" Everyone will laugh!
2. Next, ask the person who asked you "What are you doing/Unafanya nini?" to now to enter the circle and to mime what you said you were doing – ie. "Digging in the ground/Nalima shamba"
3. Then their neighbour asks what they are doing and that person also says something different, and so the game continues, until everyone in the circle has had a go at doing one thing and saying they are doing something else.
4. **Ask the group:** What does this game have to do with sexual health? / Je hii mchezo inauhusianaje na sexual health?

**Explain:** We often say we are doing one thing in our sexual lives whereas in fact we are doing another. This secrecy makes it more difficult to practice safer sex.

**For example:** A person might say they always use a CD when having sex, but in reality they don't / Mtu anaweza sema huwa anatumia CD wakati anaposhiriki ngono, lakini ukweli.





## Exercise B.2: MEN AND WOMEN / WANAUME NA WANAWAKE

**AIMS:** To explore people's perceptions of the ideal man and woman and how different men and women can be in reality.

**DESCRIPTION:** Group discussion

**MATERIALS NEEDED:** Flip chart and markers, Maasai Stick

### DIRECTIONS:

1. Explain that we are now moving on to explore how different people in our society are expected to behave.
2. As the facilitator, on a flip chart divide the paper into two columns.
  - In this first column, write **"how people of their own age and gender are expected to behave in their communities, among peers, and in relationships"**
3. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group one way in which they are expected to behave in the community, among peers, and in relationship.
  - As the facilitator record each participants' response on the flipchart under the heading
4. After the participants have each had a chance to say one thing, in the second column write **"What you are expected to say and do, or not say and do in relationships/Ni nini unatarajiwa kufanya na kusema ama kutosema na kufanya kwa uhusiano"**
5. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group what you are expected to say and do or not say and do in a relationship.
  - As the facilitator record each participants' response on the flipchart under the heading
6. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group one way in which the **OPPOSITE GENDER / KIJUME JINSIA** are **expected to behave in the community, among peers, and in relationship.**
  - As the facilitator record each participants' response on the flipchart under the heading
7. Explain that now using the Maasai talking stick we are going to go around again one by one and tell the group what the **OPPOSITE GENDER** are **expected to say and do or not say and do in a relationship.**
  - As the facilitator record each participants' response on the flipchart under the heading
8. Now facilitate a group discussion about the situation for people of their gender and then of the other gender.

### Ask participants/Uliza:

- Is it easier to live as a man or women in our community? / Je ni rahisi kuishi kama mwanaume ama

mwanawake kwa jamii?

- Are the differences fair? / Utafauti ni sawa?
- Do we all want to live as men and women are expected to by others? / Sisi wote fundhitajika kuishi kama wanaume na wanawake tunavyotarajiwa na wengine?
- Do these ideas and expectations make us happy or unhappy? / Je hizo wazo na matarjio inatufanya tuwe wachangamfu au la?
- Do these differences influence our ability to achieve our life goals? / Je hizi utafauti ina ushawisi opi kwa uwezo kufikia lengo la maisha?

**9. FACILITATOR DISCUSSION POINTS:** As the facilitator you will now summarize the discussion and discuss the following concepts....

- The idea of this exercise is to help people to appreciate that there are expectations in our families, by peers, in the community and in relationships of how we should behave.
- These are **different for men and women**. They place different pressures on us, as well as providing us with different opportunities. Sometimes we are under pressure to behave in ways that we do not want to behave, that don't make us happy and may undermine our ability to achieve our goals in life.
- Generally **men** are privileged and have control over their relationships with women, but they may have other disadvantages.
- **Men** may be expected to be strong and tough and, for example drink a lot and settle arguments with a fight, but some men do not want to behave like that and would rather help their mothers or grannies at home and may be called names for doing this.
- **Women** may be expected to be submissive and help most at home. This can make them feel happy because they receive appreciation for their help or very unhappy because they feel they have little control over their life.





## Exercise B.3: IMAGES OF OTHERS / MIFANO YA WENGINE

**AIMS:** The aim of the exercise is also to show how we and others influence the way men and women act and learn about how they should act.

**DESCRIPTION:** Group exercise of advice giving and discussion. One person will sit in the middle of the group and receive advice from others about a topic related to their lives on the street.

**MATERIALS NEEDED:** None

### DIRECTIONS:

1. Explain that the previous exercise raised difficult issues about how society expects us to behave and in this exercise we want to understand more about how people influence the way we act.
2. Ask participants to sit in a semi-circle. Invite a volunteer to sit in the middle and to adopt a character of the **same gender and age** as the participants.
3. Explain that you are going to talk of the theme of glue / biere / gum
4. Ask the other participants to choose a character who would have an influence on this person. Go round the semi-circle and ask each person which role they have chosen. Explain that that one or two participants give advice as themselves (or someone like themselves) as Mshefa.
  - **For example:** Pastor, Mwalimu, Doktari, Counselor, Nurse, Social Worker, Mshefa
5. Explain to the group that each in turn should tell the person in the middle how they should act. In doing so they should state the roles from which they speak. Encourage one person to start, for example, by saying "**I am a Pastor and I am telling you using glue is sinful**".
6. **Ask the person in the middle:**
  - What do you think motivated each of the people giving you the advice? / Ni nini haswa unafikiri kimewapa motisha wale watu wanaokupa mawaidha?
  - How does it feel to be given advice from all these different sources? / Unajiskiaje aje kupewa mawaidha kutokana wale watu?
  - Whose advice are you going to take? / Ni mawaidha ni yapi utakayoyafuata?
  - How does the different advice fit in with your life and values? / Je hayo mawaidha tufautitofauti uliyoyapata unafikiri inakufaa aje kimaisha?
7. Repeat the process with different participants in the middle and volunteers giving advice on 3-4 different subjects listed below:
  - Using a condom and practicing safe sex / Kutumia CD na kujaribu ngono sawa
  - Drinking chang'aa and busaa / Kunywa kusamba chang'aa na busaa
  - Being on the streets and hustling / Kua mtaani na kuhustle
  - Dealing with an unwanted pregnancy / Kupambana na mimba isiyohitajika

- 
8. Then ask the group to change the situation and have a new person in the middle act someone of the same age as themselves but of the **OPPOSITE GENDER**.
  9. Ask the other participants to choose a character who would have an influence on this person. Go round the semi-circle and ask each person which role they have chosen. Explain that that one or two participants give advice as themselves (or someone like themselves) as Mshefa.
    - **For example:** Pastor, Mwalimu, Doktari, Counselor, Nurse, Social Worker, Mshefa
  10. Explain to the group that each in turn should tell the person in the middle how they should act using the topics listed below:
    - Using a condom and practicing safe sex
    - Drinking chang'aa and busaa
    - Being on the streets and hustling
    - Dealing with an unwanted pregnancy
  11. **Ask the person in the middle:**
    - What do you think motivated each of the people giving you the advice? / Nini unafikiri inawapa mafisha wale wanaokupa mawaitha?
    - How does it feel to be given advice from all these different sources? / Unaskiaje kupewa mawaitha na watu tufauti?
    - Whose advice are you going to take? / Je haya mawaitha unaenda kuchukuwa?
    - How does the different advice fit in with your life and values? / Je haya mawaitha tofauti inakufaa wawe kidiafusi?
  12. **FACILITATOR DISCUSSION POINTS:** As the facilitator you will now summarize the discussion and discuss the following concepts....
    - What do we learn from this about how we influence the behaviour of others? / Je kunakifunza nini kwa kuiya tabea za wegine?
    - Encourage the group to think about how they themselves give advice to people and the influence they can have on others.
    - In what ways have we shown that our influences are harmful to the people we interact with? / Ni njia zipi zimeonyesha kuwa ushawishi wtu ni ya kudhuru watu ambao wanaongea nasi?
    - Do we give different advice to people based on their gender? / Je tunapatiana mawaidha tofauti kuligana na jinsia?



## Exercise B.4: BODY MAPPING / SEHEMU ZA MWILI

**AIMS:** To introduce participants in a very non-threatening way to the anatomy of the body and to encourage participants to feel comfortable talking about matters concerning their bodies and that of the opposite sex, particularly the reproductive organs.

**DESCRIPTION:** Drawing and discussion exercise

**MATERIALS NEEDED:** Craft paper, markers, crayons.

### DIRECTIONS:

1. Explain that we are going to share what we know about how our bodies work. Divide the larger group into two groups.
2. Ask each group to **draw two outlines of bodies** on the craft paper of someone like them. The easiest way to do this is for a group member to lie down and for someone to draw around their body.
3. Once the body outline has been drawn, ask the groups to add in the body parts and their names that are i) visible ii) covered by clothes.
4. Ask groups to start with the outline of their own sex and to identify body parts:
  - They like / Ambazo wanapenda
  - Dislike / Ambazo upendi
  - Make them feel embarrassed or uncomfortable and why / Zinazo wafanya kuhisi ama auyoke sawa na kwa nini?
  - Find pleasurable / Zinazo kunfanya kuhisi poa

**Facilitator Note:** The facilitator should spend time observing each group and ask each group in turn about what they have discussed, particularly about the more difficult areas.

5. After the group has completed their own sex. Ask groups to use the other outline to identify body parts of the **OPPOSITE SEX:**
  - They like / Ambazo wanapenda
  - Dislike / Ambazo upendi
  - Make them feel embarrassed or uncomfortable and why / Zinazo wafanya kuhisi ama auyoke sawa na kwa nini?
  - Find pleasurable / Zinazo kunfanya kuhisi poa

**Facilitator Note:** The facilitator should spend time observing each group and ask each group in turn about what they have discussed, particularly about the more difficult areas.

6. Bring all the participants together into a big group and ask each group in turn to present their body maps. Encourage people to ask questions about the body maps and use this as a way of encouraging the groups to share some of what they discussed.
7. **FACILITATOR DISCUSSION QUESTIONS:**
  - Which body parts do they have sex with, which they do not? / Ni sehami gani za mwili zinazo tumika kufanya ngono, na zipi hazitumiki?
  - Which are 'private'? / Ni ipi ni ya siri?

- Which make you feel embarrassed? When and why? / Ni sehemu gani ya mwili inakutia aibu?
- Which body parts do the other sex find pleasurable? / Ni sehemu gani ya mwili ambayo unadinyana nayo unahisi utama?

**FACILITATOR NOTE:** This session should enable participants to decide on names that are acceptable to use for the different body parts and an opportunity to raise in discussion body parts that are associated with sex with which participants might otherwise have difficulty talking about. The facilitator should encourage participants to identify body parts themselves as far as possible. Accuracy in their positions on the body map is not important. The list of pleasurable body parts that the facilitator should ensure are discussed should include: ears, neck, lips, the penis, breasts, thighs, vagina, and clitoris. Many participants will be unfamiliar with the clitoris and the facilitator may need to explain about this carefully and suggest that participants go home and find it.

**Facilitator Guide:** The table below outlines body part names in Sheng, Swahili and English, which participants may come up with.

| English          | Sheng                                                           | Swahili      |
|------------------|-----------------------------------------------------------------|--------------|
| Breasts          | Manyonyo                                                        | Matiti       |
| Vagina           | Kibwenye, Pussy, Kae                                            | Kuma         |
| Penis            | Machine, Makugari                                               | Deki         |
| Testicles, Balls |                                                                 |              |
| Buttocks         | Haga (Saidongi) Vitu ya kazi, muumbile, matako, mabuti, Assets, | Rasa         |
| Hair             | Manywela                                                        |              |
| Head             | Mheady, Heady                                                   | Kichwa       |
| Ears             | Masikio                                                         |              |
| Knees            | Magoti                                                          |              |
| Neck             | Kishigore, Shingo                                               | Shingo       |
| Chest hair       | Kifua                                                           | Kifua        |
| Shoulders        | Mabegare                                                        |              |
| Stomach          | Tumbore , Kitambi                                               | Tumbo        |
| Hands            |                                                                 |              |
| Fingers          | Chill                                                           | Vidole, Dole |
| Feet             |                                                                 | Mguu         |
| Hips             | Maspika                                                         |              |
| Eyes             | Machore                                                         | Macho        |
| Mouth            | Bakuli                                                          | Mdomo        |
| Nose             | Mapuare                                                         |              |
| Arms             | Nguvu                                                           | Mkono        |
| Legs             | Strongholds, Nasgwembe                                          | Mguu         |



## Exercise B.5: CLOSING CIRCLE AND LOCAL SONG / MWISHO WA MAJADILIANO

**AIMS:** To finish the session on a happy note.

**DESCRIPTION:** The participants choose a song, which they all know, to sing together.

**MATERIALS NEEDED:** None

### DIRECTIONS:

1. Sit in a circle together. Thank everyone again for coming to this session.
2. Ask each person to say one thing, which they have learnt from this session and one thing they will share with someone before the next session.
3. Arrange a mutually suitable time and place for the next session together. Ask everyone to remind one another again about it.
4. Ask all the participants to think of a happy song they all know, which they would like to sing together now, to finish off the session.



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# SESSION C: SEX AND LOVE / NGONO NA MAPENZI

**PURPOSE:** A first look at images of sex and sexual health problems and an exploration of what we look for and give in love

**MATERIALS NEEDED:** Flip chart, makers, sex cards for activity C.4

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### INTRODUCTION

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| C.5 | Closing Circle / Mwisho wa Majadiliano.....                                            | 48 |

## INTRODUCTION

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Using the Maasai stick, have everyone go around once and recount quickly one good thing that has happened to them since the last session and one thing they like about themselves.
4. Summarize the last session. Ask participants to recall what we learnt together at the last session - images and reality, gender norms, how much we influence how others act... Remind them if they have forgotten.
5. Explain that we are going on to discuss other things in this session.



## Exercise C.1: BODY NAME GAME / MICHEZO YA KUTAJA VIUNGO VYA MWILI

**AIMS:** Warm up game

**MATERIALS NEEDED:** None

**DIRECTIONS:**

1. Everyone sits in a circle. Start by slapping your thighs and then clicking the fingers of your hands. Do this again but with the first click, name a body part.
2. Continue round in the circle. If anyone breaks the rhythm or mentions a body part already named they are 'out'. Speed up the tempo so its gets harder and harder to stay 'in'. The game ends when only one person is left or when participants seem to have had enough.





## Exercise C.2: WHAT IS LOVE? / MAPENZI NI NINI?

**AIMS:** To explore what we mean by “love”

**DESCRIPTION:** Group Discussion

**MATERIALS NEEDED:** Flip chart and markers, Maasai Stick

### DIRECTIONS:

1. Have participants seated in a circle
2. Tell participants we are going to brainstorm as a group.
  - **Ask participants:** What the word ‘love’ means to them. Note: If there is more than one word for ‘love’ in the language of the workshop, define these different words.
  - Jina mapenzi ina maanisha nini kwa nyinyi?
3. Write the various words for love given by participants on a flipchart.
4. Find out more what people take the words for ‘love’ to refer to.
  - **Ask participants:**
  - Is this a word or an expression, which applies to the love someone has for their partner (i.e. their husband or wife or boyfriend/girlfriend) alone, or between brothers and sisters also, or school friends? / Je hii ni neon au ni kujieleza, ni nini inatekeleza kwa upendo mtu aliyonayo kwa mwenziwe (kama vile bwana au bibi au galfriend/boyfriend) pekee, au dada na ndungu pia, au marafiki wa shuleni?
  - Ask the group to agree on how they use the word. Uliza vikundi wakubaliane jinsi ya kuitumia meno hilo.
  - Is everyone agreed upon a word or an expression, which applies just to love someone has for a partner (i.e. their husband or wife or boyfriend/girlfriend),
  - Is it also used for love between sisters and brothers or school friends?
  - If other words or expressions are used to describe those relationships, ask everyone to agree on those also.
5. Explain that now using the Maasai stick we are going to go around one by one and tell the group an example **of how to show love between friends, or family members, that is love, which does not involve sex.**
  - As the facilitator record each participants’ response on the flipchart under the heading for **‘love between family and friends’**
6. **Facilitate discussion** using the following questions as a guide in relation to love between family and friends:
  - How do they show love to these people (family/friends)? / Wanaonyeshaie upendo kwa hawa watu?
  - What things they expect from friends and family they love? / Wanatarajia nini kutoka kwa marafiki na famalia zao wanaowapenda?
  - Do participants believe that the things they have chosen would be agreed by the person they were thinking of? / Je wahusika wanaaminini kuwa vitu zote wamezichangua zinaweza kubalika na mtu wiyenye wanafikiria?
  - In what ways might their views differ? / Kwa njia ngani maono yao yanaweza tafautiana?

- 
- What are things friends or family do that do not show love? / Ni vitu gani marafiki au familia wanafanya zisizo onyesha upendo?
  - What do they do that are hurtful? / Ni nini wanachokifanya kinuamiza?
  - Are any of the things mentioned as ways of showing love also hurtful?
7. Explain that now using the Maasai talking stick we are going to go around one by one and tell the group an example of **how to show love between people who have a sexual relationship together (husband/wife or girlfriend/boyfriend)**.
- As the facilitator record each participants' response on the flipchart under the heading for love between family and friends
8. **Facilitate Discussion** using the following questions as a guide in relation to love between **two people in a sexual relationship**:
- How do you show a partner love? / Unaweza mwonyesha aje mwenzako mapenzi?
  - What do you expect a partner who loves them to do to show love to them? Unatarajia nini kwa mwenye anayependwa kuwaonyesha upeno?
  - What are things partners do to each that do not show love? / Ni nini haswa wapendanao wanaeza fanya kuonyesha hakuna mapenzi?
  - What do they do that are hurtful? / Ni nini wanafanya chenye inahumiza?
  - Are any of the things mentioned as ways of showing love also hurtful? / Kuna vitu vyovyote zimetarjwa kama njia ya kuonyesha upendo na kukwaza?
  - How sex or marriage alter ways of showing love in relationships? Ni vipi ndoa ama ngono ?
  - Does love = sex or does love = marriage? Do they automatically go together? Kufanya mpenzi = ngono ama mapenzi = ndoa? Je inaendana yote pamoja?
  - How should each person in a relationship show love and respect to each other? / Ni kwa njia ngani mtu kwa urafiki anaweza kuonyesha upendo na heshima kwa mweziwe?
9. **Facilitator Summary:** Finally, if there are some clear differences in the things we do to show love to partners compared with those which show love to sisters and brothers or friends, point these out to participants. Ask them to define these differences more clearly. Encourage them to try to explain why these differences exist.

**FACILITATOR NOTE:** This exercise is designed to encourage participants to focus on their own perspectives first and only on their partner's perspective when asked to. It is likely that issues such as **trust (trusti), sharing, responsibility, sex (ngono), and money (pesa)** are all mentioned.



## **Exercise C.3: SEXUAL RELATIONSHIPS: HAPPY AND UNHAPPY / URAFIKI WA MAPENZI WA FURAHA NA SHIDA**

**AIMS:** To explore further what we mean by 'love' in sexual relationships, how relationships can be unhappy and how this is shown

**DESCRIPTION:** Role-play

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Divide the group into three and give each group one of the below scenarios.

**Group 1:** Happy sexual relationship – husband and wife who want to have a baby

**Actors:** Husband, Wife – others guide and support rest of the group should discuss and guide them on how they should behave towards each other to demonstrate happy sexual relationships.

**Group 2:** Unhappy sexual relationship - a husband is rejected by his wife who doesn't want to have sex.

**Actors:** Husband and Wife others guide and support rest of the group should discuss and guide them on how they should behave towards each other to demonstrate unhappy sexual relationships.

**Group 3:** Unhappy sexual relationship – Mpango wa kando – A girlfriend discovers her boyfriend has another woman on the side.

**Actors:** A girlfriend, a boyfriend, a girlfriend on the side (mpango wa kando) - others guide and support rest of the group should discuss and guide them on how they should behave towards each other to demonstrate bad sexual relationships.

2. Give the three groups 5-10 minutes to practice their role-play scenarios and come up with a scene.
3. Have each group present their role-plays to each other.
4. Facilitate a group discussion using the following questions as a guide:
  - What makes the role-plays happy and unhappy? / Nini ilifanya michezo iwa ya furaha na shida?
  - What advice would they like to give to the women and men shown in each role-play to improve their relationships from unhappy to happy or happy to happier? / Ni mwaitha ipi ujependa kuwapa fame na budu kwa hii mchezo?
  - If it is not possible to make the unhappy relationships happy, what advice would you give the unhappy partner? / Kama ni vigumu kwana furaha kwa usiano je ni ushauri garii unaeza kuwapa marafiki?
5. Continue to facilitate discussion with the following questions:
  - Consider the role-plays where the women were unhappy. Kwa nini kwa hi mchezo fame hakuwa

mwenye furaha.

- What would she lose by leaving that relationship? / Nini atapoteza kwa kuwacha ndoa?
- What would she gain? / Nini ata pata?

6. Then consider the role-play where the man was unhappy.

- What would he lose by leaving the relationship? / Nini atapoteza kwa kuwacha ndoa?
- What would he gain? / Nini ata pata?

7. Then consider the role-play where there was 'mpanga wa kando'

- Is each partner happy? If so, why? Je kwa mwenzaka ana furaha kwa nini?
- Are any of the partners unhappy? If so, why? / Je kwa mwenzaka hana faraha, kwa nini?
- Do the husband and wife trust each other? Je bombe na fame wanaaminiana?
- Can they trust each other when one has a relationship on the side? / Wanaweza aminiana iwapo moja yao aka na usiano wa kimapenzi kando?

#### 8. Summary Discussion

- Has this discussion changed our thoughts on our own relationships?

**Facilitate Note:** Try to ensure that everyone has a chance to air their views in their discussions, but do not encourage an argument to develop! This is a chance for people to respect and listen to one another, without having to agree on everything said by others. There may well be some people who are feeling upset by these exercises. You need to be sensitive to their needs. You may need a break after the exercise for a few minutes or for the group to sing a song.





## Exercise C.4: JOYS AND PROBLEMS WITH SEX / FURAHA NA SHIDA ZA NGONO

**AIMS:** To help people to realize that it is no wonder that we have differences between images and realities of sex too.

**Facilitator's note:** many issues raised here will conflict with your values. It is important to remain non-judgmental through out.

**DESCRIPTION:** The group will explore different ideas and needs, which they have about sex, through discussion and sorting ideas about sex.

**MATERIALS NEEDED:** Empty sheets of paper, facilitator cards with the ideas of sex

### DIRECTIONS:

1. **Start off with the following explanation:**

We are now going to move on to talk about our images of sex in our lives. Most of us often find sex enjoyable, fun and rewarding, and none of us would have been born if it wasn't for sex! But at the same time, almost all of us at some time in our lives can have questions or difficulties related to sex, which we may find painful or embarrassing, and with which we would like some help. This exercise is a way of helping us to share with one another our own understanding of the good things and the difficult things about sex in our own lives.

2. Have participants divide into three groups. Explain that you want them to brainstorm and write down on the pieces of paper provided what comes to mind when you say the word 'sex'. Give groups 5-7 minutes.
3. Collect the pieces of paper and gather the group back into a circle. Add the pieces of paper to your facilitator idea cards about sex.
4. Explain that as a group you are going to sort the cards into three piles representing, joys, problems, and unsure (third pile).

**Facilitator Note:** Remind participants that they will not agree on all issues and may disapprove of some but even though we may hold different views we need to listen to each other and not condemn each other for having different views. If some cannot handle the discussion, suggest that they are free to take a break and those who want to can continue.

5. As the facilitator hold up each card one by one and generate discussion about what is on the card and as a group decide which pile "Joys/Furaha", "problems/shida" or "unsure/netural/sijui" to put each card in. Discuss why the group is putting each card in each pile.
6. **Facilitator Discussion:** Explain that the pile of problems shows just how many problems we have with sex. The Stepping Stones workshops are concerned with sexual health, we hold these workshops with one goal in mind, namely the achievement of a complete state of sexual health for everyone. Sexual health is sex that is pleasurable and free from infection, unwanted pregnancy and abuse. The problems we have discussed in this exercise are some of the issues we have to address in striving for sexual health.



## Exercise C.5: CLOSING CIRCLE / MWISHO WA MAJADILIANO

1. Thank everyone again for coming. Ask each member of the group in turn to mention one thing that they have learnt today, one thing they will share with someone else and one thing that they are looking forward to doing before the next meeting.
2. Ask if there are any more questions about today's session that anyone would like to ask.
3. Remind everyone of the time and place for the next meeting and say you look forward to seeing them all again there.





## PEER GROUP MEETING No. 1 / MKUTANO NA PEERS MOJA

It is preferable to include meetings of the peer groups if this is feasible in the community. We suggest three meetings, each of which would be about 1.5-2 hours long. If there are peer groups of older and younger men and women in the community being held in parallel, they can all be brought together in these meetings. Some planning is needed so that there is one presentation from each peer group on each topic.

### FIRST MEETING OF THE PEER GROUPS

**PURPOSE:** *To share peer group ideas to far*

**AIMS:** *To enable the groups to meet together to share and communicate with each other about gender norms and pressures on them and how these influence their sexual experiences.*

### DIRECTIONS:

1. After welcoming the participants, agree which group will start and ask them to present to the other group an account of the community ideal of how men (or women) like them should be and behave.
2. Ask the second group to present.
3. Discuss with everyone:
  - What pressures does this places on men/women? / Ni shinikizo gani kwa wanawake na wanaume mahali hapa?
  - What they gain from it? / Nini walipata kuto kwao?
  - What they lose from it (how it may hurt them)? / Nini walipotea kwao nini iliwaumeza?
  - Do people live according to the ideal? / Je watu wanaishi kulingana mawaia yao?
  - How easily is it to decide to do things differently? / Je ni rahisi kudadiliana vitu tufauti?
4. Then ask each peer group to present their joys and problems with sex. Some participants may find this difficult, so try and find members of the peer group who are bolder for this presentation and emphasise that one of the aims of Stepping Stones are to help us communicate across age groups as well as with relationships.
  - *What are the common joys and problems and which ones are different between the peer groups? / Ni nini ndio kuwaida furaha na shida za kawaida na gani ndio tofauti kati ya rika moja?*
  - *Why are there differences? / Mbona kuna utafauti?*
  - *What do you think/ how do you feel about gender differences between the joys and problems? / Nini unafikiria unafeel aje kuhusu jinsia tafauti kati ya furaha na shida?*
  - *How can we help each other to minimize the problems and maximize the joys? / Tunawezaje saidiana kupngoza tatizo na kuongeza furaha?*
5. To conclude the meeting go round the room and ask everyone to mention one thing they have learned from this discussion that they didn't know before about the other (or another) peer group. Encourage everyone to continue coming to meetings, explain that all the issues raised will be discussed in later sessions.

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# SESSION D: CONCEPTION AND CONTRACEPTION / FP & BALL

**PURPOSE:** To understand our fertility, how to protect our fertility and how to ensure we plan our children

**MATERIALS NEEDED:** flip chart, marker pens, examples of contraceptives, cards with notes on contraceptives, Maasai Stick

## CONTENTS:

### INTRODUCTION

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## INTRODUCTION

1. Sit in a circle with the group.
2. Everyone should be at the same level, including yourself.
3. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
4. Ask each participant to recount quickly something good, which has happened to them since the last session.
5. Review the last session. Ask participants to talk about what they learnt from the last session.
6. Explain that we are going on to discuss our fertility and planning when to have children.



## Exercise D.1: MENSTRUATION / KUNYESHA

**AIMS:** To describe the menstrual cycle and when and how pregnancy occurs and changes in a woman's body through out the cycle

**DESCRIPTION:** Discussion exercise

**MATERIALS NEEDED:** Flip chart and red, yellow, and blue crayons

### DIRECTIONS:

1. Explain that we are going to think about how pregnancy occurs and women's bodies.
  - **Start by asking the group:**
  - When do men produce seed or when are they fertile?
  - When do women produce seed or when are they fertile?
2. **Explain** that we know that most women who are not pregnant menstruate each and every month – we call this the **menstrual cycle / kunyesha** **Explain** that when we think about the menstrual cycle we typically remember the days women bleed.
3. **Ask the Group:**
  - **How many days each month do most women bleed? / Ni siku ngapi za mwezi ombapo mademu wengi hunyesha?**

**Facilitator Note:** Ask for suggestions from different people in the group. There will be some disagreement as it varies. When you sum up suggest you agree on **five days as that is the average.**

4. Using the flip chart and the coloured crayons, draw 5 red circles to signify the days a woman menstruates.
5. Mention that a menstrual cycle is normally four weeks or 28 days like the cycle of the moon.
6. **Ask the group:**
  - If a woman bleeds for five days how many days does she have without bleeding? / **Kiwa demu ananyeshe kwa siku tano ni siku ngapi hajanyesha?**
7. Draw 23 blue circles in the row after the five red ones – these signify the days when a woman is not menstruating.
8. **Ask the Group:**
  - Does anyone know of the time when women are most fertile? / **Je kuna yeyote ambaya anajua iwapo demu ana uwezo wa kupata ujauzito?**
9. Ask for ideas from everyone. Then take the yellow crayon and explain that the most fertile period is the middle of the menstrual cycle – days 12-14 – and that you count these from the first day of menstruation. Colour around the blue circles signifying days 12-14 below these beads.
10. Then explain what is happening inside a woman. Explain that menstruation occurs when the lining of the womb is shed – it's rather like cleaning the house after a cold winter. After that in the days leading up to the fertile period the womb lining gets renewed and the womb is prepared in case there is a pregnancy. This period is like preparing the home for something special. If the woman gets pregnant her womb lining grows (and then her womb grows) so the baby is nurtured. If she does not get pregnant her body keeps the womb lining for a couple of weeks and then decides it is better to clear it out and start again and so after 14 days the process of menstruation starts again.

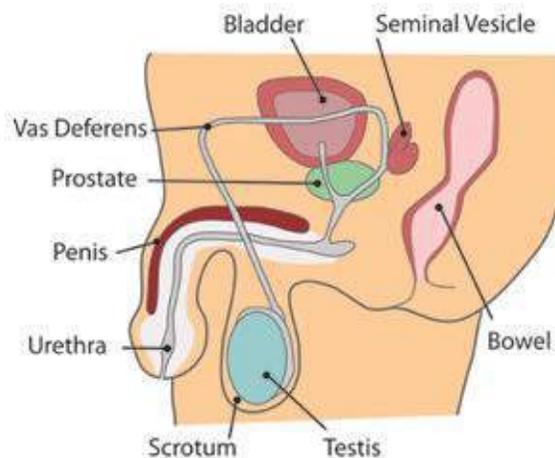
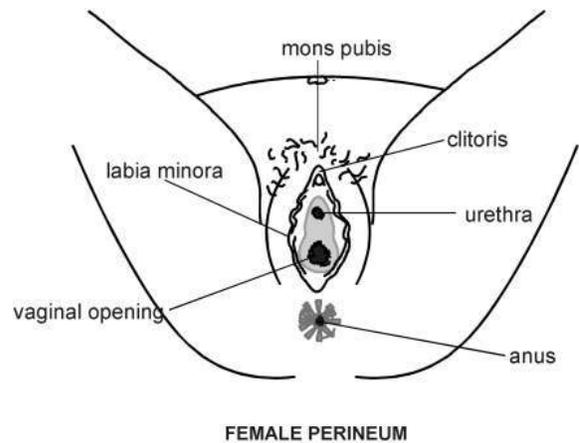
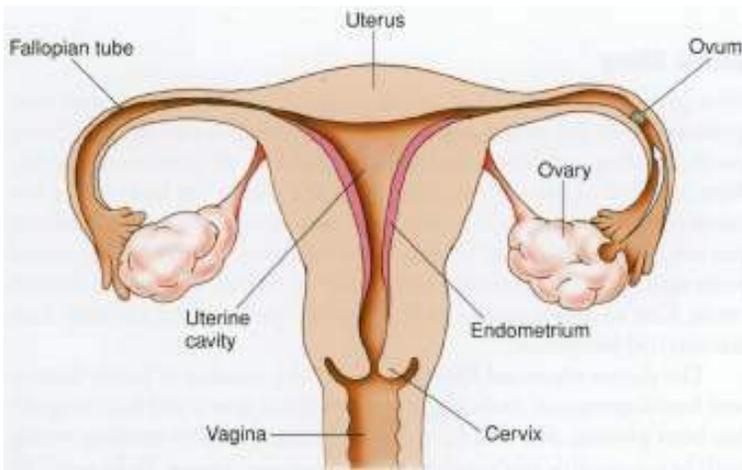
11. Ask the group:

- This explains what is happening in the womb, but what other parts do women have in her body? / **Hihi ufafanunzi inatendeka kwa nyumba ya uzazi, lakini ni sehemu gani ingine ambayo mademu waka nayo kwa mwili zao?**

12. Circulate the laminated cards of female anatomy and explain the female reproductive organs using one.

Explain that at the top of the vagina is the cervix or neck of the womb. The cervix has a very tiny passage through it, its about as wide as a straw. If you pass through this you come to the womb. There are two narrow tubes, coming from the top of the womb, these are called the fallopian tubes. At the end of the fallopian tubes are the ovaries. Explain that a woman's eggs are made in her ovaries and when she is fertile, during those yellow days, one tiny egg is released and passes down the fallopian tube to the womb. If it does not meet with a fresh seed of a man (or sperm) it passes out of the womb into the vagina. If it meets with a fresh sperm a pregnancy will result. Sperm can only live in a women for 24 hours then they die of they do not meet an egg.

13. Circulate laminated cards of male anatomy and explain reproductive organs.





## Exercise D.2: CONCEPTION / BALL

**AIMS:** to learn about when someone can get pregnant and to reflect on when we may want to have children

**MATERIALS NEEDED:** Flip chart and markers

### DIRECTIONS:

1. Explain that there are lots of ideas about what you can do to control your fertility and we are going to start with a quick quiz to discuss these
2. Read out the following statements and ask people to respond if they agree with the statement. If they are certain something is true they should put up both hands, if they think it might be true they should put up one, and if they think it is false they should not put up either.
3. **Statements:**
  - A woman can only get pregnant if she has sex often / Mwanamke anaweza pata mimba kwa anadinya mara kwa mara
  - If pregnancy is wanted, you should have sex during menstruation. / Kama mimba inaitijika, mnalalakiwa kufanya ngono wakati dame ananyesha.
  - The best time to get pregnant is to have sex one week after the end of menstruation (12 -14 days after the first day of menstruation) / Wakati mzuri wakupata mimbi ni kufanya ngongo baada tu ya dame kunyesha (siku 12-14 baada ya siku ya kwanza kunyesha)
  - A woman can't get pregnant until she is 16 / Mwanamke awezipata mimba mpaka awe na miaka kumi na sita
  - A woman can tell she is pregnant as her breasts feel heavy or painful and she stops menstruating / Mwanamke anaweza sema yuku mjamzito
  - Women can't get pregnant if they are over 40 / Wanawake hawawezi pata ball kama wamepita miaka 40
  - A woman who is breast feeding cannot get pregnant / Mwanamke anyenyonyesha hawezi pata mimba
  - It is possible to get pregnant when a man comes on the vulva (outside of the vagina)
  - If a man has sex with a menstruating woman he will become impotent / Kama mwanume kifanya ngono kwa mwanamke ambaye ana nyesha atakua bure?

### FACILITATOR DISCUSSION

4. Have a discussion after each statement drawing on the following comments:
  - **A woman can only get pregnant if she has sex often = FALSE.** Pregnancy can occur on one occasion and if couples wanting pregnancy have sex too often they can reduce the likelihood of conception as the sperm become too few.
  - **If pregnancy is wanted, you should have sex during menstruation = FALSE.**
  - **The best time to get pregnant is to have sex one week after the end of menstruation (12 -14 days after the first day of menstruation) = TRUE.** This is the most likely time for a woman to release an egg. She only does this once a month. Some women may release an egg earlier or later but this is the most common time. The egg only lives for about two days after it is released so make sure you have sex at the right time if you want to get pregnant!
  - **A woman can't get pregnant until she is 16 = FALSE.** A woman can get pregnant as soon as she

~~~~~  
has had her first menstruation.

- **A woman can tell she is pregnant as her breasts feel heavy or painful and she stops menstruating = TRUE.** Ask what are the other signs of pregnancy? These include nausea or vomiting especially in the morning, going off food, breasts getting larger and after about three months the stomach getting larger.
- **Women can't get pregnant if they are over 40 = FALSE.** A woman can get pregnant at any time between her first and last menstruation (which is usually towards age 50) but older women may find it much harder
- **A woman who is breast-feeding cannot get pregnant = sometimes true and sometimes false.** If a woman is providing her child only with breast milk then it is unlikely that she will get pregnant when breast feeding. Once a child is given porridge or other milk or water as well as breast milk a woman is at risk of pregnancy even if her period has not yet returned.
- **It is possible to get pregnant when a man comes on the vulva = TRUE.** Usually a woman can only get pregnant when the penis is inside the vagina when the man ejaculates but it is possible for sperm on the vulva to swim into the vagina and up into the womb and for conception to occur.
- **If a man has sex with a menstruating woman he will become impotent = FALSE.** But it may be a useful thing for a woman to tell a man if she is menstruating and does not want to have sex or is in danger of being raped!!!

FACILITATOR NOTE: Make sure you are familiar with the material from the quiz and the answers. You might want to mention that although some people get pregnant the first time they have sex without contraception, it's normal for women to take some months to get pregnant. It's often longer for women over 30 years. The older the woman is, the longer it usually takes her to get pregnant.

5. **Ask the group:** Using a flipchart and marker, lead a group discussion with the following question and record participants answers.
 - Ask them to discuss when is a good time for someone like them to have a child? / Ni wakati gani mzuri wa mtu kupata mtoto?
 - What are the advantages for themselves of having a child now (or even earlier)? / Nini uzuri wakupata watoto kwena mapenda ama ikiwa umechelewa?
 - What are the disadvantages for themselves? / Nini ubaya ya nyinyi wenyewe kupata watoto?
 - What do they want for their children? Are they able to provide these things now? / Nini ambayo unataka kwa watoto wenu? Je wana uwezo wa kutoa kwa hizo vitu kwa sasa?
6. **Summary Discussion:** Mention that it is important to think when you have a child about what is good for the child as well as what is good for you. Most parents want to do the best they can for their children. Do you think you are well placed to do the best you can for a child now? / Unafikiri unaweza shujulikia moto kwa sahizi?



Exercise D.3: CONTRACEPTION / FP

AIMS: To share information about contraception.

MATERIALS NEEDED: Cards about contraceptive methods

DIRECTIONS:

1. Explain that in this exercise we are going to discuss different ways of ensuring that we control when we have children and protect ourselves from HIV and STIs. We are going to start by learning more about contraceptives and thinking about which contraceptives are the best for us. We are going to do this by having a debate and competition between the contraceptive methods.
2. Explain that you participants to form small groups of three or four. Give each small group a card about common contraceptive methods: male condoms, female condoms, emergency contraception, the pill, injections, the implant, IUDs, and dual protection with condoms and the injection/IUD/Implant. The group having dual protection should receive cards for the condom, and injection/IUD/implant options. The cards give a simple description of each method and rate them for preventing the transmission of HIV and STIs as well as for preventing pregnancy.

FACILITATOR NOTE: The best method is **dual protection** - using condom for preventing the transmission of HIV and STIs and one of the following for preventing pregnancy (implant/IUD/injection).

3. As the facilitator go around to each group and ensure they understand the contraceptive method they have received on the card and make any clarifications needed to assist them if literacy levels are low. Then ask each small group to nominate one volunteer who is good at arguing who is going to represent the method.
4. **In order to do this they are going to have to argue:**
 - Why they are good for preventing pregnancy? / Kwa nini ni vizuri kuzuiya ball?
 - Why they are good for preventing HIV? / Kwa nini ni vizuri kuzuiya kamchuna?
 - Why they are easiest to use? / Kwa nini ni virahisi kutumia?
5. Explain that first you want each contraceptive representative to convince everyone about why they are good (and better than the others) for **preventing pregnancy**.
6. Have each representative come into the middle of the circle, tell the group what their contraceptive method is and make a statement about their ability to prevent pregnancy. After each has made their statement everyone watching has one vote to give the contraceptive they think did the best job at **preventing pregnancy**. State each contraceptive method and have participants raise their hands to vote for the MOST EFFECTIVE CONTRACEPTIVE FOR PREVENTING PREGNANCY.
7. Now explain each will have a chance to explain why they are **best for preventing HIV**, and then there is another vote. Again, have each representative come into the middle of the circle, tell the group what their contraceptive method is and make a statement about their ability to prevent HIV. After each

has made their statement everyone watching has one vote to give the contraceptive they think did the best job at **preventing HIV**. State each contraceptive method and have participants raise their hands to vote for the **MOST EFFECTIVE CONTRACEPTIVE FOR PREVENTING HIV**.

8. Finally have each contraceptive method explain **why they are easiest to use**. Then there is another vote.
 - Which is the easiest to get access to? / Gai ni rahisi kufikia?
 - Which is the easiest to solve problems that arise if there is a mistake in how they are used? / Gani ni rahisi kusulisha shida amazo zina nuka kama kuna kusa fafika jinsi zina vyo tumiwa
9. **Finally ask the group to vote on** - Which is the best all round for contraception and HIV prevention? / Gani ndio bora pande zote kwa uzazi wa mpongo na kuingu ukimwi?

FACILITATOR NOTE: If the group doesn't vote on the dual contraception method, facilitate open discussion about contraception and the myths and misconceptions about the methods. **It is important to stress that no methods of birth control cause infertility. That using latex condoms correctly is the best protection against the transmission of HIV and STIs.** This is an opportunity to clarify all myths and misconceptions about contraception.

10. **Ask the group:** did they learn anything new about contraception from this? / Je waliweza kujifunza kitu chochote kipya kuhusu kupanga uzazi kutukana na haya?



CONTRACEPTION CARDS

IMPLANT

The implant is a thin small rod that contains progesterone. It is inserted under the skin on the inside of the upper arm, using a needle. It can stay in for up to 3-5 years. It is easy to remove when the time comes to take it out.

Advantages:

- You do not have to remember to take a pill or remember to get your injection.
- It prevents pregnancy very well.

Disadvantages:

- Can have side effects including: mood changes, spotting (small amount of vaginal bleeding that is not predictable).

HIV Prevention: ☒

- No protection is given against HIV or STIs.

Ability to prevent pregnancy: ★★★★★

- One of the most effective for preventing pregnancy. If you are HIV positive and taking Efavirenz, it may be less effective than if not taking Efavirenz, but is still more effective than most other methods of preventing pregnancy.

IUD

The IUD is a small "T" shaped piece of plastic with a tiny copper wire around it that is inserted into the womb (where a baby grows). It can stay in for 10 to 12 years, depending on the brand. It stays in the womb and cannot move elsewhere in the body.

Advantages:

- You do not have to remember to take a pill or remember to get your injection.
- It prevents pregnancy very well.
- It is effective immediately after insertion.
- It is easy to remove.
- Your partner will not feel it so it is a private method of contraception.

Disadvantages:

- It requires a vaginal exam with a speculum to insert it.
- It can sometimes cause periods to be heavier or more painful, but this usually improves over time.

HIV Prevention: ☒

- No protection is given against HIV or STIs.

Ability to prevent pregnancy: ★★★★★

- This method is one of the most effective for preventing pregnancy. If you are taking Efavirenz, this is the most effective method for preventing pregnancy.

CONTRACEPTIVE INJECTIONS

DepoProvera is an injection, which contains a hormone called progesterone, it is given every three months. Injections work by slowly releasing the hormone, which prevents the woman's ovary from releasing an egg.

Advantages:

- Injection given once every 3 months.
- The method can be used secretly.
- It does not interfere with milk production so is good during breastfeeding.
- Safe to use for many years.

Disadvantages:

- Injections may cause changes in a woman's periods.
- It often takes a few months for women to get pregnant after they stop the injection.
- Some women experience other side effects when they use an injection. These include increased appetite, stomach pain, dizziness, tiredness and headaches.

HIV Prevention: ☒

- No protection is given against HIV or STIs.

Ability to prevent pregnancy: ★★★

- Contraceptive injections are very good at preventing pregnancy but they only work if you have the injection on the right date.

MALE CONDOM

Advantages:

- One size fits all.
- Distributed free from government clinics and are widely available.
- Good protection against STIs and HIV and may prevent pregnancy.
- Easy to carry and have available for unexpected encounters.

Disadvantages:

- Must be used every time a couple has sex.
- Must be put on an erect penis before vaginal penetration.
- If not used properly they can break or come off. If an accident occurs the woman should take emergency contraception as soon as possible within three days.

HIV Prevention: ★★★★★

- Prevents the transmission of HIV and most STIs when used correctly and consistently.

Ability to prevent pregnancy: ★★

- Good if used correctly at EVERY sexual encounter.

FEMALE CONDOM

This is a condom used by women in the vagina, which, like the male condom, prevents pregnancy and provides protection against HIV and STIs.

Advantages:

- One size fits all.
- Easy to carry and have available.
- Can be inserted secretly hours before sex starts.
- Can be used during menstruation.

Disadvantages:

- Must be used at every sexual encounter
- They may be difficult to get used to for women
- Not widely available

HIV Prevention: ★★★★★

- Prevents the transmission of HIV and most STIs when used correctly and consistently.

Ability to prevent pregnancy: ★★

- Good if used correctly at EVERY sexual encounter.

EMERGENCY CONTRACEPTION

Emergency contraception is used by a woman to prevent pregnancy after she has had unprotected sex. They work best the sooner they are taken.

Advantage:

- Can prevent pregnancy when another method has failed or unprotected intercourse has occurred.

Disadvantages:

- They are not as good as a regular contraceptive and do not provide protection against HIV or STDs.

HIV Prevention: ☒

- No protection is given against HIV or STIs.

Ability to prevent pregnancy: ★

- Can prevent pregnancy if taken when another method has failed.

ORAL CONTRACEPTIVE PILL

The oral contraceptive pill is another hormone method. One pill must be taken every day.

Advantages:

- Protection against pregnancy is provided during the whole time if taken daily at the same time.

Disadvantages:

- Difficult to remember to take the pill daily.
- The pill is not effective immediately; when a woman starts taking it she must use condoms as well during the first pack of pills as it does not provide full protection until the second packet.
- Reduced effectiveness when taking antibiotics.
- It is not suitable for breast-feeding women.

HIV Prevention: ☒

- No protection is given against HIV or STIs.

Ability to prevent pregnancy: ★

- The pill is easy to forget and may be difficult for street-connected young women to use.



Exercise D.4: UNPLANNED PREGNANCY / HAIJAPANGWA MIMBA

AIMS: To explore the causes and consequences of unplanned pregnancy and the options for people who find themselves in this situation; to determine appropriate forms of prevention and support.

DESCRIPTION: Diagram and role-play

MATERIALS NEEDED: flip chart and markers

DIRECTIONS:

1. In this exercise we are going to think more about the causes and consequences of unplanned pregnancy, and what can be done to prevent the adverse consequences.
2. Explain that we are going to discuss the causes and consequences of unplanned pregnancy by using a spider diagram.
3. As the facilitator write "Unplanned Pregnancy" in the centre of a flip chart.
 - **Ask the group:** Then, ask them to think of as many **causes of unplanned pregnancy / madhara ya mimba zisizopangwa** as they can and write each one as a 'spider's leg' on the top half of the paper.
 - **Ask the Group:** to think of all the **consequences of unplanned pregnancy / majuto ya mimba zisizopangwa** and write them on the bottom half of the paper as the bottom half of the spider in a different colour marker.

FACILITATOR NOTE:

- *Causes may vary by age for young women they may include:* inaccurate knowledge of conception and contraception; religious opposition to contraception; use of unreliable non- medical methods or improper use of reliable methods; fear of the clinic nurses; lack of parental guidance; fear of contraceptive side-effects (especially sterility); lack of power in the relationship; rape; societal expectations of a person not being sexually active.
 - *For older women they may include:* Lack of knowledge of contraception; opposition to contraceptive use; use of unreliable contraceptive or improper contractive use; lack of power in relationships; rape; fear of contraceptive side-effects; unfriendly clinics.
 - *Consequences may be negative or positive, negative ones include:* being forced to leave school early leading to difficulty getting a job later on, financial responsibilities may force one into having sex for cash, backstreet abortion, poor care for the child, abandoned children, teenagers forced to leave home, rejected by partner, and greater strain on the family. Of course some women have support from their partner or relatives and some women feel their unplanned pregnancies are very much wanted.
4. Divide the group into 4 groups to role-play about unwanted pregnancy scenario in which a person became pregnant when she did not plan it. Give each group one of the scenarios below:
 - Partner didn't want to use a condom and could not negotiate condom use and didn't have another family planning method
 - Pregnancy due to rape and not wanting the baby
 - FP method failed

5. Group Discussion after role plays

- Ways in which unplanned pregnancy, might be prevented? / Njia kuzuiya mimba isiyo hitajika?
- What are the options for a person who has an unplanned pregnancy? / Nini uwamuzi wa mtu ambaye ako na ujauzita usio tarajiwa?
- For each of these options what advice would you give a person to ensure that she is healthy? / Kwa uwamuzi huo utampa mawaitha gani kumfanya awa mwenye furaha?

Facilitator Note for Group Discussion

The options are:

- Continuing with the pregnancy and raising the child
- Continuing with the pregnancy and giving the child to someone else to bring up. Often a relative may be willing to raise the child. It is possible to arrange for a stranger to do this. Often childless couples want to adopt a child who was born to someone else to bring up as their own. A social worker will have information about adoption or fostering facilities.
- Many people try to abort the pregnancy themselves or go to herbalists or backstreet abortionists. This is **very dangerous** and has caused the deaths of very many women.
- Marie Stopes in Kenya may provide abortion services in Kenya. Abortion in Kenya is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.
- Pregnancy confirmation - it is essential that people find out for sure as soon as possible after they suspect pregnancy so that they can plan.



Exercise D.5: CLOSING CIRCLE / MWISHO WA MAJADILIANO

1. Thank everyone again for coming. Ask each member of the group in turn to mention one thing that they have learnt today and one thing that they are looking forward to doing before the next meeting.
2. Ask if there are any more questions about today's session that anyone would like to ask.
3. Remind everyone of the time and place for the next meeting and say you look forward to seeing them all again there.

SESSION E: HIV / KAMCHUNA

PURPOSE: To explore our knowledge about HIV

MATERIALS NEEDED: Cards or small pieces of paper, flip chart, pens

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INTRODUCTION

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Using the Maasai stick, have everyone go around once and recount quickly one good thing that has happened to them since the last session.
4. Summarize the last session. Ask participants to remind us what we learnt together at the last session - about contraception, conception and planning when you want to have children....Remind them if they have forgotten.
5. Explain that we are going on to discuss HIV in this session, but will start with a game.



Exercise E.1: MUDDLING MESSAGES / SAMBAZA UJUMBE

AIMS: Energizer, to make people laugh. To help us appreciate in a funny way how easy it is to misunderstand what someone has said.

DESCRIPTION: Participants whisper the same message around the circle, one to the next. Then the finished version is compared with the original.

MATERIALS NEEDED: None

DIRECTIONS:

1. Think of a phrase to whisper beforehand, such as “many people round here like eating bananas” or “the sun at this time of year is very hot” or whatever.
2. Whisper this quietly to the person sitting next to you and ask them to whisper it quietly to the next person.
3. This should be repeated until the phrase has been whispered around the whole circle. Each person should only whisper on what they heard and they are not allowed to ask for the phrase to be repeated.
4. Finally, when the phrase has been whispered all round the circle, your next door neighbour on your other side should have received it. Ask them to say out loud what s/he heard.
5. Then announce to the group what you originally said. The message normally changes quite a lot as it goes round the circle!
6. If there is time, you could ask someone else to start off another phrase. You could point out how easy it is for messages to be misunderstood!





Exercise E.2: STIs / MCHANGA NYIKO MGONGWA YA ZINAA

AIMS: To enable participants to understand what sexually transmitted infections are and how to prevent infection.

DESCRIPTION: Group discussion

MATERIALS NEEDED: Craft paper, markers, crayons

DIRECTIONS:

1. Divide participants into 4 groups. Give each group a sheet of craft paper and markers/crayons.

Ask participants to write down or draw:

- Do they know any names for these diseases? They can suggest commonly-used names or medical names. / Wanajua magina mengine ya hi maradhi? Wanaweza pendekezo magina yanyo?
 - Ways of knowing that you have got a STI? / Vile unaezajua uko na STI?
 - Ways in which you see the infection on your body and ways in which you feel it? / Ni kwa jinsi gani anaona magonjwa kwa mwili yako na jinsi unaifeel?
 - How do these differ for men and women? / Vile kwa mwanaume and mwanwake?
 - How do we get STIs? / How are STIs transmitted? / Tunafutaje STI, zinasambazwa aje?
 - How can we prevent STIs? How can we avoid getting STIs? / Tunaeza kinga aje STI?
2. Call everyone back into the main group and ask someone from each group to present their discussions.
3. Facilitate Discussion and clarify any myths and misconceptions that came up in group's presentations:
- Does everyone agree with what has been said? (Clarify myths and misconceptions) / Tumekubaliana na vile imesemwa?
 - Are there any other ways of telling if you have a STI? / Kuna njia zingenezo unaeza jua kama uko na STI?
 - What can we do to stop ourselves getting STIs? / Tunaeza zuiage sisi wenyewe kupata STIs?
 - What are the consequences if we don't treat them? / Mashida gani taeza pitia tusipo tibu STI?
 - What can we do if we think we may have one? / Unaeza fanya nini ukidhani uka na moja ya STI?
 - Why do people not get treatment? / Mbone wafu hausatibui san asana?
 - What other questions do you have about STIs? / Mswali yapi uko nayo kuhusu STIs? (Facilitator to answer to the best of their ability.)

FACILITATOR NOTE: make sure the groups cover the following concepts...

STI Types & Names: participants will definitely know some names, these may be medical, such as syphilis or gonorrhoea, or these may be street names such as Kamchuna, Kisonono, Kaswende (etc). Review the different types of STIs: HIV/AIDS, Gonorrhoea, Chlamydia, Syphilis, Genital Warts, Herpes, Trichomoniasis, and Pubic Lice.

Ways of seeing: having a sore on the penis, vagina or opening of vagina (or any part of the body near by), pus coming from penis, seeing brown insects slowly moving in pubic hair and small white eggs on hairs (pubic lice), painful ulcers (herpes), end of penis being red, small cauliflower-like growths on or near the genitals (men and women), swellings (swollen glands) at the top of the legs (men and women), heavy and smelling

~~~~~  
discharge on a woman's panties.

**Ways of feeling:** itchiness inside vagina or itchy pubic hair (men and women), painful ulcers (men and women), burning pain when passing urine and feeling like you have to go all the time (men and women), pain in the womb and lower part of the abdomen, sometimes also with fever, pain when having sex, and painful or swollen testicles.

**Unfortunately STIs often have no obvious signs**, which is why they are so easy to catch and pass to others. HIV is a sexually transmitted disease, we will talk more about HIV in the next exercise.

**Please raise in discussion:** not all the signs of STIs are found when you have a STI. For example it burns when you pass urine when you have any type of urine infection and women can get itching in their vagina and a thick discharge, which looks like sour milk from thrush, which is not sexually transmitted. If you have any of these problems you should go to a clinic or hospital for treatment and doctor or nurse will tell you if your problem is caused by a STI.

**There is only one way of getting STIs:** that is having sex without a condom (*although some STIs can be spread just through skin-to-skin contact*) with someone who has a STI! Some people have ideas about causes of STIs, which are not correct. Common ones are that:

- You can get STIs from sitting on a toilet seat
- Women get STIs from peeing squatting
- STIs are caused from having sex and not having a shower afterwards
- Circumcision causes STIs

**Prevention:** The only way to be sure you do not catch STIs is to practice safer sex - **to use a condom when having sex** or abstain from sex (unrealistic).

**Treatment:** It is very important that we get treatment as soon as we think we may have a STI or if a sexual partner tells us that he or she has a STI. It is not possible to treat yourself. Some people believe that it is good to go to a traditional healer when they have a STI. If people are going to get treatment from a traditional healer **it is important to go to the hospital or clinic and take all the treatment from there first. In order to be properly treated we must make sure that our sexual partners are treated too. Otherwise we will catch the STI from them again.**

**Consequences of not treating STIs:** If STIs are not cured, a person remains able to spread STIs to others they have unprotected sex with. Untreated STIs are the most common cause of infertility in men and women. If a woman is pregnant some STIs cause her to be more likely to miscarry, and even for baby to die. Some STIs make a person much more vulnerable to catching HIV if they have sex with an HIV positive person. Some STIs make a person more likely to infect others with HIV if a person is HIV positive. A woman who gets genital warts is at greater risk of developing cervical cancer and so needs to visit a clinic for regular Pap Smears.

**Some STIs are caused by viruses and they cannot be cured by treatment** – just like HIV cannot be cured, there is no cure for herpes and for warts. If we are infected with these we have times without herpes ulcers and there is treatment to make the warts disappear, but the viruses live on in our body and we continue to be able to infect others and to be at risk of the problems caused by these including greater risk of getting HIV and cancer. **That is why prevention with condom use is essential.**



## **Exercise E.3: Everything you want to know about HIV/AIDS but were afraid to ask / Kila kitu ambacho unge penda kujua kuhusu kamchuna lakini unauwoga ya kuuliza?**

**AIMS:** to learn about HIV/AIDS

**DESCRIPTION:** A discussion session with questions and answers

**MATERIALS NEEDED:** Paper slips and pens

### **DIRECTIONS:**

1. Sit in a circle with the participants. Explain that nowadays everyone is familiar with HIV/ AIDS and we often get bored with being lectured about HIV. Today so we are going to learn about HIV in a way that is fun.
2. Give each participant a piece of paper and ask them to write one question they have about HIV/AIDS that they want answered. Mention, that if someone cannot write their question you can come over and assist them to write it down. Fold all of the papers and place them in a hat.
3. Then mix the papers around. Explain that you would like each to take one paper and try to answer the question on it as a group. Read the question aloud to the group.
  - **Ask the group:**
  - Would someone like to answer the question? / Kuna mtu angependa kujibu hayo maswali?
  - Does everyone agree with the answer? / Kila msee anakubaliana ni jibu hiyo?
  - Does anyone want to add or correct anything? / Nani unataka kuongeza kitu ama kukasoa?
  - **\*\*\* Facilitator \*\*\*** After the group tries to answer the question, correct any myths, or inaccuracies yourself.
4. Move on to the next question and repeat the above process, until all questions raised are answered
5. If there are areas in the facilitator's note that are not raised as questions, ask the group if they would mind if you added in some additional information and facilitate discussion.

### **FACILITATOR NOTE:**

The nature of this discussion is going to vary greatly depending on how much participants already know about HIV. **It is very important that misconceptions are corrected in this discussion. If questions are raised that you do not know the answer to, tell the group you will find out the answer and bring it to the next session.** It is essential that you are happy that the group knows the following, but it is not necessary to bring anything into the discussion that the group is clearly already familiar with.

### **FACILITATOR GUIDE:**

#### **HIV and AIDS**

HIV stands for the Human Immunodeficiency Virus. This is what people catch and transmit to others. People with HIV in their body go on to become sick with AIDS unless they have treatment. They do not "catch" AIDS. AIDS only develops after HIV has stayed in the body for a long time (usually years). AIDS stands for acquired immune deficiency syndrome. The immune system is the body's defence against infection. Immune deficiency means that the immune system is weakened and so cannot defend properly. The body's defences are no

longer able to fight the disease and the person becomes sick. Not everyone who had HIV develops AIDS. Antiretroviral therapy prevents a person from getting AIDS, but also a small number of people who are infected with HIV have it for many years without developing AIDS.

### **Which illnesses that are signs of AIDS?**

When a person's immune system is weakened by HIV they become more vulnerable to a range of illnesses. These are called 'opportunistic infections'. TB is a particularly common one, nowadays 3 out of every 4 people with TB have are HIV positive. Signs of TB are weight loss, lack of energy, loss of appetite and sweating greatly at night. If TB is in the lungs, a person may cough and even coughing up blood, but TB can be in many different parts of the body and not everyone with TB has a cough. Other common opportunistic infections are infections around the brain (meningitis, particularly caused by a bacterium called a cryptococcus) which cause a severe headache; pneumonia, which is an infection of the lung and usually the signs are of a high fever and general illness; severe diarrhoea; thrush in the mouth and throat is very common and makes swallowing very painful. There are a range of other illnesses including cancers that people with HIV who are not on treatment may develop. Opportunistic infections are all treatable but they all cause a great deal of suffering and death if they are not treated. That is why its important for people to know about the signs of these so that they can get health care early if they are suffering from these symptoms.

### **How can you tell if a person has HIV or AIDS?**

You can't tell if a person has HIV just by looking at them, there are plenty of people who are fat and healthy who have HIV. The only way to be sure if a person has HIV is to do a blood test. The ones we normally use test for anti-bodies to HIV – these are generated by the body in response to the HIV virus. It's not a direct test for the virus. If the test is 'positive', a person has HIV. If it is 'negative' it means a person probably doesn't have HIV, but unfortunately a person who has been infected with HIV only shows positive on a test between 6 weeks and 3 months after the infection occurred because it takes time to make the anti-bodies. The time when a test is 'negative' but a person is really infected is called the 'window period'. If we want to be sure we do not have HIV we have to have a test three months after the last time when we could have been exposed to HIV by unsafe sex or another type of exposure. Babies who are born to HIV positive mothers will often test positive for HIV for two years after their birth even if they have not been infected. It is necessary to do a special test for the virus called a PCR to test babies in the first two years of life if they have HIV positive mothers. A PCR test is directly for the virus and it can be done on anyone, but it is expensive and so it is not normally used.

We only know whether we ourselves are infected with HIV if we have a test, and if it is negative we need to test often and practice safe sex to be sure we remain uninfected. That is why we need to take responsibility to protect ourselves and others from the virus: it is not just the responsibility of those who know they HIV-positive to make sure they do not spread it.

### **What is CD4 and viral load?**

CD4 is the name of a cell in your body that is important for the immune system to work well and is destroyed by HIV. There is a blood test called a CD4 count which is done on a person who has HIV to measure of the health of the body's immune system. A normal CD4 count is over 1000, but the count drops as the immune system is attacked by HIV. When it is below 500 a person is at risk of opportunistic infections and when it is below 200, these are particular common and a person is said to have AIDS. Anti-retroviral treatment restores the immune system and as it does so, the CD4 rises. Viral load is a measure of how much HIV a person has in their body. A person with a higher viral load is more infectious. Anti-retroviral therapy causes the viral load to drop to very low levels, but this is not the same as a cure.

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### **What about HIV vaccines, immune boosters and AIDS cures?**

At present there is no AIDS vaccine, although there is research underway to try and develop one. It is likely to still be many years before this is successful and a vaccine is available. There is also no AIDS or HIV cure. Many people have claimed over the years to be able to cure AIDS. All their claims have proved to be false. Many drugs, vitamins and traditional medicines are sold as 'immune boosters' and none of them have been shown to be effective when tested scientifically. The only drugs which are true 'immune boosters' for people with HIV are anti-retroviral drugs. There is a myth that having sex with a virgin can cure a person of HIV, it is not true. There is no HIV cure.

### **How does a person become infected with HIV?**

HIV only survives in body fluids such as semen, vaginal fluids, blood and saliva so we can only catch it if we have contact with body fluids. Most HIV infections in the world are caused by sex either between a man and woman, or sex between two men. Partners can use a male or female condom to protect against sexual transmission. Infections are all caused by HIV positive mothers transmitting the virus to their babies either during childbirth or through breastfeeding. It's important that pregnant women test for HIV and those who are HIV positive take anti-retroviral drugs to protect their unborn babies. Babies born to positive mothers can be protected from the risk of breast feeding by formula feeding, but if it's hard to prepare formula with boiled water and clean bottles well babies can also be safely breast fed provided the child is given absolutely nothing except breast milk. That means no water, no formula, no porridge and no traditional remedies. If it's not possible to give a child just breast milk, its important to use formula all the time. A person can get HIV from any contact with HIV infected blood, and its important to remember this is a risk if helping someone who has been stabbed or injured and is bleeding. It is also a risk if there is a taxi or car accident. Other body fluids such as vomit, faeces, sweat and urine are quite harmless, so you cannot get HIV from cleaning up or bathing a person who has HIV and their bedding so long as there is not bleeding as well. Mosquitos, bed bugs and fleas cannot transmit HIV.

### **Can you have discordant couples?**

Not everyone who is exposed to HIV catches it. This is because our immune systems differ in their strength and also the amount of HIV virus present in different fluids varies. It is possible for couples to be 'discordant' – that means one has HIV and the other does not – even if they have unsafe sex. Obviously every time they have unsafe sex there is a risk of HIV transmission. Because of this, it is important for both members of a couple to test for HIV. The same is true for transmission from mothers to children as without treatment only one in three babies become infected if their mother is HIV positive.

### **What about circumcision and HIV?**

Men who have been circumcised are less likely to catch HIV than other men. That doesn't mean that they are completely protected from HIV and so they still need to test to see if they are HIV positive, and if they are as likely to infect their sexual partners as other men. If they are negative they still need to use condoms because circumcision only makes them less vulnerable, it doesn't provide complete protection and doesn't protect them from other STIs.

### **What about post-exposure prophylaxis, rape and HIV?**

A person can get HIV from rape. Fortunately after rape a person can be given anti-retroviral therapy to take for 4 weeks. If they take this, it is very likely that they will be protected from getting HIV. These medicines are called post-exposure prophylaxis (or PEP) and they only work if they are taken within 72 hours (4 days) of the

rape. For this reason it is very important to go to a hospital as soon as possible after rape. There a rape survivor will be offered a test for HIV and given these medicines if she is HIV negative. If a person goes within 4 days of the rape and tests HIV positive it means that they had been infected with HIV before the rape. Post-exposure prophylaxis is also effective if there is any other exposure to HIV, so if a person is splashed with blood in a taxi crash or cut by a razor used by someone who has HIV they should also go to a health facility and ask to be given PEP.

### **What about ART and HIV?**

For many years HIV was seen as a death sentence, but anti-retroviral therapy (ART) has changed everything. These are medicines that a person who has HIV can be given which restore their immune system. They are available free of charge from public hospitals. This is not a cure, as the HIV is not removed from the body, and it is necessary for the medication to be taken every day exactly as directed as otherwise the virus can develop resistance to the medication and so they are no longer effective. If a person with HIV takes anti-retroviral therapy as directed by their doctor, he or she can lead a full and healthy life. In order to benefit from anti-retroviral therapy a person must know their HIV status (whether they have the virus) and that is why testing is very important. Anti-retrovirals can benefit people who have very advanced AIDS, but many of these people do start them too late. It is much better to be tested and start treatment before a person gets sick and in that way a person with HIV may never develop opportunistic infections.



## **Exercise E.4: PRRR AND PUKUTU**

**AIMS:** A quick exercise to make everyone laugh and move. This kind of exercise is important after such a thought-provoking previous one.

**DESCRIPTION:** As everyone stands in a circle, they have to react to what you call out.

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Ask everyone to stand in a circle. Explain that you would like them to think of two birds. One calls "prrr" and the other calls "pukutu".
2. If you call out "prrr", all the participants need to rise up on their toes and move out their elbows sideways, as if they were a bird ruffling its wings. If you call out "pukutu", everyone should stay still and not move a feather!
3. Proceed, by calling out "prrr" or "pukutu". Anyone who moves when they shouldn't, or who stays still when they should move, has to fall out of the game. They can then help you to watch the other participants. Go on until you have just a few people left in the circle. Everyone should have had a good laugh.



## Exercise E.5: TESTING FOR HIV / KUJIPIMA KAMCHUNA

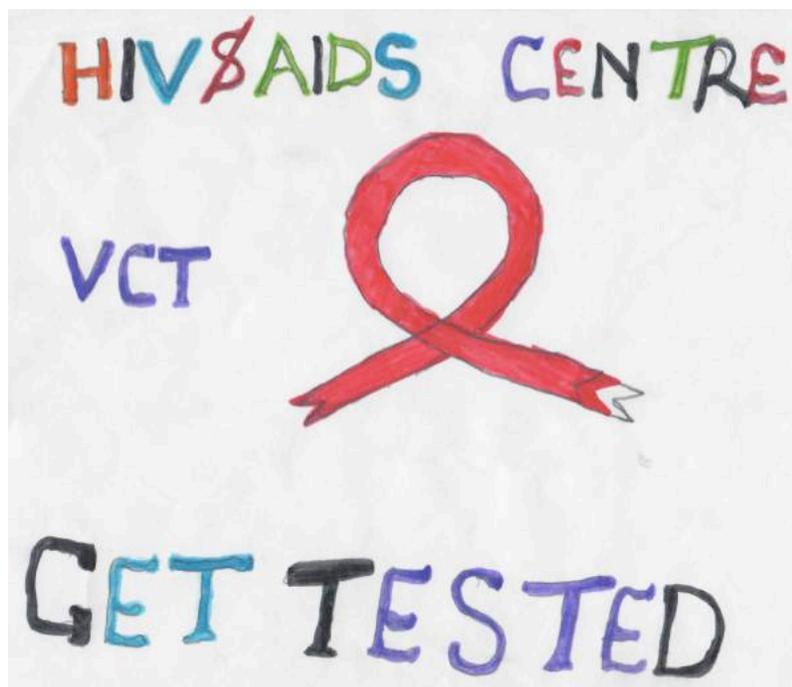
**AIMS:** To explore the pros and cons of having an HIV test

**DESCRIPTION:** Role-play

**MATERIALS NEEDED:** None

### DIRECTIONS:

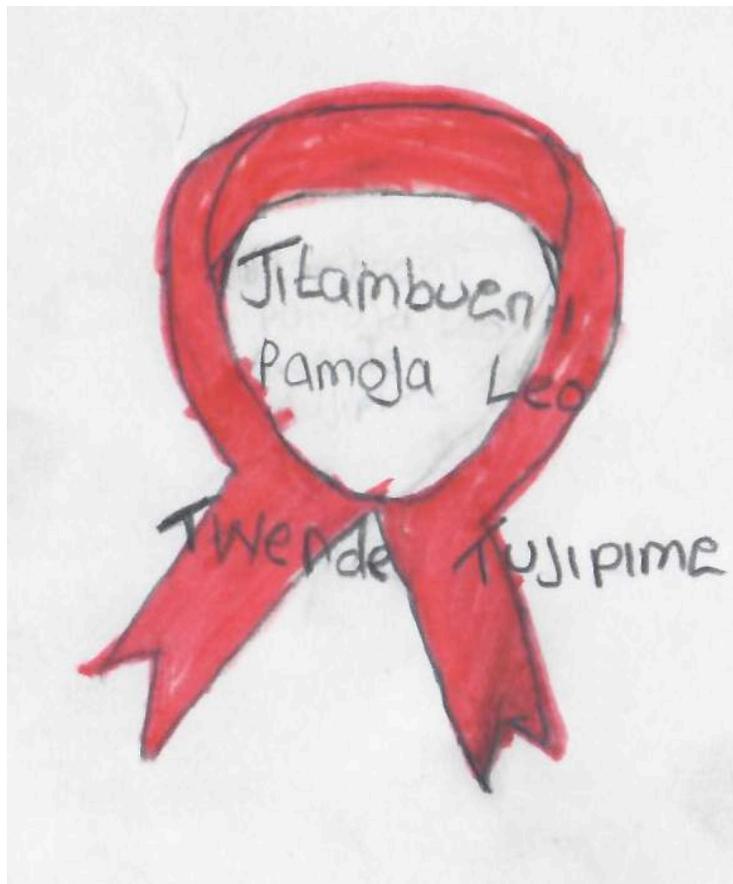
1. Explain that in this exercise we are going to use role play to explore the reasons why we may and may not want to test for HIV and how we can help our friends and family make decisions around testing.
2. Ask for two volunteers to role-play in front of the group. Assign one volunteer one of scenarios below. Assign the second volunteer the role of a Peer Navigator, HIV counselor or friend.
3. Scenarios when a person is asked if they want to test for HIV or may think about testing
  - You are a pregnant street girl
  - You are a man who is feeling sick and has a cough
  - You are a 16 years old and have had unprotected sex
  - You are a street boy and were in a fight and are in casualty getting sutures.
4. Explain to the two volunteers that the person offering the test should start and the other should explain why they don't want the test. The person offering the test needs to argue why testing is a good thing for that person in that situation.
5. Repeat this role-play for scenarios A to D with different volunteers.
6. For each Scenario **ask the group:**
  - Did the person manage to persuade him or her to test? / Alifaulu kumshawishi ajimpime?
  - Is there anything else they could have said? / Kuna kitu yeyote angeweza kusema?
  - What have we learned about HIV testing? / Nini tunejifunza kuhusu kujipima kamchuna?





## Exercise E.6: CLOSING CIRCLE / MWISHO WA MAJADILIANO

1. Ask everyone to sit down again in a circle for the closing time.
2. Using the Maasai stick, ask each participant to mention one thing which they liked about this session and one thing which they didn't like or found hard. Ask each to identify one thing that they will share with someone else.
3. Finish off by thanking everyone once more for coming to this session. Remind participants of a local place where people can go for individual counselling, or counselling and testing. Arrange a mutually convenient time and place for the next session, before saying goodbye.



# SESSION F: SAFER SEX & CARING IN A TIME OF AIDS / KULANA KARATASI

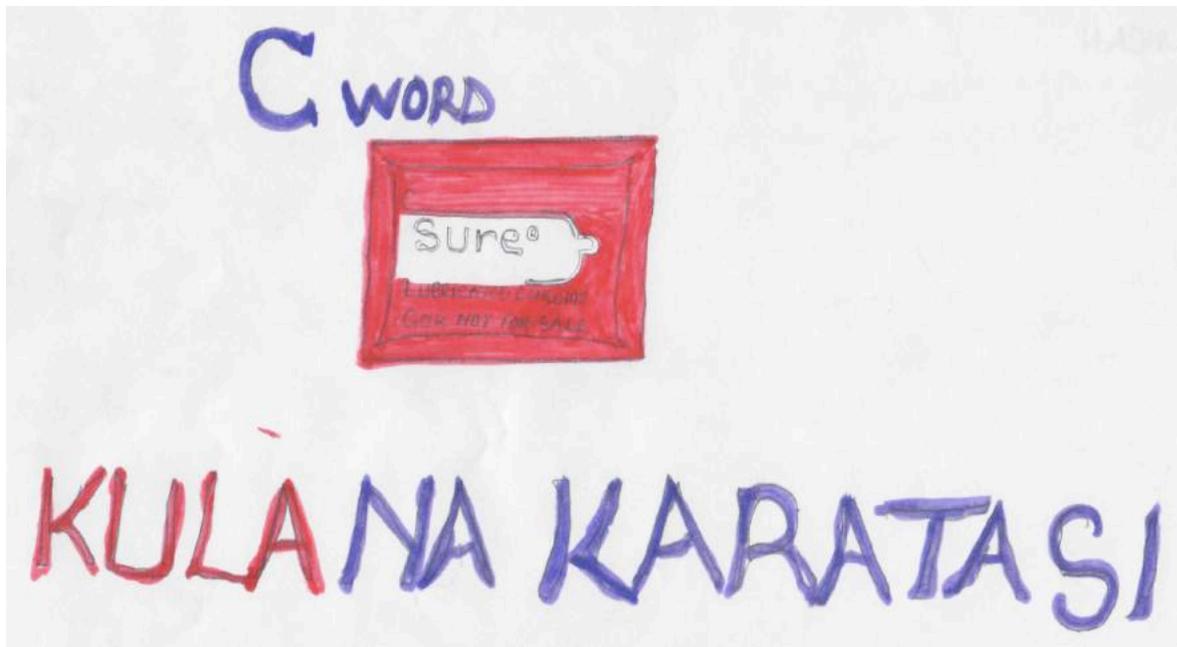
**PURPOSE:** To explore further ways to prevent the sexual transmission of HIV and how to care for people with HIV

**MATERIALS NEEDED:** Pieces of paper, flip chart, pens, lots of condoms, a dildo or some bananas to put condoms on

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## INTRODUCTION

1. Sit in a circle with the group. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
2. Using the Maasai stick, have everyone go around once and recount quickly one good thing that has happened to them since the last session.
3. Review the last session. Ask participants to remind us what we learnt together at the last session - about HIV and why we should have a test and.... Remind them if they have forgotten.
4. Explain that we are going on to discuss HIV prevention in this session.





## Exercise F.1: HIV TRANSMISSION GAME / MICHEZO

**AIMS:** An energizer, to get people moving around and laughing, while recapping about HIV transmission.

**DESCRIPTION:** A physical exercise.

**MATERIALS NEEDED:** none

### DIRECTIONS:

1. Ask everyone to stand up. Then explain that you will call out different ways in which HIV may be transmitted and you want everyone to go to the left of the room if they think HIV can be caught that way, go to the right if they think HIV can't be transmitted that way and stay in the middle if they are not sure.
2. Read from the following list and look carefully for those who seem uncertain where to go or go to the wrong side. When you see that ask them what they are thinking, why they are uncertain – or why they think HIV could be transmitted/acquired that way (or not – depending on what is wrong about their view) and discuss it with the group.
3. Recap that HIV can only be transmitted from someone who has HIV to someone who hasn't by contact with body fluids including blood, semen, vaginal fluids and breast milk.

Circumstances of possible transmission to call out:

#### Very low or No Risk

- Sex with a condom / Ngoni na CD
- Masturbation alone / Kujipunyeto pekeyako
- Masturbation by a partner Punyeto na mapenzi
- Kissing / munju
- Kissing with tongues / kumunju na ulimi
- Sharing a tea cup / kushare kikombe
- Sharing a plate or cutlery / kushare sahani
- Sharing a toilet / Kushare choo
- Cleaning bed linen of someone with AIDS / Kuosha vitamba vya kulala vyo mtu ako na virusi
- Bites from mosquitos / Kummwa na mbu
- Hugging and holding someone with HIV / Kuhug na kushika mwenye ako no virusi

#### Transmission Risk

- Vaginal sex without a condom / Ngoni ya uke bila kutumia CD
- Oral Sex without a condom / Ngoni yam domo bila kutumia CD
- Anal sex without a condom / Ngoni ya matako bila kutumia CD
- Traditional scarring with a shared blade / Kutumia wembe pamoja
- A blade used to do a no. 1 hair cut that isn't cleaned / Kutumia webe kunyoa kipara
- Childbirth if a woman has HIV / Kuzaliwa kwa motto kama mama ako na virusi
- Breast feeding if a mother has HIV / Maziwa na mama ako na virusi
- Sharing a razor / Kutumia wembe kwa umoja
- Sharing an injection needle / Kutumia shindana pamoja
- Getting splashed with blood or cut in a car crash / Kumwagiwa damu ama kugongwa na gari



## Exercise F.2: TAKING RISKS / KUCHUKULIA HATARI

**AIMS:** To help participants to reflect on their own behaviour with regard to risk-taking in life in general.

**DESCRIPTION:** Facilitator Guided Individual Reflection

**MATERIALS NEEDED:** none

### DIRECTIONS:

1. Explain that when people have problems or seem confused, or scared, we like to have clear, simple answers to things. However, we have seen how our lives are full of uncertainty and that easy solutions are rarely available. Explain that this exercise will help us to think about how we handle risk in general in our own lives.
2. Ask participants to define "risk" and briefly discuss in general what they consider "risk" in a group discussion.

**Facilitator Note:** Risk may involve a situation involving exposure to danger. It may expose oneself, someone else, or something valued to danger, harm or loss. Risk perception is the subjective judgment people make about the severity and probability of a risk, and may vary person to person. Mention that what may seem risky to one person may not appear risky to another. Yet, some situations are dangerous for everyone.

3. Ask participants to close their eyes, relax, and sit silently. You will leave them in their thoughts for a few minutes and then guide them through an individual reflection after asking a series of questions. After each question give them a few moments to think through the answer before going on to the next question:
  - Think back over your life and identify any occasion when you took a risk. It may be something quite trivial or it may have had great significance. / Fikiria maisha yako ya nyuma na urikire wakati ulichukua risk ama ilikuwa kitu ya ukubwa Fulani ama ilikuwa na usawa fulani?
  - What factors influenced your decision to take a risk? / Nini ulifanya vehukue risk?
  - What were your feelings at the time? / Ulijua unafeel age wakati hio?
  - What was the outcome of taking that risk? / Baada ya kichukua risk nini kilitokea?
  - Was it positive or negative? / Je ilikuwa kizuri ama kibaya?
  - Are you generally a risk-taker? / We ni mtu wa kutake risk?
  - How do you view risk-taking in others? / Unaonaje watu wakitake risk?
  - What implication does this have for your attitudes towards HIV? / Ukifikiria ukedi/kamchuna achange aje mafikiro yako?
4. Ask participants to open their eyes.
5. **Ask the group:** From their thinking, what thoughts have they had in general about risk-taking behaviour and any ways in which it may affect our responses to HIV/AIDS? / Kwa fikira zao, wanafikiria ni kubusu kuchukua risk wa vile iko na mabadliko kuhusu fikira yao kuhusu ukedi

**Facilitator Note:** We often tend to feel that it is OK to take risks, if they turn out well. We might be praised for our courage! But we tend to blame others if they take risks and things go wrong. We are also much less harsh in judging ourselves, on the whole, than we are in judging others. We must recognise how judgmental we often are about the problems of others. Yet we are all taking risks all the time: when we cross a road in the town; when we give birth to a baby; when we cut something with a knife, etc. Life without risk-taking would be very difficult!



## Exercise F.3: ALL ABOUT CONDOMS / CD

**AIMS:** To enable participants to use a condom correctly, to know where to obtain condoms and to negotiate the use of condoms with a partner.

**DESCRIPTION:** Group demonstration with questions asked to the group by the facilitator, followed by condom use negotiation role-play game.

**MATERIALS NEEDED:** Penile and vaginal model, bananas for everyone present to practice putting on the male condom. Box of male condoms and examples of female condoms, role-play negotiation cards.

### DIRECTIONS:

1. Explain that you are now going to show one another how to use a male condom and find out how much they know about condoms. Hand out a condom each and a dildo or banana and start the demonstration, **asking the class the questions as you go and correcting any wrong or missing information.**

**a) Why are condoms important? / Mbona CD ni muhimu?** A condom will stop a man's sperm or other fluids (semen) coming into contact with a woman's vaginal fluids. So she will not be able to get pregnant and, if either the man or the woman has a HIV, or another STI, it cannot be passed between them.

**b) How can you tell if a condom packet looks and feels good or not? / Unafeel aje CD ikiwa fiti?**

Condoms come in sealed wrappers and are lubricated so they should feel slippery from the outside of the packet. (Help everyone to feel how the condom feels lubricated inside the still-sealed wrapper.)

- Check the manufacturing and expiry dates
- Show that you can check for bubbles
- Slide the condom to one side of the wrapper in preparation for opening

**c) How do you open the wrapper? / Unafunguaje CD?** Demonstrate that the condom wrapper has a smooth and a zig-zag side. Explain that after you shift the condom to one side, you use the zig-zag side to open the wrapper with your hands. Do not use your teeth. Open it carefully, so that the condom does not tear.

**Encourage everyone to do this.**

**d) What can damage condoms? / Nini inaeza haribu CD?** Vaseline and other oil-based lubricants damage condoms. If you need lubrication, only use water-based ones, such as KY jelly, or glycerine or spermicides. If a woman is properly aroused and ready for sex before penetration, then her vagina will be moist enough and no extra lubrication will be needed. (You may need to add here an explanation about the importance of foreplay in enabling a woman to feel properly aroused. You will have discussed the role of the clitoris in sexual arousal and sexual satisfaction during Session C. Remind participants of this.)

**f) How many times can you use a condom? / Unaeza tumia CD marangapi?** Once only. Each time you have sex, you must use a new, unused condom on the penis before it enters the vagina or anus.

**g) When do you put the condom on? / Saa ngapi unaweka CD?** Only when the penis is erect.

**h) How do you put the condom on? / Unaekaje CD ndani?** Pinch the top, closed end of the condom first.

~~~~~  
This leaves a small empty space, to hold the semen. Then unroll the condom down the length of the penis all the way to the base. **Demonstrate this with your condom. Encourage everyone else to have a go.**

i) What happens if the condom tears during sex? / Nini inafanyika CD ikitoboka wakati ni ngono? This is less likely to happen if the condom is good quality and if you have put it on properly. However, it does occasionally happen. The best thing to do is to withdraw the penis immediately and put on a new condom. If the woman is using no other means of contraception she is at risk of pregnancy so must take emergency contraception to prevent pregnancy. If one of the partners is known to have HIV and the other one not to, antiretroviral drugs can be taken for a month in the same way as a person does after rape to prevent infection. If the condom breaks and you do not know your HIV status or your partner's it is a good time to have an HIV test and then you may take antiretroviral drugs if one of you has HIV.

j) What do you do after ejaculation? / Unafanya nini ukisha mwago? After ejaculation, before the penis goes soft, hold on to the bottom of the condom as you pull the penis out, so that the condom does not slip off, then take off the condom carefully without spilling semen. **Demonstrate this and encourage participants to copy you.**

k) How do you dispose of the condom? / Unatupafe CD? Tie the end of the condom in a knot to keep the sperm inside. Wrap the condom in toilet paper or newspaper until you can dispose of it in a toilet, or a pit latrine or dustbin. Then, if you wipe yourselves after sex, remember to use separate cloths. Condoms should be disposed of away from where children or animals can find them and play with them. Where is a suitable place here for you to dispose of them?
(Wrap up the condom in something easily available locally.)

l) What else can a condom protect against, as well as HIV? / Magonjwa and kitu ingine CD inaprotect? Condoms protect against all kinds of STIs and because these can cause infertility, condoms also protect against infertility. They also protect against unwanted pregnancy.

PART 2. Female Condom Demonstration:

- Take out the two female condoms and pass them round in the wrapper for everyone to feel.
- Then open one of the packets and take out the condom.
- Pass it round and ask everyone to notice that there are two rings.
- Mention a woman has to put the female condom in before sex and because she may not yet be aroused it is good to use lubricant and either a water or oil based lubricant can be used.
- Using the vaginal model demonstrate how to insert the female condom.
- Then explain that in order to insert it a woman has to squeeze the inner ring or make a figure 8 shape and push it as far as it will go into her vagina. The outer ring stays on her vulva outside the vagina.
- During sex it's important to make sure the outer ring is not pushed inside. If it is going inside or there is a squeaky noise during sex, it is a sign that more lubricant is needed.
- After sex the outer ring can be squeezed and the condom twisted a bit and then pulled out and the semen will remain inside and it can be discarded safely.

3. Facilitate Group Discussion: One facilitator should write the answers on a flipchart.

- What do men say to women when they don't want to use a condom? / Nini wanaume wanasema wakati wanawake hawataki kutumia CD?
- What do women say to men when they don't want to use a condom? / Nini wakawaka wanasema

wakati wanaume hawataki kutumia CD?

- What do they mean by this? / Wana maanisha nini kwa hii?

4. Now explain that we are now going to role-play condom use negotiation using a game. Pass out the condom use negotiation cards – one to each participant. Explain that everyone has to find their partner by going around and reading each other's cards.

5. When everyone has found their partner, each team will take a turn role playing their condom use negotiation scenario for the group.

Facilitator note: You may need to assist helping participants find their partner if literacy levels are low. Card A matches with B, C with D, and so on.

This exercise calls for strong facilitation, as it is important to push participants to consider what underlies things, which are commonly said about condoms. It is important to draw out the contradictions between what is said and the concern that we protect ourselves from HIV. So if we see "we don't need condoms as we trust each other" as a facilitator push them to say what trust means here. Have the partners both had negative HIV tests? Do they know for sure they are monogamous? How can they be sure? Is it actually the case that they both trust each other or is it just used to try and manipulate the woman? This exercise aims to get participants to reflect on how we often say things about condoms that are not based on how we know things are in our relationships and then we take risks with our health.

6. Facilitate Discussion:

- Ask what they have learnt about condom? / Uliza wamejifuna nini kuhusu CD?
- What can we do to make condom use easier? Tuna weza fanya aje matumizi ya mpira iwa rahisi?

It would be a good time to have a break for 10-15 mins after this exercise before completing the rest of the session.



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**Condom use negotiation card guide. Laminated cards should be made to hand out.**

A. I don't have any kind of disease! Don't you trust me?

A. Sina ugonjwa wowote! Hauniamini?

B. Of course I trust you, but anyone can have an STI and not even know it. This is just a way to take care of both of us.

B. Nakuamini, lakini kila mtu anaweza kupata ugonjwa wa sehemu za siri na hauwezi kujua. Hi ni njia tu ya kutuinga wote.

**C. I don't like sex as much with a rubber. It doesn't feel the same.**

C. Sipendi ngono kutumia mpira. Si sawa kama kawaida

D. This is the only way I feel comfortable having sex but believe me, it'll still be good even with protection! And it lets us both just focus on each other instead of worrying about all that other stuff...

D. Hi ndio njia tu nasikia afadhali, bado ni poa kama tumejikinga! Na inafanya sote kusikia poa kushinda kuwa na wasiwasi kuhusu vitu vingine.

**E. I'm [or you're] on the pill.**

E. nimeza(umemeza) dawa ya kuinga mamba.

F. But that doesn't protect us from STIs, so I still want to be safe, for both of us.

F. Lakini haiwezi kutuzuia kupata magonjwa ya zinaa.

**G. I didn't bring any condoms.**

G. Sikubeba condoms

H. I have some, right here.

H. Ninazo hapa

**I. I don't know how to use them.**

I. Sijui kutumia

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J. I can show you – want me to put it on for you?

J. Naweza kukuonyesha – unataka nikuweke

**K. Let's just do it without a condom this time.**

K. Wacha tu tufanye bila CD.

L. It only takes one time to get pregnant or to get an STI. I just can't have sex unless I know I'm as safe as I can be.

L. Ni mara moja tu na unapata mamba au ugonjwa.

**M. No one else makes me use a condom!**

M. Hakuna mtu hunilazimisha nitumie CD!

N. This is for both of us...and I won't have sex without protection. Let me show you how good it can be – even with a condom.

N. Hii inatuhusu wote... na siwezi kufunya ngono bila CD. Wacha nikuonyeshe vile ni poa -hata ukitumia CD.



## Exercise F.4: HOW DO WE FEEL? / TUNASKIAJE?

**AIMS:** To explore our feelings and fears and how they differ in different situations

**DESCRIPTION:** Discussion with flip chart and guided individual reflection

**MATERIALS NEEDED:** Flip chart and markers

### DIRECTIONS:

1. As the facilitator draw three circles on a flip chart. Start with an inner circle, followed by the middle, and an outer circle.
2. In the inner circle, draw a stick figure. This represents someone in participants' lives who may be a best friend or family member or someone very close to them. Ask participants to think of someone in their lives who is in their "inner circle"
3. Next, ask participants to think of someone in their community, preferably a neighbour or friend on the street who is placed on the middle circle.
4. Next, on the outer circle, ask participants to identify someone from the 'world out there' i.e. a famous politician, musician, actor and so on.
5. Ask participants to close their eyes for a moment and visualise all these people whom they have identified. Whilst their eyes are still closed ask them to imagine that all these people have HIV. They may now open their eyes.
6. Ask for volunteers to discuss what came to their minds when thinking about the people they identified, imagining that they have HIV and that those in the inner and middle circles are people who they live closely with and have lived closely with for a period of time.
  - How do you feel about your risk of catching it from them? / Unafeel hatari gani kwa kupata kutoka kwao?
  - How do you feel about them? / Unafeel aje kuhusu kwao?
  - Would you think they should change their lives if they have HIV? / Unafikiri wanafua kubadilisha maisha yao wakiwa na virusi?
  - Do you think differently about the person in the different circles? Why? / Unafikiri age tafauti kwa ule mtu ako nje ya circle? Kwa nini?
7. Now ask participants to imagine themselves in the inner circle and imagine that later you find that you too have HIV.
  - How would you feel if you were treated in the ways, which you have suggested for the other people? / Unafeel aje ukitritiwa vile wewe mwenyew umepitisha?
  - Does it make you think differently about how others with HIV when you imagine that you have it yourself? / We hufikiria tafauti kuhusu watu ambao wana virusi? Na ukifiri uko nayo?
  - How would you like your friends and community and family to treat you if you had HIV? / Ungependa marafiki na jamii watu wa mtaa wakutunze aje?

**FACILITATOR NOTE:** Points you may wish to cover and discuss

- Since HIV cannot be transmitted by casual contact such as sharing a chair or a mug, there is no reason why people without the virus should fear being infected by normal daily interactions.
- If we take anti-retroviral therapy we can live a healthy, active life with HIV. Many famous film stars, actors, directors, academics, politicians and even sportsmen and women work very effectively whilst

being HIV positive.

- Any of us could get or have the virus or any of our family or friends, even our parents. We should not treat other people in ways we would not want to be treated ourselves.
- If communities reject people who have HIV, those who fear that they have it will try to hide it and not seek medical care, use condoms and so forth. This will cause them great stress, harm their health and place others at risk if they do not use condoms.



## **Exercise F.5: CARING FOR PEOPLE WITH HIV OR AFFECTED BY HIV / KUWAJALI WALE AMBAO WAKA NA VIRUSI VYA NGWENGWE**

**AIMS:** *The aim of this exercise is to reflect on problems experienced by those with HIV, or by those affected by HIV such as orphans and to consider how we can support them*

**DESCRIPTION:** *Discussion*

**MATERIALS NEEDED:** flip chart and markers

### **DIRECTIONS:**

1. Explain that we are going to think about the problems encountered by people with HIV and the problems experienced by others who have been affected by HIV, such as children who have lost parents.
2. Start by drawing a spider belly on flip chart and label it '**problems/shida**'. Ask what are the problems people with HIV encounter or people encounter because of HIV. Write each one on a leg of the spider.
3. When there are no new ideas, ask what can we do as friends, family, neighbours and the community to help with the different problems. What can people like us do? Discuss each one in turn. Take a different coloured pen and note the ideas suggested linked to each spider leg.
4. Conclude by explaining that we all face problems in life and there are always times in life when we need help from others. The principle of '**kusaidia**' is that we should help others. It's one of the most valuable gifts we have from our culture. Everyone faces problems and we can get through our problems much more easily if we don't have to do it on our own.



## Exercise F.6: ONE NEW THING / KITU MOJA KIPYA

**AIM:** Winding down exercise.

**DESCRIPTION:** Everyone shares one new thing they have learnt.

**MATERIALS NEEDED:** Maasai stick

### DIRECTIONS:

1. Say that you would now like to bring the session to a close with a reminder of how much knowledge and experience we already have to share among ourselves.
2. Using the Maasai stick, ask the participant to your right to share with the group "One new thing which I have learnt today is...../ Kitu moja kipya nimejifunza leo ni...." Then ask them to pass the stick to their right and the next person to speak. Go around the circle, finishing with yourself as the facilitator, so that everyone has made a contribution.
3. Go around the circle again with the Maasai stick. This time. Ask each participant to identify one thing that they will share with someone else.
4. Finish off by thanking everyone once more for coming to this session. Remind participants of a local place where people can go for counseling and testing. Arrange a mutually convenient time and place for the next session, before saying goodbye.



# SESSION G: GENDER VIOLENCE / VITA KATI YA MAFAME NA MABUDA

**PURPOSE:** To explore violence in relationships

**MATERIALS NEEDED:** Flip chart, pens

**SPECIAL INFORMATION:** Before the session find out if there are any women's organisations or NGOs, which provide services for abused women in your area. Find out their contact details.

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## INTRODUCTION

1. Sit in a circle with the group. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
2. Ask each participant to share with the group something good that has happened to them since the last session.
3. Review the last session. Ask participants to remind us what we learnt together at the last session - about HIV, about condom use,... Remind them if they have forgotten.
4. Explain that we are going on to discuss other things in this session but will start, as usual, with a game.



### **Exercise G.1: STATUES OF POWER / MSUKUMO WA NGURU**

**AIMS:** To look at the emotions we associate with power and how they affect us.

**DESCRIPTION:** A physical exercise, in pairs.

#### **DIRECTIONS:**

1. Divide the group into pairs. Each pair is going to produce a still image, like a statue. The image will show one person in a position of power and the other in a powerless position.
2. Allow them a few minutes to prepare, then ask them to swap around (so that the powerful figure becomes the powerless and vice versa)
3. Give each pair the opportunity to show them to the rest of the group.
4. Ask for quick comments about what people observe. Ask both members of each pair to express what they are feeling in one word (proud, scared, humble, or whatever).

#### **Feedback and Discussion:**

- Which of the two positions felt more familiar to participants? / Je kati ya nafasi hii mbili ni gani wamusika wamezoa?
- Can they relate any of the emotions they felt to situations in their lives? / Je wanaeza husisha na hisia wanazohisi kwa hali maisha yao?
- What did they feel for the powerless person when they were in the powerful position, and vice versa? / Je walifeel nini kwa watu wasiyu na nguvu au wezo wakati walikua na nguvu, badalisha?

**Facilitator note:** This exercise can activate strong associations and emotions quickly, and it is recommended that you are conscious of this. Those who have strong emotional reactions might welcome an opportunity to talk about them, in which case it can be a good idea to have feedback in small groups.



## Exercise G.2: ABUSE IN RELATIONSHIPS / UGOVYI KWA WA PENZI

**AIMS:** To enable participants to think about abuse in relationships and to distinguish between the use of physical force and other forms of abuse.

**DESCRIPTION:** Group discussion and role-play

**MATERIALS NEEDED:** Flip chart and markers, role-play cards and scenarios

### DIRECTIONS:

1. In this session we are going to think about abuse in relationships. We have all seen this happening on the streets, in our families and neighbourhoods. We are going to start this exercise as a whole group thinking of all the different forms of abuse in relationships.
2. Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group an example of **non-physical and physical forms of abuse**. **Keep going around the circle until no one else has anything to add and everyone has passed.**
  - As the facilitator record each participants' response on the flipchart on categories with headings as outlined below.

**Facilitator Note:** Make sure that at least one example of each of the categories of abuse listed below has been suggested. If one of the categories is empty, as the facilitator make some suggestions based on the content listed below.

- **Emotional and psychological abuse may include:** insults "You're so ugly" or "You're so useless"; being put down in front of others; forbidding a partner to leave the yard or house, or from seeing family and friends; wanting to know everything a partner does; offering no help with work in the home; preventing a woman partner from speaking with other men; hurting something or someone she loves to punish and scare her; not caring about a partner's health and well-being; making a partner know you have other partners; making a partner know you don't love her; yelling, throwing things and threatening violence.
  - **Financial abuse may include:** refusing to give to support your child; taking a partner's earnings; not sharing the money in the home fairly;
  - **Physical and sexual violence may include:** slapping, beating, pinching, hair pulling, threatening or attacking with a weapon, locking a partner in a room, or forcing a partner to have sex or do something sexual they do not want to do.
  - Many men say its abuse when their partners do not do domestic work at home, such as cooking, ironing and cleaning. It is very important that you challenge this and say that when we talk about emotional abuse and hurt we are referring to unfair treatment. Is it fair that women should be expected to cook and clean when men eat at home?
3. Divide participants into groups of four or five people and assign them one of the short role play scenarios below showing ways in which partners may hurt each other.
    - a) A husband insults a wife's cooking (emotional / psychological abuse) / Bwana kukahifa upishi ya mweke

- 
- b) A boyfriend takes a girlfriend's earnings away from her and goes out drinking (financial abuse) / Mwanaume kuchuku mshaara ya mpeziwe kitumia kulewa
  - c) A partner threatens the other that if they don't have sex they will not provide for them anymore / Mwengine kutish mwingine kwa wasipofanya ngono hawatotoa mahitaji yao
  - d) A wife beats a husband when he comes home drunk / Mwanamke kupiga mumewe akicome nyumbani akilewa

4. Give the groups 5 minutes to prepare their role plays

5. Ask each group to present to the whole group.

6. **Facilitate Discussion:**

- What can a person do to help him/herself why they experience such problems? / Mtu anaeza fanya nini kusaidia mbona wanapatia shida kama hayo?

**Facilitator Note:** Many women find it particularly difficult to talk about the ways in which their partner abuses them as they feel that they are to blame or responsible as they 'chose' this man. Men who are hurt by their partner's behaviour may also find it very difficult to talk about as they may feel it makes them feel like they are not men. Encourage people to think about the situations of others if it is easier than personalising it.

7. Remember about the importance of de-roling. Emphasise that it is just a role play and although it can evoke quite strong emotions it is important to remember that you are just acting.





## Exercise G.3: WHEN MEN GET VIOLENT / VITA KATI YA MABUDA NA MAFAME

**AIMS:** To encourage the group to think about sources of help for women who are abused physically, problems which they may encounter seeking help from these sources and ways of strengthening help for abused women

**DESCRIPTION:** Diagram and discussion

**MATERIALS NEEDED:** Flip chart and markers

### DIRECTIONS:

1. Explain that although you recognise that men and women both can hurt each other, men are much more powerful than women in our society and so the impact of men's abuse of women is very much greater. **For that reason we are now going to focus on situations in which women are abused by men.**
2. In this exercise we are going to reflect on the consequences that may follow physical and sexual violence for victims and perpetrators.
3. Ask participants to sit in a circle. As the facilitator, divide a flip chart into two columns. Title one side "**Consequences for women victims of physical violence**". On the other side "**consequences for men as perpetrators of physical violence / matokeo ya wanaume wenye wanahusikia na vita**".
4. Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group one consequence for women and one consequence for men of **physical violence**.
  - As the facilitator record each participants' response on the flipchart on categories with headings.

**Facilitator Note:** If the law on domestic violence is not raised, ask whether anyone knows whether there is a law against hitting your wife or girlfriend. Ask if anyone can tell you what it says? Provide information on the law if no one knows about it. Protection Against Domestic Violence Act of Kenya 2015.

### 5. Ask the Group:

- What are some of the challenges in reporting physical violence as the victim? / Mashida watu hupitia kureport vita kama muhusika?
- What would make it easier for victims to seek care? / Vile unaeza fanya wahuusika kupata asaidizi?
- How can we support victims of physical violence? / Unaeza kusaidia wahuusika na vita?

**Facilitator Note:** In facilitating this exercise it is important to make sure participants consider the immediate consequences in terms of their feelings, and for the relationship, as well as help-seeking actions, possible punishments, and the long-term implications of those punishments.

- **Consequences that may follow for women may include:** physical injuries, depression, anxiety, fear, difficulty sleeping, being frightened of it happening again, hating him, divorce or leaving the relationship, death, taking another boyfriend who loves her, reporting abuse to the police and getting a protection order, moving to a shelter, reporting to the family
- **Consequences that may follow for men may include/Matokeo yanao weza kufuata wanaume:** feeling guilty, feeling bad about himself, fear he will get punished, being arrested and possibly jailed with implications for school completion and working life, divorce / relationship splitting up, losing her

love, becoming more jealous, embarrassment caused by the family becoming involved, being shunned by friends or family

6. Next, we are going to reflect on the consequences that may follow sexual violence for victims and perpetrators.
7. Ask participants to sit in a circle. As the facilitator, divide a flip chart into two columns. Title one side "**Consequences for women victims of sexual violence/Matokea ya wanawake mwafuirika wa vita vya kingono**". On the other side "**consequences for men as perpetrators of sexual violence**"
8. Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group one consequence for women and one consequence for men of **sexual violence**.
  - As the facilitator record each participants' response on the flipchart on categories with headings.
9. **Ask the group:**
  - **Ask if anyone knows about the law and rape? / Unajua kuhusu sheria za rape?** Ask what is defined as rape under the law, can anyone explain? Provide information on the law if needed. Sexual offences Act in Kenya. Age of consent is 18 years of age. Imprisonment of 10 years for rape.

**Facilitator Note:** Again in facilitating this exercise it is important to make sure participants consider the immediate and long-term consequences and things that can be done to get help

- **Consequences for women may include:** injuries, depression, anxiety, fear, difficulty sleeping, being frightened of it happening again, hating him, divorce or leaving the relationship, reporting to the police, reporting to the family, health problems including pregnancy, STIs and HIV unless treatment is taken, following a legal process after opening a case
- **Consequences for male perpetrators may include:** feeling guilty, feeling bad about himself, fear he will get punished, being arrested and possibly jailed with implications for school completion and working life, divorce / relationship splitting up, losing love, embarrassment, being shunned by friends or family



## Exercise G.4: SUPPORTING ABUSED WOMEN / KUWASAIKIA MAFAME AMBAO WAMETHULUMIWA

**AIMS:** To develop and practice ideas for ways of helping to support abused women in the community

**DESCRIPTION:** Role-play

**MATERIALS NEEDED:** none

### DIRECTIONS:

1. Explain that in this exercise we are going to consider how people like us can help when we see a person being mistreated. Ask for four volunteers to do a role play of the scenario of abuse below.
  - **Scenario:** A husband is threatening and starts to beat his wife at home in Langas because dinner isn't ready when he comes home drunk
  - **Actors:** Husband, Wife, two-bystanders/neighbours (one male, one female)
2. **Ask the bystanders:**
  - How do you feel witnessing this scene? / Unahisi aje kuwa shaidi wa dhambi?
  - What could you do to stop it or help the situation? / Nini utafanya kusimamisha ama kuzuiya hali?
3. Ask for the role-play to be run again and this time get the by-standers to act to help the situation or stop the abuse.
4. **Ask the group:**
  - Did this seem real for their community? Any other ideas? Could they do the same? / Waza lingine inaweza fanya sawa?
5. Then ask for another 4 volunteers and ask them to do another role-play. This time do sexual violence, if the previous one was physical or vice versa.
  - **Scenario:** A street boy is trying to force a street girl to have sex because "she owes him" for having had some glue.
  - **Actors:** Mshefa (male), Mshefa (female), two bystanders
6. **Ask the bystanders:**
  - How do you feel witnessing this scene? / Unahisi aje kuwa shaidi wa
  - What could you do to stop it or help the situation? / Nini utafanya kusimamisha ama kuzuiya hali?
7. Ask for the role-play to be run again and this time get the by-standers to act to help the situation or stop the abuse.
8. **Ask the group:**
  - Did this seem real for their community? Any other ideas? Could they do the same? / Waza lingine inaweza fanya sawa?
9. Then ask for another 4-6 volunteers and ask them to do another role-play.
  - **Scenario:** A group of street boys wants to welcome a new girl with collabo
  - **Actors:** Mshefa (female), Many street boys, and a few bystanders
10. **Ask the bystanders:**
  - How do you feel witnessing this scene?
  - What could you do to stop it or help the situation?

11. Ask for the role-play to be run again and this time get the by-standers to act to help the situation or stop the abuse.

12. **Ask the group:**

- Did this seem real for their community? Any other ideas? Could they do the same?

13. **Facilitate Discussion:** Conclude by saying that violence against women hurts all of us. It greatly hurts women and it makes good men feel bad that other men behave in these ways. We have power to stop it if we make it clear that we think that violence is wrong, that no woman deserves to be beaten or forced into sex and that we will not tolerate it in our community. **We have the power to stop violence against women!** / Tuko na nguru ya kukataza vita kinyuma ya wanawake!

**Facilitator Note:** If people do not have ideas about what could be done, you could suggest the following:

- When neighbours hear that a woman is being beaten they could pick up some wood and start beating a cooking pot. In this way the abuser will know that the community knows that he is beating his wife.
- Barracks leaders or older men could be called and they could come and beat at the door to break it up. They might try and take the man away to the Chief or Village Elder (if in the community)
- The neighbours could come and try and take the woman and children to their home for the night to protect her or fetch the police
- Witnesses or Bystanders could try to intervene and protect a woman on the streets if she is being harassed or forced into sex.
- Street youth can encourage others to take up an initiation process that doesn't involved sexual or physical violence





## Exercise G.5: KUCLAP NA VITI

**AIMS:** To lighten the mood. To energise everyone with laughter and movement.

**DESCRIPTION:** In a circle, the facilitator starts a clapping rhythm and people circulate around the chairs. There is one chair too few. When the facilitator disrupts the rhythm with one single clap everyone has to sit down.

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Stand in a circle behind chairs. Ensure there is one chair less than the number of people standing.
2. The Facilitator starts to clap in a quick rhythm and everyone walks circling around the chairs. When the facilitator disrupts the rhythm with one single clap everyone has to sit down in the closest chair.
3. The person without a chair when everyone has sat down is out.
4. One more chair is removed from the circle.
5. This process goes on until there is just one chair and two people left.



## Exercise G.5: CLOSING CIRCLE / MWISHO WA MAJADILIANO

**AIMS:** Winding down exercise.

**MATERIALS NEEDED:** Maasai Stick

### **DIRECTIONS:**

1. Explain that this has been a session which has discussed a lot of areas which people find very difficult to discuss. Say that you would now like to bring the session to a close with a reminder of how much knowledge and experience we already have to share among ourselves.
2. Ask a participant to your right to share with the group "One new thing which I have learnt today is....." Then ask the next person to speak. Go round the circle, so that everyone has made a contribution. Ask each person to identify one thing that they will share with someone else from this session.
3. Finish by thanking everyone once more for coming to this session. Arrange a mutually convenient time and place for the next session.



## SECOND MEETING OF PEER GROUPS / MKUTANO MBILI YA PEERS

**PURPOSE:** To share peer group ideas so far.

**AIMS:** To enable members of the peer groups to meet together and communicate about gender power inequity in relationships and experiences of violence. Role-play is used to assist the discussion.

**DESCRIPTION:** At this meeting the peer groups will share with each other some of their short sketches on how men and women mistreat each other and role-plays on supporting abused women.

### DIRECTIONS:

1. The lead facilitator and/or one other facilitator should:
2. Thank everyone for sparing their time to come to the meeting. Explain that all peer groups have been developing role plays and now they have a chance to learn about women's and men's experiences of gender power inequity in relationships and violence and how it impacts on them.
3. Ask first the women's group to present their sketch on women's experiences. This should be one prepared from the session, and it is best to ensure that it includes emotional abuse or men's controlling behaviours as well as physical or sexual violence. Make sure the role play is not too long or too complicated.
4. After the presentation facilitate a discussion by first of all inviting the opposite gender group to comment on:
  - What was the mistreatment shown in the role play? / Nini illikuwa kufanywa vodoya kwa huu mchezo?
  - Is this common in your community? / Je hihi ni common kwa mtaa yenu?
  - Do you recognise the situation presented? / Je ulielewa hali kwa sahzio?
  - **Then turn to both groups and ask:**
  - What are the underlying expectations that led to the man behaving as he did in the play? / Ni vitu zipi ambazo zili vutia chali a behave kama chali kwa mchezo?
  - What are the underlying expectations that led to the woman behaving as she did in the play? / Ni vitu zipi ambazo zili vutia demu a behave kama demu kwa mchezo?
  - What does it feel like to be the woman? / Je unajihisi age kukaa kama demu?
  - How does the man feel? / Je machali wana sikiaje?
  - What advice do you give the man and woman? / Ni mawaida yani tuta wapa ma demu na machali?
5. Then ask the other peer group to present and repeat the discussion. Facilitate a discussion on how we can work as a community to reduce men's expectations of controlling women and stop men's use of violence.
  - What can we do to help women who experience violence? / Tuta wasaidia aje mafame ambao wanapigwa?
  - How can we stop men being violent? / Tuna wezaje zuiya mabuda juu ya vita?

- 
- How do we change men's expectations about women's roles in relationships? / Nijinsigani tunaweza badilisha matarajio ya wanaume kuhusu roles ya wanawake kwa uhusiano?
  - Do we need to change women's expectations so they stand up to men more when men try to control them? / Wa Tuna badilisha matarajio ya wanawake kukaa ngumu kutawa chap na wanaume?
6. To conclude the meeting go round the room and ask everyone to mention one thing they have learned from this discussion that they didn't know before about the other (or another) peer group. Encourage everyone to continue coming to meetings, explain that all the issues raised will be discussed in later sessions.

# SESSION H: ALCOHOL, DRUGS, AND RISKS / POMBE MADAWA ZA KULEVYA, NA KUJIHATARISHA

**PURPOSE:** To look at how our alcohol and drug use changes our sex practices and to reflect on our attitudes towards drug use and what influences our drug use.

**MATERIALS:** Drug use voting cards, blindfolds, chairs, Maasai stick,

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### INTRODUCTION

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Ask each participant to share with the group something good, which has happened to them since the last session.
4. Review the last session. Ask participants to remind us what we learnt together at the last session - about gender violence. Remind them if they have forgotten. What else did the last session explore?
5. Explain that we are going on to discuss drug and alcohol use this session, but will start with a game.



## Exercise H.1: TRUST & COMMUNICATION / UAMINIFU NA MAWASILIANO

**AIMS:** This game aims to have participants trust their peers and strengthen communication skills.

**DESCRIPTION:** Two teams will aim to have one of their teammates reach a station while blindfolded by following their directions. The first team to have their blindfolded member reach the station wins.

**MATERIALS NEEDED:** 2 bandannas to be used as blindfolds, white plastic chairs placed in the field as obstacles by the facilitator(s), 2 blue plastic chairs – 1 placed at each end of the field as a final destination

### DIRECTIONS:

1. Explain that the session will improve trust and communication amongst the class.
2. Split the class into two groups.
3. The groups should select 1 person from each group to be blindfolded.
4. Have the groups start at opposite ends of the field.
5. With the groups at each end of the field, the blindfolded participant should be spun around 3 times.
6. The facilitator(s) should blow a whistle and the groups should proceed to direct their blindfolded teammate to reach the other end of the field and the blue chair.
7. While the teams are directing their blindfolded player they can also be misleading their opponents. So listening carefully and having strong communication skills with your blindfolded player is important.
8. Should a player bump into a white chair the facilitator will escort them back to the starting point where they start again.
9. The first team to have their blind-folded player reach the blue chair wins.
10. After the game is complete, have all of the participants come together for discussion.

### Discussion Questions:

- Was it hard to direct your teammate? / Ilikuwa ngumu kumwelekesha mwenzako?
- How did it feel to be blindfolded and relying on your peers? / Unafeel aje kufungwa macha na utategemea marafiki?
- Did you trust that your peers would get you to the other end safely? / Uliwaamini marafiki wako?
- How can you improve your communication to get them there easier? / Unaezaje kuboresha mawasiliano kuwafikisha kirahisi?
- Why is it important to communicate clearly? / Mbona ni muhimu kuwasiliana vizuri?
- Why is it important to trust our peers? / Mbona ni muhimu kuamini rafiki?



## Exercise H.2: VOTING ON ATTITUDES TO DRUGS

**AIMS:** To determine participants attitudes towards drug use in a confidential manner. To assist in allowing participants to share their social and personal attitudes towards drug use.

**DESCRIPTION:** This exercise has participants vote on statements about drug use and then discuss why the group voted for the specific statements.

**MATERIALS NEEDED:** Voting cards about drug use

### DIRECTIONS:

1. Explain the purpose of the exercise to the class and that the statements will pertain to their attitudes about drug use.
2. The facilitator should read out the 10 statements one at a time. Ask the participants if they have any questions.
3. Send the participants out into the hallway to line up in order for the voting process to be confidential.
4. Have one participant at a time come in and vote by placing a checkmark on the statement page (have enough copies so there is 1 per person)
5. After everyone has voted have the group come in.
6. The facilitator(s) will tally the vote and calculate what percentage each statement received.

### Discussion Questions:

- Why each attitude statement received votes? / Mbona mtazamo ya taarifa kupata kura?
- Why one got the most and others no votes at all? / Mbona ingine ilipata kura mingi na ngingine ikupata?
- How do other participants positions affect how you voted? / Washinki wengine wali affect aje kupiga kwako kura?
- Would you change your attitude in order to conform? / Unaweza kubadilisa mtazamo wako ndio ilingane?
- Encourage open discussion and stress the importance of making your own decisions and forming your own attitudes and they will be respected.

### Facilitator note:

- Hand out voting cards and prepare copies of them ahead of time

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## Substance Use Voting Statements

- Gaga inafanya nisikie poa  
Glue makes me feel good
- Gaga inanifanya niwe na nguvu  
Glue makes me feel energetic
- Biere/Gaga inanipea nyege  
Glue makes me feel like having sex
- Natumia gaga ndio nipeane kibwenye  
I use glue so I can trade/sell sex
- Gaga inanitoa uoga  
Glue makes me feel courageous / brave
- Sipendi gaga  
I don't like glue
- Mashefa pekee yao ndio hutumia gaga  
Only street youth use glue
- Natumia gaga kwa sababu marafiki zangu wanatumia  
I use glue because my friends use it
- Siwezi wacha gaga  
I can't stop using glue
- Nivigumu kuacha gaga  
It is hard to stop glue
- Hakuna anyejali kama natumia gaga  
Nobody cares if I use glue
- Ninajua venye naweza wacha kutumia gaga  
I know how I can stop using glue



## Exercise H.3: PEER PRESSURE & MADAWA ZA KULEVYA

**AIMS:** To assist youth to solve problems in a non-confrontational way. To give youth a skill set for problem solving.

**DESCRIPTION:** This exercise aims to have the participants practice solving problems they may encounter on the streets related to substance abuse.

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Divide the class into two groups and assign each group a scenario.

**Situation 1:** Two children are being encouraged to use drugs by their peers although they are trying to quit / Watoto wawili wanasawishiwa kutumia madawa na marafiki lakini wanajaribu kuwacha

- **Roles:**
- Child 1 – trying to quit drugs
- Child 2 – drug user
- Child 3 – not using drugs has already quit
- Child 4 – pushing drug use as a leader
- Child 5 – drug dealer
- Child 6 – outreach worker
- Child 7 – drug user

**Situation 2:** A gang leader is trying to force a child into a gang in order to go steal money or goods from a community member / Mkubwa wa kikondi anajaribu kulazimisha mtoi kwa kikundi ndi aende aibe pesa ama bidhaa

- **Roles:**
- Child 1 – gang leader
- Child 2 – gang member (unsure of what to do)
- Child 3 – policeman
- Child 4 – policeman
- Child 5 – community member
- Child 6 – gang member (doesn't want to steal)
- Child 7 – gang member (cooperating with leader)

2. Read the scenarios to each group and have the participants decide fairly who will play which role by drawing a number from a hat.
3. Give the groups 15 – 30 minutes to discuss how the problem and how they would solve it
4. Have each group act out solving the problem for their peers or have everyone sit in a circle and say one thing their character would do in the situation.
5. After each group presents, the facilitator should discuss the manner in which the problem was solved, how it can be improved and if other methods that may be available to solve the problem. Recording the children's answers will provide insight in how to improve these specific problems and give ideas about what the children need.

**Possible solutions to Situation 1:**

- Create support network – reaching out for other non-users for support
- Contacting an outreach worker for support
- Saying 'no' and removing yourself from a situation without conflict
- Getting yourself out of a gang and off the streets
- Going back home if possible

**Possible solutions to Situation 2:**

- Seek help from outreach worker
- Reach out to peers to talk with gang leader about the issue
- Getting yourself out of a gang and off the streets
- Going back home if possible
- Tell police forced into it and pinpoint gang leader





## **Exercise H.4: INFLUENCES ON YOUR DRUG AND ALCOHOL USE / KWA NINI UNATUMIA POMBE NA MADAWA ZA KULEVYA**

**AIMS:** To increase self-awareness about what influences a participant's drug use. Identifying what influences drug use in order to attempt to find ways to mitigate use

**DESCRIPTION:** This exercise aims to explore what influences drug and alcohol use by street youth in Eldoret, while creating self-awareness among the youth participants.

**MATERIALS NEEDED:** none

### **DIRECTIONS:**

1. Have the group sit in a circle.
2. Ask the group what factors influence their drug use: situations, people, places, feelings etc.
  - What encourages them to use drugs? / Nini inawapa motisha kutumia madawa ya kulevya?
  - What discourages them to use drugs? / Nini inakosa kuwapa motisha kutumia madawa ya kulevya?
  - How does using drugs or alcohol affect your risk taking? / Je utumizi wa madwa za kulevya au pombe yanaduru your risk taking?
  - What happens when you have sex when using drugs or alcohol? / Nini inafanyika wakati umefanya ngono ukiwa high?
  - Do drugs and alcohol affect your ability to have safe sex? / Je? Kutumia madawa ya kulevya inazvia uwezo wako wa kutumia kinga?
3. The facilitator can be taking notes about the influences in order to assist in what might mitigate drug use.
4. Bring up safe drug use versus unsafe use. Have the group think of unsafe drug use in the local context of Eldoret. (By rivers, while driving, while riding a bike, by a river, while alone etc.)
5. Based on the factors that discourage drug use, brainstorm as a group ways that individuals can avoid drug use.
6. Good ideas can be implemented into an outreach program or curriculum activity that the group can write up.
7. Ask if there are any questions.



## Exercise H.5: CLOSING CIRCLE / MWISHO WA MAJADILIANO

1. Thank everyone again for coming. Ask each member of the group in turn to mention one thing that they have learnt today and one thing that they are looking forward to doing before the next meeting.
2. Ask if there are any more questions about today's session that anyone would like to ask.
3. Ask each person to identify one thing, which they have learned that they intend to share with another person before the next session.
4. Remind everyone of the time and place for the next meeting and say you look forward to seeing them all again there.



SESSION I: SUPPORTING OURSELVES & BEING ASSERTIVE /  
KUJISAIDIA SISI WENYEWE NA KUA SAWA

**PURPOSE:** To find new skills to change the ways in which we behave. To develop more assertiveness skills.

**MATERIALS NEEDED:** Tug of War rope, flip chart, markers, Maasai Stick

**CONTENTS:**

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**INTRODUCTION**

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Ask each participant to share with the group something good which has happened to them since the last session.
4. Review the last session. Ask participants to remind us what we learnt together at the last session - about alcohol use and taking responsibility, and the influence of each of these on the spread of HIV and other STDs. Remind them if they have forgotten. What else did the last session explore?
5. Explain that we are going on to discuss other things in this session, but will start with a game.



## Exercise I.1: PUSH & PULL / KUSUKUMA NA KUVUTA

**AIMS:** To energise the group, to introduce the idea of conflict.

**DESCRIPTION:** Two groups of participants pull against each other.

**MATERIALS NEEDED:** Rope

### DIRECTIONS:

You will need to be outside for this activity

1. Split the group into two.
2. Line up the rope
3. When you say "Anza/Start" have each side pull
4. Each team will try to pull the other over to their side. The team that pulls the other over the middle line wins.





## Exercise 1.2: CONFLICT RESOLUTION / MIZOZANO VILE TUNA RESPOND

**AIMS:** To gain an understanding of the different ways we respond in the face of conflict. To remind ourselves of verbal and body language clues which warn us of an attitude of type of behavior in others. To notice these signs in ourselves and use them as an opportunity to recognize what kind of response we are likely to get and check that it is what we want.

**DESCRIPTION:** Group Discussion and Role Play

### DIRECTIONS:

1. Sit in a circle with the participants. Explain that when people want to influence the behaviour of others they sometimes communicate in ways that are not very helpful. In this session we are going to look deeper at how we try to influence the behaviour of others and at ways we respond when others try to influence us. In particular we are going to think of way we communicate that are **assertive, attacking, passive or manipulative**. All of us use some of these strategies some of the time. In this session we look at how we try to influence the behaviour of others or ways we respond when others try to influence us and look deeper into these.

2. We are going to start with an exercise in which we think of types of behaviour which are **attacking, avoiding or manipulative**. Write these three headings on a flipchart.

### 3. Ask the group:

- What are some attacking behaviours? / Tabia gani ambazo ni za kuvamia?
- What are avoiding behaviours? / Tabia gani ambazo zina tengwa?
- What are manipulative behaviours? / Ni tabia zipi ambazo zina fao kuendeshwa?

**Facilitator Note:** Remind the group that we all use some of these approaches some of the time. Often they may be the easiest way of dealing with a situation in the short term but in the long term there can be problems, for example if you are usually passive people come to take you for granted, if you are usually manipulative, people may come to dislike and avoid you.

### Attacking

- Nagging /Kuchezea
- Shouting / Kupiga kelele
- Interrupting / kuintera na kitu
- Exploding Warning (If you don't do this!) / kulipua onyo
- Correcting (Look at the facts!) / Kuangalia ukweli or kukosoa
- Persisting (I am right!) / Kusisitiza (Niko Right!)
- Insulting / Kutusi
- Sarcastic / Kijeli
- Revenge (I'll get you back for this!) Kulipisza kisasi

---

## Avoiding

- Withdrawal / kutoa
- Sulking in silence / Kununa kimya
- Being angry with the wrong person / Kikasinikia mtu asintoa
- Avoiding conflict at all costs / Kulenga vita kwa njia vyovyote
- Talking behind someone's back / Kusengenye
- Trying to forget about the problem / Kujaribu kusahau shida
- Not saying what you think / Kutasema unayofikiria
- Not being honest in case you hurt the other person / Kutoamini kama wmekwaza mwingine
- Pretending to agree / Kijifanya kukubali
- Being polite but feeling angry / Kwa mpole lakini umekasirika

## Manipulative

- Threatening to leave or kill yourself / kufisha kutoka na kujiua
- Begging & pleading / kuomba kwa upole
- Making others feel guilty / Kufanya mtu afeel ako na makosa
- Emotional blackmail / Usaliti wa kihisia
- Crying / Kulia
- Offering something e.g. food, conditional on support in completely different areas / Kupatiana kitu eg. Chakula, kusaidia kwa nja vyovyote ville
- 

4. Separate the participants into three groups and assign each group one of the three role-play scenarios below. Give each group 5 minutes to prepare a short role-play to show an example of the aggressive, passive, and manipulative behaviours.

### Scenario 1

- A street person (male or female) has received glue from the barracks leader but has not paid.
- Character 1: Mshefa who received glue
- Character 2: Barracks leader

#### Barracks Leader:

Aggressive/Attack Response: Nitakuvunja. Nitakukata. Wewe nitapatia glue na unahitaji kulipa pesa.

Examples:

- **Aggressive/Attack:** To fight back and cause more problems where a fight erupts.
- **Avoid the barracks leader:** Run away from the barracks leader
- **Manipulate:** Cry and you say ohh please just this one time I really need this.
- **Assertive:** Let me find the money and I will give to you today.

### Scenario 2:

- Being peer pressured into stealing phones from older street youth
- Character 1: Young Mshefa is being pressured to steal phones
- Character 2: Older Mshefa

---

### Scenario 3:

- Veranda and an askari who usually lets people sleep there and then sometimes changes his mind or wants something in return
- Character 1: Street girl who usually sleeps on the veranda
- Character 2: Askari

4. Have each group present their role-play one by one and facilitate discussion after each role-play with the following questions:

- Why did the person behave in an attacking/avoiding/manipulative way? / Ni kwa nini mtu anaishi kwa kushambulia / kuepuka / kuendesha?
- How did they show that they were attacking/avoiding/being manipulative with their words and body language? / Je wanaoyesha aje ya kuwa wanashambulia, wanaepuka, kuendeshwa na maneno na lugha ya mwili zao?
- What was the effect of their behaviour on the situation? / Je nini ni athari ya tabia zao hali hiyo?
- Can you suggest a different way of behaving? / Je unaweza amua jinsi nyingine tofauti ya kuishi?

### Feedback and Discussion:

- What signs can help us to recognise and even predict others' behaviour? What signs can we learn to recognise in ourselves, which warn us that we are embarking on an unassertive approach? How can we alter our pattern of reacting and begin to learn a new response? How does it feel to change our body position?

### Facilitator Note:

Assertiveness involves telling someone exactly what you want in a way that does not seem rude or threatening to them - you are standing up for your rights without endangering the rights of others. Assertiveness has as much to do with body language as with what we say. And what we say is often unconsciously influenced by our own body language. If we adopt defensive physical postures, such as looking down, hunching our shoulders, we are unlikely to speak assertively. On the other hand, if we adopt assertive body language, this can make it easier for us to speak assertively. An assertive response is a centred response. We are balanced - not leaning forward in an attack mode, not falling backwards in an avoiding mode. Although most of our confrontations are verbal rather than physical, there are often visual signs, even if they are tiny, of our body going on the attack or defence. This exercise is a step towards using the signs we get and building up a desired response rather than an immediate reaction.

**Assertiveness:** Use 'I' statements, look the person in the eye, don't whine or be sarcastic, use your body.

**Aggressiveness:** Expressing your feelings, opinions and desires in a way that threatens or punishes the other person - you are insisting on your rights whilst denying the rights of others. Aggressive behaviour includes: shouting, demanding, not listening to others, saying others are wrong, leaning forward, looking down on others, wagging a finger or pointing, threatening or fighting.

**Passiveness/avoidance:** Giving in to the will of others - hoping to get what you want without actually having to say it - leaving it to others to guess or letting them decide for you. Passive behaviour includes: talking quietly, giggling nervously, looking down or looking away, sagging shoulders, avoiding disagreement, hiding face in hands.

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Manipulative: Whining, looking as if you are about to cry but trying to stop yourself, sometimes people who are being manipulative pretend at first to be passive and then manipulate through their speech e.g. "of course I cannot stop you going to Nairobi to work, although I expect I shall be raped and murdered here without your protection".



Exercise I.3: SAYING 'NO'? / SEMA 'LAA'

AIMS: To help participants find effective ways of saying 'No' to unwanted sexual situations

DESCRIPTION: Role-play.

MATERIALS NEEDED: None

DIRECTIONS:

1. Start by explaining that it is often difficult for us to say clearly what we want sexually. Sometimes we agree to having sex even if we do not want it because the other person has begged and pleaded with us and saying 'No means no!' is just too difficult. In this activity we are going to share our experiences of saying 'no' and practice saying 'no' in different ways to make it clear how we feel and what we want to say without hurting the other person.

2. Explain that we are going to do role-plays of three different kinds of situations. Divide the group into pairs and give each pair one of the three scenarios below.

Scenario 1: Saying no to sex with a boyfriend/husband as you are currently busy

Scenario 2: Saying no to a man or woman who is being persistent that you have no interest in having sex with.

Scenario 3: Saying no to sex because someone gave you something (clothes, food, drugs, alcohol) and expects sex in return

3. Give the pairs 5-10 minutes to practice their role-play.

4. Invite three of the pairs to demonstrate their role-plays.

5. Facilitate Discussion:

- How do you know whether the person means 'no' or not? / Tutajuaje iwapo mtu anamaanisha hapana au sio?
- What are more effective ways of saying no? / Zinaza fanya kusema laa ?
- How does it feel when your partner refuses to listen to your 'no!?' / Unahisi aje ikiwa mpenzi waka ame kata kukusikiza 'laa!?'
- How would you feel if your partner carried on having sex with you anyway? / Je unaweza fanya aje mpenziwa akikudinya kila wakati?
- Why do some people force others to have sex even though they do not want it? / Mbonda watu wengine wana lazimisha wengine kufanya nogono hata kama hawataki?
- How does this affect sexual relationships? / Je haya yana weza kuathiri uhusiano wa ngono?

Facilitator Note:

This is an immensely powerful exercise. Women should use all their bodies to say “no”. Each woman should be standing tall and firmly, she should “stand her ground” and feel that her weight is centred and not unbalanced; she should look at the “man” right in his eyes and she should look forthright, not scared. She should use her voice as a weapon and should shout, not whisper, “no!”.

Participants may find this very difficult to begin with. There may be a lot of giggles and women saying they can’t do it. You need to give them a lot of praise and encouragement. In your area the problem may not be so much for a woman to say “no” fiercely, but that she may actually want to say “yes” at times. If so, how can she react so that she feels in control of the situation? Could she say “yes, with a condom!” safely? You may want to discuss this with your participants, then encourage them to try out which alternative answers best meet their needs, through further role-play.





Exercise I.4: STOP STREET HARASSMENT / KUZUIA UNYANYASAJI

AIMS: To practice finding assertive responses. To apply skills from the previous exercises.

DESCRIPTION: An interactive group exercise exploring how to give assertive responses in difficult situations.

MATERIALS NEEDED: none

DIRECTIONS:

1. Explain that we often find ourselves in situations where we have to think very quickly about what we want to say and we often don't think of a good response until it is too late. This exercise will give us a chance to practice thinking fast...! We are going to start off by reviewing the four types of behaviour: aggressive, passive, manipulative and assertive. Run through each behaviour type asking participants to say the kinds of things that people say or do when they are behaving aggressively, passively, manipulatively or assertively. Many of us are used to behaving in unassertive ways when we are faced with a difficult situation this exercise is about building our assertiveness skills!

2. Divide participants into groups of three. Each group will be told about a different situation in which they have to pretend to be a person who is trying to get someone else into doing something they don't want to do. Each group member should decide entirely by themselves what their opening line will be. Each group will have to have a response to each statement. For example "I am a sugar daddy and you are a young girl and I want to seduce you – come with me in my car and I will get you chicken and chips" Response – "Thank you very much, but I do not want to ride in your car or have chicken and chips with you".

Group 1: An older man not from the streets is pressuring a street girl to come with him.

Group 2: Barracks leader telling boys they have to sniff glue to belong to the base

Group 3: A street boy is coercing a street girl saying he will give her alcohol and glue if she has sex with him.

3. Group discussion about what responses are most effective and why?

- How did people deal with the "bait" they were offered? / Ni jinsi gani watu wanajipanga na "bait" waliyotolwea?
- How do they usually respond to similar situations? / Ni kiaje kwa kawaida watajibu kwa hali kama izo?
- What could they do differently? / Ni nini wanaeza fanya tofauti?

FACILITATOR NOTE: The response people are aiming for is one which does not compromise them and which allows them to state their position without resentment or inappropriate anger. They should face the problem, but without being aggressive or completely shying away from it. It is hard to do, but gets easier with practice, as participants gain confidence.



Exercise 1.5: CLOSING CIRCLE / MWISHO WA MAJADILIANO

1. Thank everyone again for coming. Ask each member of the group in turn to mention one thing that they have learnt today and one thing that they are looking forward to doing before the next meeting. Ask each to identify one thing they will share with another person.
2. Ask if there are any more questions about today's session that anyone would like to ask.
3. Remind everyone of the time and place for the next meeting and say you look forward to seeing them all again there.

SESSION J: LET'S LOOK DEEPER / TUANGALIE KIUNDANI

PURPOSE: To reflect on why we behave in the ways we do

MATERIALS: Flip chart, markers, craft paper

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INTRODUCTION

1. Sit in a circle with the group. Everyone should be at the same level, including yourself.
2. Welcome everyone back to the new session. Thank everyone for coming. Enquire about late-comers or non-attenders.
3. Ask each participant to share with the group something good that has happened to them since the last session. Review the last session.
4. Explain that we are going on to discuss other things in this session.



Exercise J.1: O JINA!

AIMS: Energiser, to make people laugh. To help people realise the power of the way in which we express language to communicate our feelings to others.

DESCRIPTION: Participants each have to say "O Mary" round the circle, one after the next.

MATERIALS NEEDED: none

DIRECTIONS:

1. Stand in a circle. Explain that, as we learnt together in our second session, there are many different ways of communicating with our bodies.
2. Explain how this game will illustrate how different uses of our voices combined with our bodies can also communicate a lot to others.
3. Take a common name in the community. Using this name, and saying "O Mary" show how you can say it with anger, with fear, with sexiness, with laughter. You give an example of these first!
4. Ask each participant in turn in the circle to say "O Mary". Ask each one to try to say it in a different way, expressing a different feeling.
5. When everyone has had a go, ask participants to analyse what they have learnt from this. Points they may raise may include loud or soft voices, confident or unconfident voices, emphasis, facial expressions, eye contact, body language and so on.
6. Encourage everyone to go around again with a new name. This time they should show a different emotion/feeling.



Exercise J.2: WHY DO WE BEHAVE AS WE DO? / KWA NINI TUNABEHAVE KAMA TUNAFANYA

AIMS: To help participants consider situations from their own experience which involve sex and HIV risk and to analyse how they behaved so as to help them think of other ways of handling similar situations in future.

DESCRIPTION: Brainstorming, followed by role plays, and plenary discussion and analysis.

DIRECTIONS:

1. Ask the whole group to suggest different situations in which people like us, of the same age and gender, have sex. For example, sex with our spouse, sex with a secret partner, sex for money etc. Then say that some of these situations are happy and safe for both people involved but that some are situations in which one of the partners is unhappy or the sex is risky in terms of HIV or violence.
 - Write these on the flipchart
2. To demonstrate how we can analyse a situation, ask the group to choose one that is risky.
3. **First ask the group:**
 - What factors led to the man and woman having sex in this situation? / Je nini kinaeza fanya mwanaume na mwanamke wakifanya ngono ambayo si nzuri?
 - Why are the man and woman in this situation? / Kwa nini mwanaume na mwanamke wako katika hali hii?
4. Write these up on a flip chart in the form of a spider diagram.
5. Facilitate them to mention all the different factors in our lives that might influence these types of sexual behaviour.
6. Then suggest that as a group you take another example, one that is happier and less risky. Unpack it in the same way.
7. **Ask the group:** what are the key differences between these two situations? / Ni nini haswa ndio utofauti muhimu kati ya hali hazi mbili?
8. Divide the group up into four. Ask each small group to choose one situation in which people like us end up having sex that is unhappy and risky and work out a role play to show this. It can be one discussed or another one of their choice. Ask them to show who the people are, what their situation is and what influences the fact that they end up having risky sex.
9. **Scenarios:**
 - Sugar Daddy
 - Mpango wa kando
 - Commercial Sex situation
 - Alcohol and drug use
10. Then have each role play in turn performed to the whole group. For each role play ask the group:
 - What were the good things about this encounter? / Je? Ni vitu gani a bab zo ni nzuri kwa hii role-play?
 - What were the bad things about the encounter? / Je? Ni vitu gani ambazo ni mbaya kwa hii role-play?
 - What were the influences on the character's behaviour? / Je? Ni nini ambayo imekua motisha kwa hizi tabia?
 - Who is responsible? / Je? Muhusika ni nani?
 - What could either partner have done to improve the bad things? / Je ni nini ineezafanya

mwenzako afanye vitu mbaya ziongezeke?

- How could the actors make the situation safe or avoid having sex? / Jinsi gani watendaje wanaweza fanya hali iwe na usalama au kuavoid kufanya ngono?

Conclude by saying that although people often do not take responsibility for their own actions and lives. We cannot always protect ourselves completely, but often we can do things that make our lives safer and enable us to avoid unhappy and risky sexual encounters. It is important to learn to take responsibility for protecting our selves whilst acknowledging that sometimes this is very difficult.

Facilitator Note:

This exercise acts as an introduction to discussions about several different factors which influence who people have sex with. The influences which people may mention include:

- Wanting to feel special using sex to get status and power violence used to force sex
- Ideas and expectations in the community about sex
- Ideals of how men and women of a particular age should behave and relate to each other
- Ideas that women should be sexually available to men
- Sexual desires and love
- Poverty
- Wanting to have children
- Alcohol
- Expectations that women be controlled by men

The group might want to discuss traditions which influence sex, in particular ideas that once lobola is paid a woman may not refuse her husband sex or that if a woman is widowed she should find an older (usually married) man who will support her family, in return for sex.



Exercise J.3: TESTING THE WATER / KUNONJA MAWOTEZ

AIMS: To encourage participants to reflect on their own most common patterns of behaviour. To look at how our behaviour varies according to changes in circumstances.

DESCRIPTION: An individual exercise in personal reflection.

MATERIALS NEEDED: none

DIRECTIONS:

1. Explain to participants that we have been looking a lot at things which happen around us in our communities, and which shape our lives. We are now going to start to look at things which happen inside us.
2. Ask participants this question: "If you went to the river or dam or sea or swimming pool, and you really wanted to get cool in the water, which is the most likely way for you to get into the water? Would you:
 - Just run towards the sea and dive in? / Kimbia kwa bahuri na uogelea?
 - Walk in slowly, wetting your body bit-by-bit and getting used to the temperature? / kutembea

ndani polepole kugoja mwili kuhisi hali?

- Dip your toe in the water, then decide if you'll go in? / Weka vidole vyako kwenya maji kasha ujue kama utaingia ndani?
 - Stand on the bank contemplating the view and surroundings, and considering what you will do next? / Simama kando ama nyuma kishu ufikiri ya kufanya baadeye?
 - Note: You could act out these actions as you are saying them, to help people laugh a bit! / Unaweza fanya ambavyo unafikiri kufanya iti watu wacheke kiasi.
3. Point to four different corners of the room, one for each action described above. Ask participants to move to a certain corner depending on the action which each of them thinks is most likely for themselves.
 4. Once everyone in the group has moved to a corner, give each type of response a title, such as "plunger", "wader", "tester", "delayer". Ask participants the good and bad things about each of these types of behaviour.
 5. Now ask each participant to consider whether the type of behaviour they chose is their most common way of behaving. If they find that they behave differently in different circumstances, get them to think of a particular situation and a response. Once they have thought about this, they could share their thoughts in groups of three or so.

Feedback and discussion:

- In what ways does our behaviour change in different circumstances? / Bu jwa ndia zipi tabea zeto zinabadilika kila uchao?
- What sorts of conflicts could arise when a "plunger" has to work or live alongside a "tester"?
- In what ways could the two actually benefit from each other? / Kwa ndia gani wanaweza faidika ka wenyewe?
- What are the positive aspects of each approach? / Ni mtazamo upi wa vipengele ya kila mbinu?
- For what reasons do people adopt these different approaches? / Ni kwa sababu gani watu wanapitisha mbina tafauti?

The assumption behind this exercise is that a greater awareness of how we respond in different situations increases our understanding of how we might behave in a situation in which there is conflict. It also encourages us to pay attention to other people's behaviour, and try to understand their needs.



Exercise J.4: The Next Step – Moving on to Livelihoods / Hatua ifya tyao – Kusoga Kimaisha

AIMS: To bring Part 1 of the program to a close and reflect on expectations and what we have learnt to date

DESCRIPTION: Group discussion and song

MATERIALS NEEDED: Maasai Stick

DIRECTIONS:

1. Ask participants to sing a song, preferably one to which they can dance also, which they find happy or funny or both.
2. Explain to participants that you are now at the end of the Stepping Stones ya Mshefa workshop and it is always helpful to a facilitator to learn from participants what they think of his or her guidance and of the Stepping Stones programme.
3. Do they have suggestions for next time it is run? It is also good practice always to review a workshop process, so that everyone has a chance to reflect on what they have learnt.
4. Say that you would like to begin this process by reviewing the expectations, which everyone had of the workshop when they first began it. Remind participants that each of them mentioned thing they wanted and one thing they did not want from the workshop in Session A. Go round the circle now using the Maasai stick, asking each participant to be honest and open and:
 - To say again what these were / Kusema tena hizi ni nini
 - To comment on whether they got the thing they wanted / Kucomment kama walipata vita waivyoitaji
 - To comment on whether the thing they did not want happened / Kucomment kama vita wasiohitaji ilifanyika?
 - To make one overall comment about what they thought of the workshop / Kufanya comment moja mwingoni mwa zingine kushu mawazo yaliyofikiria ya workshop
5. Discuss any negative points, which are raised by the participants, so that you understand clearly why they felt disappointed or let down. Make sure that you take note of this, so that you can modify the way in which you run future workshops. Make sure that you accept criticism of yourself without being defensive. We often find it very hard as facilitators to listen to and accept criticism!
6. Explain that we will host our final peer group meeting next week and then we will begin *Kujijenga Maisha* and meet at the same location and time.
7. Close the workshop and thank everyone for being brave enough to share their lives here with each other and being open to new learning. Remind everyone of the confidentiality pledge at the start of the workshop.



FINAL MEETING OF PEER GROUPS / MKUTANO MWISHO

PURPOSE: To consolidate what has been learned and prepare for the future, promoting communication between the peer groups and, if possible the community more broadly.

TIME NEEDED: Maximum 3 hours.

AIMS: The focus of this session is to share and consolidate ideas about assertive communication and how it can be used to strengthen relationships. To help participants realise further that they do share some similar concerns with other peer groups.

NOTES: This meeting requires some preparation from the groups. The week before it is held the facilitator needs to discuss which role play will be used and plan what will be shown and how the assertiveness communication will be used to turn the situation around or avoid it. It is important to use this opportunity to make sure the group really understands what is required and so you might want to give them time to come up with suggestions, to work these through with them and ensure that everyone is confident about their roles.

DIRECTIONS:

1. Welcome everyone to the meeting. Ask for a volunteer to share the most important things they have learnt since the groups last met for members of the community who have not been attending Stepping Stones. Then mention that the key part of this has been learning assertive communication skills and reflecting on how we may find ourselves in unhappy and risky sexual encounters and how good communication skills can help us protect ourselves from these. Explain that we are going to look at this in role play.
2. Ask one of the groups to show a role play of an unhappy and risky sexual encounter of someone like them, and then ask the group to show how using assertive communication, including 'I' statements can help make the situation safer or avoid the problems altogether.
3. After watching it, unpack it with the other group to ensure there was understanding and processing of the situation. You may ask:
 - **HOW** did the characters come to be in this situation? / Je ni vipi au jinsi gani wahosika wanaweza jipata katika hali hii?
 - **WHY** has this situation developed? / Kwa nini hali kii kitokeya?
 - **WHAT** gendered expectations, poverty, alcohol use, social expectations or other factors influenced the situation? / Nini matarajio ya kijinsi, umaskini, kutumia pombe, maratajio ya kijamii au mambo mengine yanayosukuma hali?
 - **WHAT** were the risks and sources of unhappiness? / Nini nikua hatari na nyanzo vua kutufurahi?
 - **WHAT** was done to turn the risk around? Is this realistic? Could you have done that too? Could anything else have been done? / Nini nifanya kubadilisha hiya hatari? Zilikwaza ukewi? Kivyako ungeyinya iko?
4. The actors in the role play should themselves be encouraged to answer the questions, whilst holding their position in the role play.
5. Then ask the other group, or groups, to present. Unpack this again discussing the following:
 - Did the role plays present situations which were real life in your community? / Je hii role

play iliwakilisha vita zilikwa za ukule kimaisha kwa mtaa?

- What are the barriers to trying to solve problems by communicating effectively and assertively? / Nini ni kizuizi ya kujaribu kufatua shida kwa njia inayotao mwafaka?
 - What can we do in the community to strengthen sharing these skills? / Ni ini tunaweza kufanya kwa jami ili tustrengthen?
6. Finally, mention you are coming to the end of the Stepping Stones programme.
- Do participants have any final comments they would like to share? / Je wahusika wako na komenti yoyote ya mwisho?
7. You could then finish the whole proceedings by thanking all the participants for their great support and hard work throughout the workshop and by asking everyone to close with a song.

PART 2

Kujijenga Kimaisha



Livelihood Strengthening Program for Street-Connected Young People

Cover Illustration by: Edwin Juma

BEFORE YOU BEGIN... KABLA YA KUANZA

Stories: Ahead of Session One of Kujijenga Kimaisha it is necessary to read the story lines and select one story that will be best to use with your group, learn it, identify the key elements, and decide how you will depict these. These stories are relevant to the Kenyan context of street-connected young people, and if the intervention is to be adapted to another context this should include identifying and presenting stories relevant to that context. The stories may evoke emotional responses from some participants, which facilitators need to be prepared for.

Groups: The same groupings of participants in *Stepping Stones ya Mshefa* should be continued into Kujijenga Kimaisha. There are approximately 20 people per group and each group is single sex with two matched-savings chamas within each group.

Preparation: Sessions in Kujijenga Kimaisha often require preparation before the session. Make sure you leave adequate time to prepare flipcharts and other materials before the session.

The Circle Method: As used in *Stepping Stones ya Mshefa*, Kujijenga Kimaisha has been adapted to primarily use dialogue with the use of the 'Maasai Stick' or 'Rungu' to facilitate understanding and group discussion. The use of the Circle creates a safe space, cultivates equality, active listening, suspends judgement, and fosters respect while in the Circle.

Working towards a small achievable goal: Kujijenga Kimaisha has participants reflect on their live and life stories in Session 1 and 2 and has street-connected young people identify a small achievable goal to work towards throughout the program. The idea is that in conjunction with the matched-savings chama program, participants will be able to use their new skills, knowledge, and savings to achieve a small goal related to their livelihoods. This may be starting a small income generating activity, transitioning off the streets, or starting a training program in a vocational discipline for example. Facilitators should encourage and inspire participants to think about their goal throughout the program and work towards achieving it.





Story One: Geoffrey Wafula

Character: Wafula, Male

Born: Bongoma, Kenya

Goals: He wants to start a kuku farm that sells eggs and chicken meat to local businesses and hotels. He wants to continue his volunteer work to support street families and start a registered community-based organization (CBO) as he was helped by a CBO to help transition off the streets himself.

Family and other social capital: His mother was 18 when he was born. He did not live with or really know his father. His father engaged in criminal activity and died in 2004. Before his father died, he tried to make contact with Wafula and bought him gifts. However, Wafula wanted more than just financial support, he wanted a father. His mother had three children from his father, and three from another man. His mother died when he was 10 years old. He ended up shifting between Aunties, but spent time on the streets to make a financial contribution to his Aunt's family, because she had 8 children of her own. His mother was his role model, and she did all she could to love and support her children. She taught him to be the go-getter, and that is why he decided to go to the streets to make money to help his Aunt. He stopped school in Standard 7 when he was 13 because there was no longer enough money for school fees at his Aunt's house.

He is now 19 years old, and lives with his girlfriend in Kamukunji, with whom he has a child. She is dependent on him and he finds her demanding. He does informal jobs like carrying luggage and has a small trolley that he got through support from a community-based organization. This has helped him support himself and some of his siblings who are still in school and live with his Auntie. He is hopeful he will get a breakthrough in his life, which will make him achieve all the things he has ever hoped to do. He depends on prayer.

Wider political/social/economic context: Political violence in 2007/2008 in Eldoret saw the collapse of his Aunt's duka. There was also a lot of crime, alcohol and drugs among the young boys in the area.

Financial Capital: His mother was selling alcohol before she died and didn't leave him or his siblings any money or property. When political violence hit, his Aunt and the family moved back to Bongoma to the family home. Once the violence stopped, his Aunt's family moved back to Kamukunji.

Education: Wafula reached Standard 7. He could not finish primary because there was no money for school fees as he was the oldest and the provider.

Employment/Skills: He was very independent, trustworthy, likeable, and a good business minded as a young person. He got the community organization to support him to get a trolley business started in town. He was also trained on tailoring and makes and fixes clothes.

Health: He doesn't use drugs and is in good health.

People who influenced him:

- Mother
- CBO social worker

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- Auntie who helped him and his siblings

**Life crises and challenges:** Pregnant girlfriend who cannot sustain herself and he was an orphan and ended up on the streets.

**Lessons:** His mother was an inspiration. He really benefited from meeting the worker at the community-based organization. They assisted him a lot and got him some training and an income generating activity. He wanted to finish his primary education and really wants to make sure his children can too. He wants to be able to provide for his family, this will bring him peace in life.

## Geoffrey Wafula

I was born in a small village close to Bungoma, my family is Luhya and my family has lived in this area as subsistence farmers growing sugarcane, maize, and had chickens.

Growing up in the village, life was difficult. My mother was not well supported by my father who lived a separate life as a criminal and had another wife and three kids. My mother resorted to brewing busaa and chang'aa to help support my two siblings and I.

My mother was very young when she gave birth to me at 18 years old - she was just a teenager. I was the first born in the family. My father did not live with us he only occasionally came around and gave us very little money. He stayed in Bungoma town and I hardly ever saw him and he rarely supported us. I really didn't know my father.

Growing up, I discovered my father did not lead a good life. He was a thug, he stole cars and money and was in and out of jail. I found out he had a second wife and three other children. He died in 2004 when I was only six years old. My aunt told me about my father's life when I was older. As a man we needed him to be there for us, to support me and my siblings in ways other than financial. My mother was unemployed and struggling in the village, so his presence would have been much appreciated. Because our father wasn't around, my mother took another man in the village and had three more children when I was very young. That made six of us in total and life was very hard. This new man didn't stay with my mother - he just gave her more mouths to feed.

Life in the village was hard because there wasn't enough food. My mother worked hard and managed to send us all to primary school. I took care of the shamba and helped a neighbour watch their cows on the weekends. As payment, the neighbour supplied my mother with milk. My Aunt would send my mother money to help support us.

In 2005 we moved to Eldoret as my Aunt had a good family and a business running a duka that made good money. She told my mom it would be good to leave the village and come to Kamukunji where she could start a new life and have help and support from her.

My mom opened a new alcohol shop in Kamukunji and made more money from selling chang'aa. We had a small house next door to my Aunt.

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In 2007, there was political violence due to the elections. Things got very rough and there was a lot of crime in Kamukunji and violence. Many of the boys my age were getting into trouble stealing, using drugs and alcohol at a young age. My Aunt and mother decided we should all move back to the village in Bongoma to stay safe until things returned to peace in Eldoret.

When we were back in the village my mother died. I was only 10 years old. This was a very hard time for me. My mother had always been loving and supportive and did her best for us. My Aunt decided to take my two youngest siblings and I in to live with her as we were now orphans. My other siblings went to live with another Uncle. My Aunt took us back to Eldoret in 2008. She kept us in school and worked hard and life was good. For three years I studied hard and was doing well in primary school. When I reached Standard 7, my Aunt told me she no longer had enough money to pay my school fees.

Being independent and a go-getter, I decided to go to the streets to hustle to help support my Aunt and my siblings. I had to drop out of school. Life was hard but I needed to help my siblings stay in school as my Aunt had done so much for us.

When I was on the street during the day I met a bunch of street boys who showed me how to hustle. I started carrying luggage, begging, and selling madimbo. I would go home at night to Kamukunji and sleep at my Aunt's house and bring some home money to help keep my siblings in school. I didn't get involved in drugs or alcohol as growing up my mother taught me lessons from the men that would come buy alcohol. She showed me that drinking and using drugs can destroy ones life. So even though I was working on the streets, I did not start using drugs and alcohol.

While on the streets, I met an outreach worker from a local community-based organization that was helping street children and youth in Eldoret. I started attending the centre and they provided me vocational training in tailoring. I was now 14 years old and knew I was not going to go back to school. I wanted skills and training so I could make money and ensure my siblings still went to school. I did well tailoring and the CBO helped me start a small tailoring business through their centre. I continued to hustle on the side. By the time I was 16, I was making enough money to get by and support myself. I met a girl and she became my girlfriend. We got a small house in Kamukunji together.

I was shocked that I got my girlfriend pregnant at 16 years. I was hustling with tailoring and other odd jobs on the streets, but I was very worried about supporting a girlfriend and a young child. The social worker at the CBO assisted me to get a trolley business started too. I worked very hard in tailoring, with my trolley and some side hustle on the streets. Learning that my girlfriend was pregnant was very hard for me. I wasn't ready to be a breadwinner and have a child. The social worker taught me about family planning so I could be prepared and not get my girlfriend pregnant again. Our baby was born in 2015. Through my hard work I managed to support my baby and girlfriend and maintain our small house in Kamukunji. My Aunt helped my girlfriend and showed her how to look after the baby.

The CBO has helped me a lot in my life. I have been given skills. My mother was my inspiration. I want to help others who find themselves in situations like I have. My dream is to start a kuku farm that sells eggs and chicken meat to local businesses and hotels. I want to continue and be able to do volunteer work to support street families. I would like to start my own community-based organization as I was helped by a CBO to help transition off the streets and now I want to help others. I want my children to complete primary and secondary

~~~~~  
school and have both a mother and father in their life. Being able to support my family and have a small business will make me very happy in life.



**Wafula's goal and dream of having a small kuku Farm**



## Story Two: Njeri Wa Mwagi

**Character:** Njeri, Female

**Birth:** Nyeri

**Goals:** A happy home for herself and her children. To ensure her children can go to school and get their diploma, to ensure they can help her when she is old and she wants them to help the community.

**Family and other social capital:** She was the fourth born child of her single mother. She didn't know her father. Her mother was a house maid/nanny. Her mother lost her job as a nanny when the family accused her of stealing money. So her mother was unable to provide for the four children. The children stopped going to school because she lost her job. All four of the kids started to go to the streets because there was no food at home. Njeri only reached class 4. Her mother met a man and remarried. The man does not want Njeri or her siblings, so her mother lets them go and goes off with the man and abandons her children. Njeri is on the streets and meets some other girls and decides to migrate to Nakuru town because they heard there is food there and people take care of children like her. When she arrives in Nakuru she joins a base, and is initiated at the base. She gets a boyfriend in Nakuru and goes to live with him. He is providing food and shelter for her. Njeri gets pregnant and goes to the clinic and finds out she is HIV positive. Her boyfriend is very angry and verbally and physically abuses her and kicks her out of the house. Njeri is back on the streets in Nakuru, pregnant, and she starts selling glue and alcohol. Njeri ends up in juvenile because they caught her selling glue and alcohol. Life was very difficult and she was released from juvenile and she got back to the streets. She meets another man who is a watchman who takes her in and provides for her until she gives birth. He becomes the Baba Mkate. The man is good and he keeps her as his wife. The husband supports her and sends her to catering training.

**Wider political/social/economic context:** Njeri grew up very poor in central Kenya and migrated to Rift Valley Province. Her mother was uneducated and did not have a lot of external social support.

**Financial Capital:** Her mother was unable to provide from a young age. On the streets she had multiple partners from whom she sought financial and material support. She sold glue and alcohol to help support herself, until she was sent to juvenile. Currently she is being sent to catering training.

**Education:** She reached class 4. She has started catering training.

**Employment and or skills learned or shown:** Currently she is getting her catering certificate. She has not had a business or a lot of education.

**Health:** HIV-positive

**Life Crises and challenges:**

- Her mother leaving her and her siblings when she was very young
- Living on the streets and migrating to Nakuru
- Finding out she was HIV positive and losing her boyfriend
- Having a child at a young age

**'Lessons' the character has shared:**

- She realizes that she needs training in order to have a job that is legal
- She says the biggest mistake in her life was selling glue and alcohol
- She doesn't want to end up like her mother
- She wants to support her children and family
- She has managed to learn from the bad experiences and find the positives.



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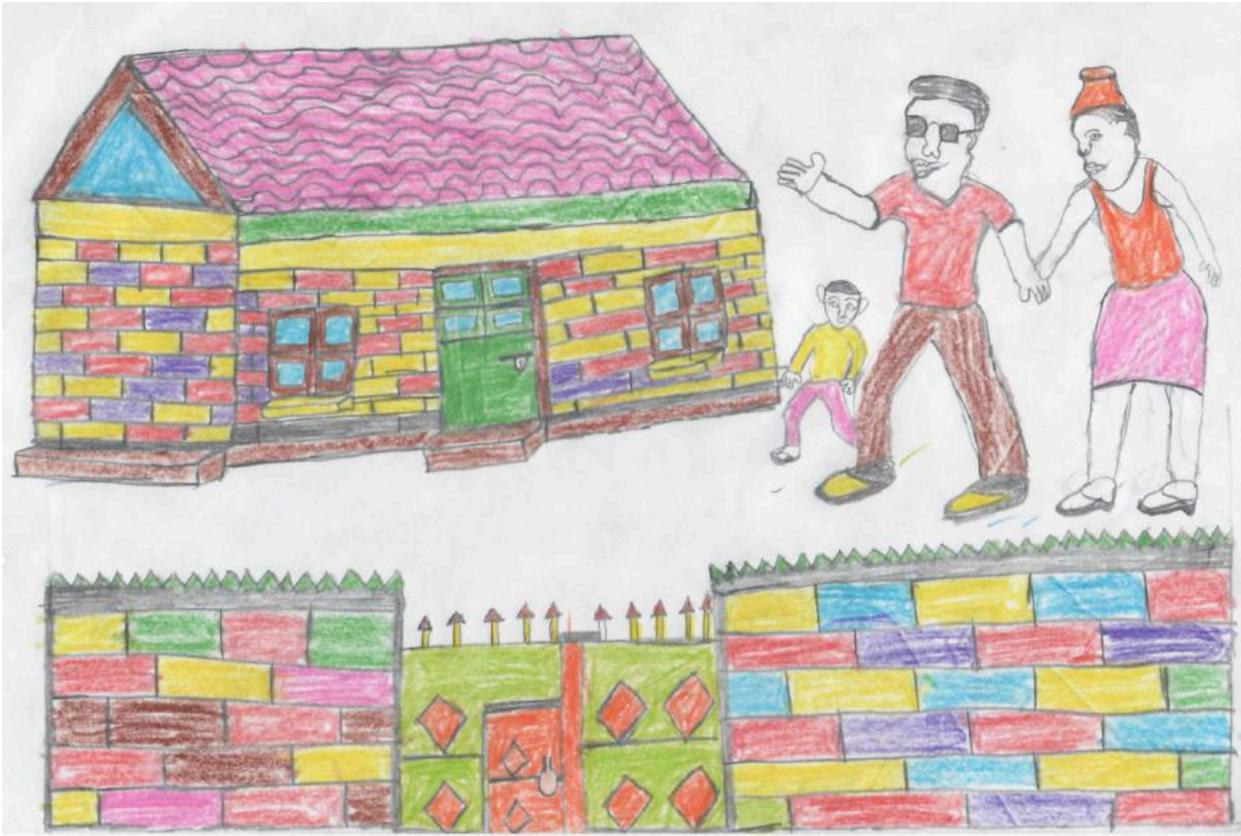
## Njeri Wa Mwagi

I was the last born in 1999 to a single mother and we lived in Nyeri. I didn't know my father growing up as he didn't stay with us and wasn't a part of our lives. My mother, bless her, was a nanny and maid in a wealthy household. She tried her best to provide for us and be a good mother, but didn't have any resources to support us. My mother didn't have a primary school education, but she did her best to send us to primary, and my siblings and I got to go to school while my mother had a job. I reached class 4, and wanted to continue in school, but my mother lost her job when the head of the household claimed that my mother stole money from them while cleaning. We then had nothing at home and had to learn to survive on our own. My siblings and I went to the streets in search of food for survival and to beg to help our mum. My mum engaged in transactional sex and remarried a bad man who did not want us around. He kicked myself and my siblings out of the house and my mother abandoned us to be with this bad man.

I was very young on the streets, I think I was 10 years old and met a group of girls in town who became my friends. They suggested we go to Nakuru as they heard there was lots to eat there and an organization that helped street children like myself. I was scared, but we set out on foot and got rides on and off throughout our journey. We reached Nakuru town and met many other street children there. The girls and I found a base to join and were initiated into the barracks by the boys. I stayed in the barracks the next few years in Nakuru and begged and lived on the streets with my girl friends. When I was 14 I got a boyfriend who was also *Mshefa*. He provided me food and a small shelter in a slum around town. He was difficult and demanding though, he would physically and emotionally abuse me if I didn't stay home and cook and clean the house. He didn't want me to leave our house. Because he provided for me, I did as he said as it was the only shelter and sense of security I had. At 16 I found out I was pregnant. My friends encouraged me to go see a doctor at the clinic. While receiving care, I found out I was HIV-positive, I was devastated and considered taking my life. I was counselled that I needed to let my boyfriend know my status and find out if he knew his status as well. I went home to tell him the news that I was pregnant, but that I found out I had HIV. When I told him, he went mad and started to physically abuse me and call me terrible names. He kicked me out of our house that night and told me to never come back. I went back to the streets and found my girl friends.

The girls on the streets help me start selling glue and alcohol in the barracks. This gave me some money to support myself while pregnant. I slept on the streets at night with the other girls, and during the day would work hard to sell these items. The municipal caught me though and I was sent to juvenile detention. I was released from juvenile and went back to the streets. I was sleeping on a verandah at night and met a night watchman who was very nice. This night watchman and I established a relationship and he decided to provide and take care of me. He helped me get into HIV-care and was very understanding as his sister is HIV-positive. I started taking ART and have achieved viral load suppression.

At 17 my baby Shiro was born. The watchman and I live together and he provides for us and treats Shiro like his own child. He has helped me to get some training and has sent me to catering school. It is my dream to finish my catering certificate and start a small business cooking as I really enjoy it. I want to have a happy and healthy family and be able to support my children and ensure they have a better life than I have had.



**Njeri's goal of having a happy and healthy family and small catering business**

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# SESSION 1: INTRODUCTION AND STORYTELLING / UTANGULIZI NA KUSEMA HADITHI

## **PURPOSE:**

- Introduction participants to the broad aims of the livelihood *Kujijenga Kimaisha* program
- Explore course expectations
- Get participants to reflect on their life stores

## **MATERIALS AND PREPARATION:**

- Craft paper for each participant
- Crayons
- Flipchart
- Markers
- Maasai Stick
- As the facilitator(s), choose a story from those at the beginning (Wafula / Njeri). Read and familiarize yourself with this story. On craft paper draw the character's story. (You must draw this ahead of time. An illustration of Story One and tips on what needs to be included is provided in Exercise 2 of this session)



## Exercise 1: Expectations and consent / Matarajio na Idhini

**AIMS:** The aim of this exercise is to introduce participants to Kujijenga Kimaisha, and explore course expectations

**DESCRIPTION:** Participants sit in a circle and express their hopes and fears or concerns about participating in the Kujijenga Kimaisha workshop.

**MATERIALS NEEDED:** Maasai Stick, Flipchart, Markers

### DIRECTIONS:

#### 1

- Explain that the livelihoods component of the intervention is aimed at helping them to think about, and plan for, their futures in ways that will assist them to make a living in the long term.
- Say that Kujijenga Kimaisha hopes to help them work towards three outcomes in their lives that are particularly important to survival: saving money, finding work and generating income through small business initiatives. The goal is to think about how you can use your matched-savings chama money to start a small business.
- Say that the intervention will focus on these three areas in particular during the last five sessions.
- Say you understand that they don't know much about what the coming weeks hold, and that in this exercise they will share their hopes and concerns regarding the workshop and their participation.

#### 2

- Ask each participant to think of one hope (tumaini/ombo) and one fear (jail/agopa) or concern around the Kujijenga Kimaisha workshops.
- Ask participants to share these with the group.
- Using the Maasai stick, have participants sitting in a circle go around one by one and share one hope and one fear.
- Record them on a flip chart. Make sure the comments are limited to the workshop and their participation.
- Look out for any feedback relating to how participants will treat each other. Say that the workshop is a group effort and the group needs to work together. Remind participants about the exercise at the beginning of Stepping Stones that spelt out the ground rules for group participation.
- Explain that what will be offered is information about various life 'building blocks', and a place to share and learn about better ways of addressing their life challenges. Emphasise that the workshops aims to help participants find ways that work for them in building their own futures.



## Exercise 2: Sharing the Stories / Kushare Stori

**AIMS:** The aim of this exercise is to get participants to reflect on their life stories as a way of facilitating thinking about their own livelihood resources

**MATERIALS NEEDED:** Maasai Stick, Flipchart, Markers, Illustrated timeline of character

### DIRECTIONS:

1

- Explain that story telling will be used to demonstrate the kinds of things the intervention will be covering over the next weeks. It will also help explain the idea of 'livelihoods'.
- Explain that you are going to tell the true story of a young person's life. Names and places have been changed to protect the person's identity. The participants need to listen carefully because the exercises that follow will use the information from the story.

2

- Tell participants the story you chose. As you go through it, show them the illustrated 'life continuum' you have prepared on a flip chart. This will help them draw their own life stories in the next step. The story must map out the issues that will be covered in the workshop, but in the context of a 'real life'.
- Highlight these aspects of the story, also noting the prompts in Exercise Three below:
  - a) The various resources that the character was able to draw on during his or her life
  - b) How the resources were used
  - c) Life challenges, as well as opportunities and good experiences
  - d) Points of learning and reflection
  - e) Shocks and stressors and how these were dealt with.

# MAISHA YA WAFULA

## PEOPLE WHO INFLUENCED ME

**Mama:** Alijiifunza kuhusu kukaa mwanauume mzuri. Sijatumia madawa ya kulevya kwa sababu nimeona effects mbaya wakati mama akona biashara ya chang'aa  
**Auntie:** Anasaidia sana mama yangu na alipatia care na alilipa school fees, na tulikaa pamoja kwa nyumbani  
**CBO:** wamepatia training na wanasaidia sana wamejiifunza kuhusu kuishi kizuri

## DAU NA SUPPORT INGINE

Mama brews chang'aa na busaa

Baba aliiba for pesa. He doesn't stay with us and is no help

Auntie ako na duka kwa Eldoret. Alipatia pesa na alisaidia mama yangu.

Auntie invites us to move to Eldoret. Mama alianza biashara ya pombe mpya kwa Kamukunji

Nilizaliwa kwa kijiji karibu Bongoma town

1998 \* 2000-2003 \* 2004 \* 2005-2006 \* 2007

## KEY EVENTS, SHOCKS, NA OPPORTUNITIES

Nilienda shule ya primary kwa Bongoma. Nafanya kazi ya ng'ombe weekendi

Baba alikufa. Hakuna pesa zaidi ya baba.

Tunashift kwa Eldy, kwa plot kati kati ya Auntie kwa Kamukunji

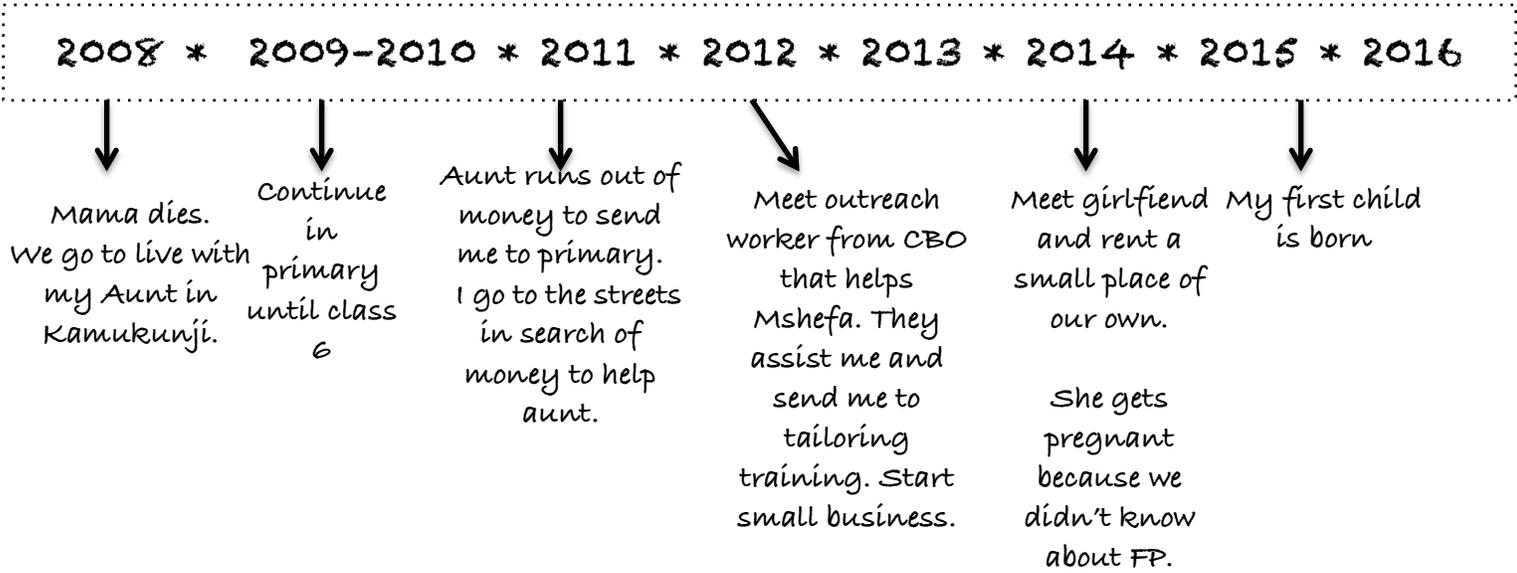
Post-election violence in Eldoret. Tunashift kwa Bongoma

Growing up in the village, maisha ni ngumu. My mother was not well supported by my father. My father was a criminal and had another wife and 3 kids. My mother brewed busaa and chang'aa to support us



To start a kuku farm that sells eggs and chicken meat to local businesses and hotels. Want to volunteer to help local street families and start a registered organization to help street youth.

**WAFULA'S GOAL** →





## Exercise 3: Unpacking the meaning of 'livelihoods' / Kutua maana ya 'Kimaisha'

**AIMS:** To have participants reflect on their own life stories and identify challenges, crises, good experiences, and resources.

**MATERIALS NEEDED:** Craft paper, crayons, flipchart, markers

### DIRECTIONS:

#### 1

- Ask participants to use the craft paper to record the story of their own lives in whichever way is most comfortable (drawing, writing, or both). If they are more comfortable with drawing, then encourage that. Leave space to add in things that may come up later on. Give them different coloured crayons.
- Use the following questions as prompts. Write them up on a flipchart:
  - a) When were you born and where? / Ulizaliwa mwaka gani na ni wapi?
  - b) What is the first important event you can remember in your life? / Tukio gani ya kwanza unaezakumbuka kwa maisha yajo?
  - c) What major challenges, family crises or other shocks can you recall? / Changamoto na shida ya kifamilia gani unaeza kumbuka?
  - d) Fill in memories of good experiences. / Jaza kumbukumbu ya uzoefu mazuri.
  - e) Fill in the times you moved houses or moved from one area to another. / Jaza masika ulihama kutoka kwa nyumba ama kutoka kwa mtaa ingine hadi nyingine.
  - f) What schools did you attend? Did you complete your schooling? / Ulienda shule gani? Ulimaliza shule?
  - g) Fill in any family loss, deaths or illnesses that have affected your life. When was this? What happened? / Jaza kama umepoteza mtu kwa familia, kifo, magonjwa ambayo lmedhuru maisha yako? Ilikuwa lini? Nini ilifanyika?
  - h) Fill in any special people who influenced your life. Who were they? When did you meet them? / Jaza mtu maalam abaeo amekushauishi kwa maisha. Ni akina nani? Ulikutana nao lini?
  - i) Fill in the good times and bad times because of having money or being short of money. / Jaza ngakati nzuri na nyakati mbaya kwa sababu ya kupata pesa na kukosa pesa.
  - j) Fill in times when you felt particularly safe or in danger – what happened? / Jaza ngakati umefeel kama uko safe ama hatari.

#### 2

- Participants work in pairs (with someone they don't know very well) and discuss and share their stories.
- They must focus on discussing:
  - a) The resources they have in their lives / Rasilimali wako nayo kwa maisha
  - b) How they use them / Wanazitumia aje?
  - c) Points of learning and reflection on their lives. / Pointi ya kujifunza na ksengere nyuma kwa maisha yao

- Write these points on their craft paper
- Each person has 10 minutes.
- Participants must ensure that they only give snippets of their lives in order to make the exercise more interesting and save time for discussion.



## SESSION 2: SITUATING SELF / HALI YA KIBINAFSI

### PURPOSE:

- Participants reflect further on their life stories in order to reflect on the resources they draw on in building their lives and livelihoods
- Facilitate participants' identification of some medium term goals for their livelihoods

### MATERIALS AND PREPARATION:

- Flipchart
- Markers
- Crayons
- As a facilitator, familiarize yourself with the five kinds of resources or 'capitals' below. Have a copy of this ready to use with the group.

### FIVE LIFE RESOURCES

|                            |                                                                                                                                                                                                                                       |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Human / Binadamu</b>    | These include education, faith, health and physical strength, life experiences and wisdom, intelligence, knowledge and skills. Spiritual resources include prayer, fellowship and hope.                                               |
| <b>Social / Kijamii</b>    | These resources include people's support networks – family and friends, kinship networks, religious groups and the organisations to which they belong. This includes farmers groups, savings and loan groups, and HIV support groups. |
| <b>Physical / Material</b> | These can include homes, equipment, trolley, boda boda, and tools, bicycles, vehicles, wells, clothes etc.                                                                                                                            |
| <b>Financial / Fedha</b>   | These resources include cash or items that can be converted to cash quickly and easily. Financial resources might include income from a hustling, a job, well-wishers, or payment from abroad.                                        |
| <b>Natural / Asili</b>     | These include access to natural resources such as soil, water, plants, trees, animals, air, rainfall and oceans.                                                                                                                      |



## Exercise 1: Dreams and wishes for our lives / Ndoto na matakwa ya maisha yetu

**AIMS:** The aim of this exercise is to facilitate participants' thinking about the kinds of dreams and wishes they consciously or subconsciously hold for their lives

**MATERIALS NEEDED:** Craft paper, crayons, flipchart, markers

### DIRECTIONS:

1

- Ask participants to spend a few minutes reflecting on the last session. Ask them to share any similarities between aspects of their own story and the story you told them.
- Briefly explain the five resources of human, social, financial, physical and natural resources. **Pin up the prepared flipchart.**
- Say to participants that livelihoods are about those resources we have or do not have which could help us make a living.
- Have participants' brainstorm and list different resources they have in their lives.
- Record these on a flipchart.
- Keep the five resources and participants' resources flipcharts pinned up for the remainder of the course.

2

- Tell participants to think about the following: "What would your life look like if you felt that life was 'good' (this is 'good enough', or 'acceptable to me' or 'I can live with it like this'). What would life look like to feel 'really great', (what is your ideal world)."
- Ask them to record these wishes on their craft paper life story if they wish. Say that they are being asked to draw two distinct 'pictures' in their minds.
- Have the flipchart below prepared and add some of the resources that came up in the previous exercise.

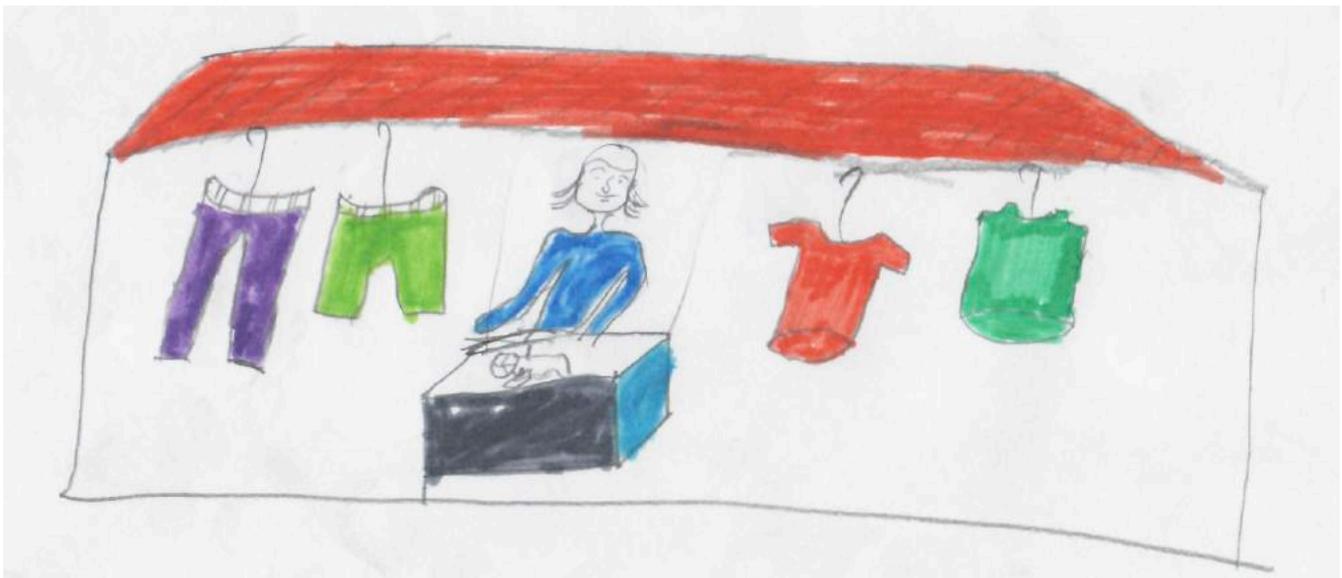
| WISH LIST                |                            |       |                                                |                                                         |                                                                |
|--------------------------|----------------------------|-------|------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------|
|                          | Good enough/<br>Acceptable | Great | What do you need for this wish to 'come true'? | What life areas or resources would you need to draw on? | What practical steps can you take to help this wish come true? |
| Money / Pesa             |                            |       |                                                |                                                         |                                                                |
| Health / Afya            |                            |       |                                                |                                                         |                                                                |
| Housing / Nyumbani       |                            |       |                                                |                                                         |                                                                |
| Safety / Usalama         |                            |       |                                                |                                                         |                                                                |
| Relationships / Uhusiano |                            |       |                                                |                                                         |                                                                |
| Food / Chakula           |                            |       |                                                |                                                         |                                                                |
| Training                 |                            |       |                                                |                                                         |                                                                |

**3**

- Give each participant a few seconds to say one thing they wished for that would make life 'good' and one that would make life 'great'.
- List these in the correct life area on the chart. Add in a new category for anything that does not fit.

**4**

- Now ask participants to think about their wishes in relation to the other categories. Ask them to think about what it would take for this wish to come true. They are only allowed to discuss the wishes on the chart.
- For example a wish for a big house means money, which mean work of some kind, and health in order to work. In other words there might be a few things that have to happen in another category for them to be able to work towards life being 'good', and life being 'great'. Write an example in the last column for participants to see.
- Ask participants to think about the following questions:
  - What are some unforeseen consequences (good and particularly bad) of this wish? / Ni matokea gani hazionekani? (mbaya na kizuri)
  - How might this wish be achieved – some practical steps? / Matakwa hya yanaweza fikiwa vipi?
  - Which wishes and steps are realistic and within their control? / Matakwa hatua gani ni za ukweli kwa uwezo wao?





## Exercise 2: Setting Livelihood Goals / Mpangilio wa maisha na malengo

**AIMS:** The aim of this exercise is for participants to think critically about what shapes their dreams and to set some realistic goals. Facilitators should encourage participants to pick one realistic small goal they would like to work towards for the remainder of the program.

**MATERIALS NEEDED:** Craft paper, crayons, flipchart, markers

### DIRECTIONS:

#### 1

- Give each participant his or her life story on craft paper. Participants work alone on their life story. They must record one realistic goal they would like to work towards that they think is possible to achieve over the next three to six months. The goal should be small and can relate to any area of their lives. The goal can be an interim step to a bigger wish, or a goal from the previous step.
- Explain to participants that for the rest of the Kujijenga Kimaisha workshops we will be focusing on working to reach or achieve this goal

#### 2

- Ask participants to think about where their dreams and goals come from and to think about what made them develop these particular goals.
- Ask participants to share their one realistic goal with the group if they would like to.
- Using the Maasai stick, go around one by one and have participants share their one realistic goal with the group they are going to work towards.
- Write participants' goals on the flipchart.
- Ask participants the following questions about their goals:
  - Where or how these goals started? / Wapi na namna gani malengo haya kuanza?
  - Why the participant has this goal? / Kwa nini mshiriki ana malengo huu?

#### 3

- Tell them that the role of this session is to help them think carefully about their chosen goals and to start developing steps towards realising these goals. Say that the workshop will also help them become more aware of the connections between their dreams and other aspects of their lives.
- Ask whether the discussion has changed how they feel about the wishes they identified in the previous exercise. Discuss.

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## **SESSION 3: RESOURCES NEEDED TO SUSTAIN LIVELIHOODS AND REACH GOALS / RASILIMALI YANAYOITAJIKA KUTOSHELEZA MAISHA NA KUFIKIA MALENGO**

### **PURPOSE:**

Create awareness about the resources that people need in order to: produce livelihoods; cope with crises in their lives; and work towards their identified goals

### **MATERIALS AND PREPARATION:**

- Flipchart
- Markers
- Story from Session One
- Maasai Stick
- Blank paper slips and pens

### **WELCOME**

1. Welcome participants to the session for the day.
2. Go around and do check-in using the Maasai talking stick. Each person to share something good that happened to them since the last session. Or anything else they want to share.
3. Conduct an ice breaker energizer
4. Have the group come back to sitting in a circle
5. Ask the participants:
  - a. If they see their goals as achievable, or whether they still need work? / Kama wameona matakwa yao inaeza kutimika, uma bado wanaitaji jara?
6. Tell them that they are going to work on clarifying these goals in the next session.
7. Give them 5-10 minutes to revisit their goals. Go around to participants and discuss any concerns or questions, or help them make changes to their goals.



## Exercise 1: Thinking about livelihood resources / Kufikiri kuhusu rasilimali ya maisha

**AIMS:** The aim of this exercise is to create awareness about the resources that people need in order to produce livelihoods and cope with crises

**MATERIALS NEEDED:** Craft paper, crayons, flipchart, markers

### DIRECTIONS:

#### 1

- Say: It is clear from our stories that we all have resources in our lives, which are very important for our livelihoods. These resources help us cope with the crises and other shocks we may experience.

#### 2.

- Ask the group to recall the different resources in the story that helped the character to build his or her life. Participants should feel free to refer to their own life stories if they would like to.
- Use the prompt questions below to get participants to recall resources or resources which may not have been mentioned, particularly human, social and financial resources.
- Write participants' responses of the various resources on pieces of paper.
  - If people are struggling to think of resources, get them to think of an example of a livelihood and the types of tools, equipment or resources people use to do that job or skill.

Highlight how several resources are often combined to build livelihoods. Write these up separately on pieces of card.

### The following prompt questions should be used:

- What knowledge and/or skills did the character have that helped him or her in his/ her livelihoods?
- What level of formal/informal education?
- Was he or she in good health and strong enough to work? If not, why not? Was it because of sickness or poor nutrition?
- Did s/he receive support (either financial or practical) from inside or outside the immediate household, or from friends, neighbours, extended family or others?
- What type of support and how often?
- Did any community structures or support groups assist him/her in any way?
- Did any political structures assist or cause problems in any way? Did s/he have access to connections with influence or people with power? Examples of these could be local leaders, politicians, NGOs or churches.
- What possessions did the character have access to that helped him/her? What kind of home did s/he have and what was the physical environment like in terms of water, sanitation, transport etc?
- Did s/he have savings, or things that could easily be turned into cash? Did s/he get work or was s/he able to receive financial help from someone else?
- Did the use of any land, water, produce or livestock help? Did she or he have access to any?

**3.**

- After all the resources have been written down, ask participants to sort the cards listing the resources into categories.
- Which resources belong together? / Ni rasilimali gani ziko pamoja?
- Give them a few minutes to start thinking and discussing categories.

**4.**

- Review the definitions of resources presented in Session Two. Explain that this is one way of thinking about different resources. Ask the group to sort the resources into the five categories, moving the pieces of card to the 'correct' group.





## Exercise 2: Examining my resources / Kupima rasilimali yangu

**AIMS:** The aim of this exercise is to work on participants own resources and how these might be developed to reach their own goals.

**MATERIALS NEEDED:** Craft paper, crayons, flipchart, markers, Maasai Stick

### DIRECTIONS:

**1.**  
Have two copies of the below flipchart drawn up before the session to use with the group.

|           | Describe the resources you have access to and how you use them? / Kuelezea rasilimali na upatikanaji na jinsi ya kuzitumia? | How can you access new resources? Write down ideas. / Jinsi gani unaweza kupata rasilimali mpya? | Write down any ideas you have to make better use of the resources you already have or have access to. / Andika chini mawazo yoyote unayo ambayo iko tumia vizuri au fuifikia rasilimali tayari? |
|-----------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Human     |                                                                                                                             |                                                                                                  |                                                                                                                                                                                                 |
| Social    |                                                                                                                             |                                                                                                  |                                                                                                                                                                                                 |
| Physical  |                                                                                                                             |                                                                                                  |                                                                                                                                                                                                 |
| Financial |                                                                                                                             |                                                                                                  |                                                                                                                                                                                                 |
| Natural   |                                                                                                                             |                                                                                                  |                                                                                                                                                                                                 |

- 2.**
- Split the group up into two and half the group go with one facilitator and half with the other.
  - Using the two pre-drawn up flipchart sheets, you will facilitate discussing resources in participants' lives.
  - Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group **one HUMAN resource you have access to in the present time and how you use it.**
    - As the facilitator record each participants' response on the flipchart under the heading
  - Now as the facilitator – do this again for the other categories – Social, Physical, Financial, and Natural. Pass the Maasai stick around one by one and have each person tell you a resource and how they use it. If someone doesn't have a resource in a category they can pass.
    - As the facilitator record each participants' response on the flipchart under the headings
  - Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group **one way in which you can access NEW RESOURCES for each RESOURCE CATEGOGORY (Human, Social, Physical, Financial and Natural)**
    - As the facilitator record each participants' response on the flipchart under the headings

- 
- Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group ***an idea you have to make better use of the resources you already use or have access to (HUMAN, SOCIAL, Physical, Financial, Natural)***

- As the facilitator record each participants' response on the flipchart under the headings

### 3.

- Participants work alone again to review their livelihoods goal (written or drawn in the previous session). They must follow these steps:
  - Look at their livelihoods goal / Kuangalia lengo lao la maisha
  - Review Goal that they have written / Kupitia teno lengo zao walizoziandika
  - Are there any steps they would like to add, now that they have thought about the resources they currently use or have access to? / Je kunayo hatua zingine mgependa kuongezea? Kwa sasa mmefikiria kuhusu rasilimali mnazaotumia kwa sasa au mnazozipata?
  - What steps would you take to achieve the goal you have created? / Je ni hatua ngani utachukua ili uweze kuifikia lengo lako uliloliunda?
  - What resources do you currently use or have access to that you can use to achieve this goal? How will you use them? / Je ni rasilimali gani unayoitumia sasa au uliyoipata na unaweza kuitumia kuweza kufikia lengo lako? Je utaitumia aje?

### 4.

- Go around the room checking whether participants are doing as instructed and helping those who need some guidance. – Ensure that you have given input and guidance to all participants. Make sure they are thinking more clearly about the intermediate steps needed to reach their goals. These must be listed on their craft paper.

### 5.

- Remind participants that the workshop provides an opportunity to review their livelihoods goals and to work on making them happen. The next session will enable them to explore the social resources, which may help them reach these goals. It is therefore important to have their next steps ready for the session.
- Ask the participants to share what they have learnt from this session about themselves and their resources.

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## **SESSION 4: SOCIAL RESOURCES / RASILIMALI ZA KIJAMII**

### **PURPOSE:**

- Increase awareness of how to build and maintain reciprocal relationships of trust (inside and outside community) that assist in improving their lives
- Enhance understanding of advantages and disadvantages of community participation and how to draw benefits from community participation
- Identify the role of social resources in reaching the livelihood goal selected in Session One.

### **MATERIALS AND PREPARATION:**

- Flipchart prepared with a copy of Box 3: Relationship analysis matrix
- Flip chart listing the roles of the social resources in the story character's life
- Flip chart with notes of key issues from the stories that are relevant to this session



## Exercise 1: Relationships / Uhusiano

**AIMS:** The aim of this session is to contribute to increased awareness of how to build and maintain reciprocal relationships of trust (inside and outside the community) that assist in improving their lives.

**MATERIALS NEEDED:** Prepared Box 3 on flipchart, flipchart, markers, Maasai Stick

### DIRECTIONS:

#### 1.

- Remind participants that social resources (our relationships with individuals and groups) are one form of resource that people draw on in building their livelihoods. They saw this in the character's story in Session 1.
- Explain that the focus will now be on issues of power in their own relationships:
  - With a sexual partner
  - A friend
  - A colleague
  - A comrade / other street youth/Mshefa
  - Or an elder/relative.
- This person is someone who is important to their survival. They cannot afford to lose their relationship with this person but they might have to take certain risks in the 'giving and taking' in the relationship in order to maintain it.

#### 2.

- Ask participants to close their eyes and clear their heads of anything but your voice. Make sure they are relaxed and aware of your voice only. Slowly go through the following questions:
  - How did you meet this person? / Ulikutanaje na huyu mtu?
  - How long have you been close to this person? / Kwa mada gani umekwa karibu nae?
  - What kind of things does this person do for you? (Maybe s/he helps you with money, gives you emotional support, got you a job, gives you love, a home to stay, pays for the children's school fees, puts you in touch with someone else who helped you, or buys you clothes. Think about any other thing that is important to you.) / Vitu ka gani hiyo msee akikufanyia (labda anakusaidia na pesa, anakupa mapenzi, kusakolajia, anakutapatia kazi, anakupatia nyumba, analipa school fees ya watoto, ananunua nguo) Fikiria dote lele ni ya maana kwako.
  - In what other ways do you benefit from the relationship with this person? / Kwa njia gani umekwa na uhusiano?
  - What is your part in the relationship? What do you have to do in order to make sure the relationship does not end, or to minimise arguments or conflict? / Wewe uko wapi kwa hyo uhusiano? Ni unafaa unafanye ndio uhusiano isishe ama kupunguza mabishano?
  - Can you afford to lose this person from your life right now? Why or why not? If this person was not doing things for you, would you still be close to him or her? Why or why not? / Unaeza kumudu kupotea hyo msee kwa maisha yako? Ni kwa nini?
  - Are there things you do to maintain this relationship, which you would prefer not to do? / Kuna vita unafanya kudumisha uhusiano huo na ungependa usifanye?
  - Did you ever get into trouble because of things you have had to do for this person? Do you still wish to be in a relationship with this person under these circumstances? If yes, why do you feel

you still need this person in your life? If no, why do you feel you don't want this person in your life? / Ushaipata shida kwa vitu unayomfanyia hyo msee? Ungependa kubaki kwa uhusinio huo? Kama ndio, mbona unafikiri unahitaji hyo msee kwa maisha yako? Mbona una hisia kaumhitaji katika maisha yako?

- Ask them to open their eyes.

### 3.

- Split group into two groups of 10 to go with each facilitator.
- Give participants 5-10 minutes to brainstorm about what they would like to share about. Referring to Box 3 on the flipchart, ask the following:
  - a) Who the person was they thought of? / Ni nani walikwa wakifikiria?
  - b) What kind of relationship was/is this? / Ilijwa husiani aina gani?
  - c) What benefits did/do you get? / Faida gani ulipata?
  - d) What risks did/do you take? / Hatua gani hatari ulichukua?
  - e) What would like you like to change about this relationship? / Is it possible? / Nini ungependa kubadilisha kuhusu hi husiano? Inaweza kana?

### 4.

- After participants have time to brainstorm about their responses bring each group of 10 back together.
- Explain that now using the *Maasai talking stick* we are going to go around one by one and tell the group **the answers to the questions**.
  - a) Who the person was they thought of? / Ni nani walikwa wakifikiria?
  - b) What kind of relationship was/is this? / Ilijwa husiani aina gani?
  - c) What benefits did/do you get? / Faida gani ulipata?
  - d) What risks did/do you take? / Hatua gani hatari ulichukua?
  - e) What would like you like to change about this relationship? / Is it possible? / Nini ungependa kubadilisha kuhusu hi husiano? Inaweza kana?

### 5.

- Referring to Box 3 on the flipchart, start filling it in:
  - Who came to mind during the reflection exercise? / Nini ulifikiria wakati sengere nyuma?
  - What kind of relationship did you recall? / Ni usiano gani ulifikiria?
  - Were they pleasant or unpleasant relationships? Why? / Husiano huo ilikuwa ya kufurahisha ama kuudhi?
  - What issues did you have in those relationships? / Maswala gani ulikuwa nayo kwa hyo husiano?
  - What benefits and risks did you experience in those relationships? / Ni hatari gani na faida gani ulipata kwa husiano hayo?
  - What would you change and why? / Ungebadilisha nini na kwa nini?
  - Would it be possible to implement those changes? / Inawezakana kupitisha hayo madadiliko?
  - What support do you think you would need in order to do so? / Ni usaididizi gani unaeza itaji ndo ufanye iro?

**BOX 3: Relationship analysis matrix**

| Who was the person? / Alikua nani? | What kind of relationship was/ is this? / Ilikua husiano gani? | What benefits did/do you get? / Faida gani ulipata? | What risks did /do you take? / Ni hatua gani hatari ulichakua? | What would you like to change about this relationship? Is it possible? / Nini ungependa kuhusu hi husiano? Inawezeana? |
|------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |
|                                    |                                                                |                                                     |                                                                |                                                                                                                        |

**6.**

- Ask the participants to think about sexual relationships - either theirs or others - that they know about that may involve compromise. In other words, having to 'take the good with the bad', or an imbalance of power between a man and a woman.
- The participants form four groups or five and discuss the following questions (in general or choose one of the stories to focus on if they prefer):
  - What kinds of trade-offs are involved in these relationships? / Ni aina gani ya biashara awami ya pili ni kushiriki katika uhusiano hizi?
  - What kinds of struggles do people have in these relationships over control or power? / Ni aina gani ya mapambano yenye watu wanayo katika uhusiano huu juu ya udhibiti au nguru?
  - What makes a sexual relationship beneficial? What makes it damaging or dangerous? / Ni nini niachofanya uhusiano wa kimapenzi iwe na faida? Ni nini kinachoiharibu au kuhatarisha?
- Have small groups share some of what they discussed

**7.**

- Ask participants:
  - How do you feel about the exercise of closing your eyes and thinking about the things you were asked?/ Je? Unafeel aje kuhusu iyo mazoezi ya kufunga macho na kufikiria kuhusu vita uliuvyoliza?
  - Was it a positive or a negative experience? Why? / Je? Ilikua mazuri au mabaya? Kwa nini?
- Explain that the intention was not only to focus on negative feelings, and you hope that as the exercises go along they will get an opportunity to learn a few things about themselves which might impact on their livelihoods.
- Summarise for the whole group: Relationships are transactional but if there are risks to one's personal and sexual health one needs to be aware and concerned about working towards making that relationship more equitable, less risky, happier and healthier.



## Exercise 2: My Community Participation / Ushiriki wa mtaa/jamii

**AIMS:** The aim of this exercise is to encourage a greater understanding of the advantages and disadvantages of community participation and how to draw benefits from community participation.

**MATERIALS NEEDED:** flipchart, markers, Maasai Stick

### DIRECTIONS:

#### 1.

- Explain that this step is about getting people to think beyond their relationships with individuals. It is about their role and participation in the community.
- Ask participants to stand if they are a member of any of the following:
  - A church
  - A football club
  - Another kind of sport group or club (ask each person to say what)
  - Chama
  - Barracks
  - Other (ask them to say any other groups they belong to)

#### 2.

- Explain that now using the *Maasai stick* we are going to go around one by one and tell the group:
  - What benefits they have experienced because of participating in groups? / Faida gani wamejifunza kwa kushiriki kwa kikundi?
  - What disadvantages have they experienced? / Ubaya gani wameona?
- List these on a flip chart
- Using the Maasai stick, go around one by one and ask them how they could tackle the problems and still get the benefits of working in a group.
- Write these ideas on another flip chart
- Ask them to think about a group they might consider joining that may benefit them. Suggest – Ushirikia, football, chamas, other support groups in Eldoret.



## Exercise 3: Developing my social resources / Kuendeleza rasilimali za kijamii

**AIMS:** The aim of this exercise is to get participants to think about their selected livelihood goal, identify the role of social resources in reaching their goals, and learn skills in maintaining relationships.

**MATERIALS NEEDED:** Story of Wafula or Njeri, flipchart, markers, Maasai Stick

### DIRECTIONS:

- 1.**
    - Put up the story of Wafula or Njeri flipchart before the session.
    - Ask participants to think about the character's story (Wafula or Njeri). Remind them of the roles of social resources in the character's life.
    - If they prefer to reflect on their own stories and social resources, that is also fine.
  
  - 2.**
    - Ask the group to sit in a circle:
      - Go around one by one using the Maasai stick and have everyone review or state his or her goal again to the group
    - Ask the group:
      - What role can social resources play in reaching their goals? / Jukumu anaweza kijamii rasilimali kucheza katika kufikia malengo yao?
    - Have participants think of three intermediate steps involving these roles that would help them achieve their stated goals.
  
  - 3. Group Energizer!**
    - **Note:** Participants might fail to make this exercise work! Be prepared to encourage everyone to trust you!
    - Say that an energiser will now be played to demonstrate how networks/relationships can be built, how they may be destroyed and what elements are needed to maintain them. It is called 'the circle sitting game'.
    - Before you start, explain that relationships with other people can be unbalanced. This is sometimes necessary in order for those relationships/networks to be functional.
      - Have all participants stand in a circle side by side, shoulder to shoulder
      - Everyone takes a quarter turn to the left (or right), and then another step inwards to tighten the circle
      - With everyone pressed together, tell them to slowly sit down at the count of three
      - Each person is now sitting on the lap of the person behind them
      - Retry if it has collapsed
      - Ask them to stay seated for a minute
      - If all goes well, ask them to put their hand up and cheer!
- Facilitate Discussion:** Ask participants to share their feelings about the exercise.
- What do they think it represents about relationships? / Nini wana fikiri ina wakilisha kuhusu uhusiano

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Facilitator Note: Prompt if necessary for features of relationships such as trust, networks, balance. (For example, unbalanced relationships can still be functional; going along with the exercise even when you are uncomfortable with it because it served a purpose). Say that the next session is a peer group session in which men and women will be together and sharing their different experiences of how an 'ideal' man (for the male groups) or 'ideal' woman (for the female) should behave.



SESSION 5: PEER GROUP MEETING / MKUTANO YA PEERS

PURPOSE:

- To enable the male and female groups to share how their livelihood goals and aspirations, and their views and experiences of gender norms and pressures, influence their sexual experiences

MATERIALS AND PREPARATION:

- Flip chart with a list of key issues from the character's story (Wafula and Njeri) as a point of reference
- Flipcharts with notes from the Stepping Stones session on societal expectations of men and women detailing the ideal expectations versus the realities of how they actually try live their lives.



PART 1: MEN & WOMEN'S BEHAVIOURS / TABIA ZA WANAUUME NA WANAWAKE

AIMS: *To enable the male and female groups to meet and communicate their particular views of gender norms; their experiences of the pressures they feel in order to conform to society's ideals of being a man or a woman; and how they respond to these.*

MATERIALS NEEDED: Flipchart, markers

DIRECTIONS:

1.

- Welcome everyone to the session. Congratulate them on having persisted in attending these sessions.
- Say that this session is a sharing session where they are going to share their understanding and experiences of issues of gender. They will share their experiences of how they may be pressured to become certain types of men and certain types of women.

2.

- If possible, refer back to the flipchart versions of what was discussed in the previous Stepping Stones sessions. If not possible, give them some time to talk about the ideals that society imposes on them and what they are currently facing to try and live up to these expectations.
- Ask the female group to present to the male group an account of their society's ideal of how woman should behave.
- Now ask the male group to present to the female group an account of their society's ideal of how men should behave

3.

- Write up the following questions on a flip chart to encourage discussion between the men's and women's groups:
 - Why do you think these are 'ideal' behaviours? / Kwa nini unafikiri hayo ni tabia bora?
 - What pressures do these expectations place on men/women? / Nini shinikizo kufanya matarjio haya kuweka juu ya mwanaume/mwanawake?
 - What risks do they take in order to meet these expectations? / Nini hatari wanayoranya ili kufikia matarjio hayo?
 - What do you gain from these expectations? What do you lose? How may it hurt you? / Nini unapata kutoka matarajio hayo? Ni nini unapoteza? Inaezakuumiza aje?
 - Did any of these expectations affect the way you came up with livelihood goals? Was it different for women as compared to men? / Kwa yoyote ya matarajio haya kuathiri njia walikuja na malengo ya maisha? Iliwa tofauti kwa wanawake kuliko wanaume?
 - How easy is it to decide to do things differently? / Ni rahisi vipi kuamua kufanya vitu tofauti?

4.

- Summarise that it is not easy to live up to other people's expectations. The most important message from the discussion is that we need to be aware that some expectations are realistic and can be met, while some are just ideals and cannot always be met.

PART 2: GENDER-BASED VIOLENCE / VIRUGU ZA JINSIA

Facilitator Note: This exercise requires strong facilitation skills in order to lead your peer group to present a short role-play.

AIMS: To enable members of the peer groups to communicate about gender inequity in relationships, and experiences of violence. At this meeting the peer groups will share role-plays on how men and women mistreat each other drawing on their Stepping Stones experience if useful.

MATERIALS NEEDED: None

DIRECTIONS:

1.

- Say that all peer groups have worked on and have had a chance to learn about women's and men's experiences of gender power inequity in relationships and violence and how it impacts on them.
- Ask each group to present a short roleplay, not more than 5 minutes, to show an account that includes emotional abuse, men's controlling behaviours, or physical or sexual violence. Refresh the group on what these four types of abuse entail.

Role Play Scenarios that the groups may use

- a) **Physical Abuse:** Man beats his wife because he wants dinner but it isn't ready and she hasn't finished cleaning the house when he comes home.
 - b) **Sexual Abuse:** A man is saying that a girl owes him sex because he bought her alcohol. He is pressuring her and starts to get violent when she says no she doesn't owe him. He tries to force her to have sex.
 - c) **Emotional abuse:** A boyfriend is emotionally abusing his girlfriend because she hasn't given him a child. He is saying: "she is fat and lazy and can't even give him a child why does he keep her as a wife, she is useless."
 - d) **Financial abuse:** A woman makes some money to help support her children. Her boyfriend is controlling and shows up and demands that she give him the money she earned because he is the man in the relationship and takes care of the money. He takes the money and goes out and spends it. The woman cannot feed her children that night.
- 2.** After both presentations facilitate a discussion on the role-plays by asking the two groups:
- What are the underlying expectations that led to the men behaving as they did? / Nini msingi ya matarajio ilifanya wanaume wajifanye vile walifanya?
 - What are the underlying expectations that led to the women behaving as they did? / Nini msingi ya mtarajio ilifanya wanawake wajifanya vile walifanya?
 - What does it feel like to be the woman? How does the man feel? / Inafeel aje kwa dem? Wanaume wanafeel aje?
 - What advice can you give the men? And the women? / Ushauri gani unaweza pea wanaume na wanawake?

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**3.** Ask each group to prepare and present a role-play of their gender's experience of the aftermath of these experiences. For example, role-play the responses they bring on, how these responses are dealt with etc. Again, not more than five minutes each.

**Role-Play Scenarios Aftermath:**

- a) **Physical Abuse:** The man goes to jail and feels guilty for his actions and is sad that he has lost his wife (divorce). Life in jail is difficult. His wife is hurt and gets treatment in the hospital but decides to leave her husband.
- b) **Sexual Abuse:** The woman is hurt and hospitalized after the man who wanted payment for alcohol decides to rape her for what is owed. The community through mob justice beats him because he did this in jua kali.
- c) **Emotional Abuse:** The woman's feels very hurt and ashamed she is unable to provide a baby. She is hurt emotionally by her husband's harsh words. She seeks comfort in another man who cares about her and likes her the way she is.
- d) **Financial Abuse:** The woman is unable to feed her kids, the kids come to the street to find food and make money to support their mother. The boyfriend/husband goes out and spends the money on alcohol.

**4.** Facilitate a group discussion using the following questions:

- How can we work as a community to reduce men's expectations of controlling women and stop men's use of violence? / Tunaeza fanyaje kwa mta kupunguza matarajio ya wanaume kubhibitina kukomesha wanaume kufanya vurungu?
- What did you find surprising or new from the roleplays, and why? / Nini la kushangaza ama kipya ulikipata katika mchezo hyo? Kwa nini?
- In what ways does it change your view of the opposite gender's experience of control or violence? / Ni njia zipi inabadilisha mawazo yako kuhusu mazeo ya kudhibiti ama virugu?
- What can we do to help women who experience violence? / Nini tunaeza kufanya tusaidie wanawake wako na uzoefu wa vurugu?
- How can we stop men being violent? / Tunaezaje kukomesha wanaume koleta vurugu?
- How could we change men's expectations about women's roles in relationships? / Tunaezaje badilisha matarajio ya wanaume kuhusu kazi ya wanawake kwa ndoa?
- Do we need to change women's expectations so they stand up to men more when men try to control them? / Tunafaa tubadilisha matarajio ya wanawake ndio kusudi wajilete kwa wanaume na sana wanaume wakijaribu kuwadhibiti?

**5.** Remind the participants that in our communities it is mostly women who experience violence. Violence occurs because of a gender power imbalance between women and men.

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## **PART 3: MEN'S & WOMEN'S GOALS / MALENGA YA WANAUME NA WANAWAKE**

**AIMS:** To enable members of the peer groups to share their livelihood goals and aspirations and to share how they would like people around them to support them. At this meeting the peer groups will perform short sketches, which summarise the kinds of livelihoods goals they have shared as a group. Using these, they should produce requests of support from people around them.

**MATERIALS NEEDED:** None

### **DIRECTIONS:**

#### **1.**

- Explain that in the previous two sessions all peer groups drafted their livelihood goals and aspirations. This is an opportunity to share these so that each peer group will be aware of the goals or aspirations of the opposite sex.
- Ask each group to prepare and present a five-minute sketch of their livelihood aspirations. What kind of support do they expect from people around them, focusing on the social resources and relationships they discussed in the previous exercise? / Njia zipi za usaidizi unatarajia kutoka kwa watu karibu nao, ukiangalia kwa rasilimali za kijamii na uhusiani walielezana kwa masomo uliopita?

#### **2.**

- Facilitate a discussion. Invite the opposite gender group to comment.
  - What was the difference between your aspirations and the other group's aspirations? / Kuna utofauti gani kwa unachowania na kile kikundi inachowania?
  - Why do you think these differences exist? / Mbona unafikiri utafauti hayo yapo?
  - How do we 'learn' to be 'men' and 'women'? / Tunajifunzaje kwa wanaume na wanawake?
  - Is it possible for men and women to share responsibilities, such as earning income or taking care of the house and home? Why/why not? / Inawezekana wanaume na wanawake kushiriki kwa majukumu kama mshahara ama kulinda nyumba? Kwa nini?
  - What kind of advice would you give to the other group? / Ushauri gani unaeza pea kikundi ingine?
  - Does a person's sexual partner have a role to play in supporting your livelihood goals and aspirations? / Je, mpenzi ako kazi anayofanya kusaidia motisha yako ya kimaisha huwiano yako?
  - What kind of support is expected from a sexual partner? How much support is adequate? / Msaada gani unatarajia kutoka kwa mpenzi wako? Msaada gani inatosheleza?
  - What support would men and women like to have from their partners? / Msaada gani chali na dem wanapenda kupata kutoka kwa wapenzi wao?
  - What is the reality about your partner's involvement in your livelihood and aspirations for a better life? Is this the same for everyone? / Ni ukweli gani kutoka kwa mapenzi inasaadia kwa kujijenga sana kimaisha? Jibu ni sawa kwa kila mtu?

#### **3.**

- Using the Maasai stick, go around the room and ask everyone to mention one thing they have learned from this discussion that they didn't know before about the other peer group.

## SESSION 6: STREET SMARTS / UJANJA WA MTA

### PURPOSE:

- Enhance participant ability to recognise that there are multiple ways of learning, including experiential and educational, formal and informal
- Encourage participants to identify strategies to identify, utilise and build on learning opportunities
- Enhance participant's ability to critically assess how they decide what determines their own success

### MATERIALS AND PREPARATION:

- Flipchart and markers
- Craft paper for groups
- Maasai Stick
- Crayons
- Action Reflection Model





## Exercise 1: Multiple ways of learning / Njia pana ya kujifunza

**AIMS:** The aim of this exercise is to enhance participant ability to recognise that there are multiple ways of learning and critically explore narratives of success related to learning

**MATERIALS NEEDED:** Flipchart, markers, craft paper, crayons, Maasai Stick

### DIRECTIONS:

#### 1.

- Explain that in this session we are going to discuss different ways of learning and how learning is a basic part of living.

#### 2.

- Split the participants into groups of 4 or 5 participants to spend 10 minutes recalling how they have learnt the things they know, and how they learnt the things they do. Give each group a piece of craft paper and markers.
- As the facilitator you will have to go around and encourage each group to focus on:
  - **HOW they have learnt the things they know. / Vile wamejifunza vitu wanajua?**
- Encourage them to focus on HOW they learnt rather than WHAT they learnt. (For example some people learnt to sew or connect electrical appliances – HOW? By being taught by adults in their family or in the community, or from observing others when they are doing so. Or, learnt to polish shoes or braid hair. HOW? After having observed and liked it when adults in the family did it).
- Emphasise you want to hear about not only the learning that takes place in a classroom or formal setting, but informal learning as well.
- Go around and check on each group and see that they are on track and assist them when necessary thinking of HOW they know the things they know.

#### 3.

- After each group has had 10 minutes to focus on HOW they know the things they know. Have each group present HOW they've learnt different things.

#### 4.

- After all the groups have presented, facilitate a discussion to develop two categories of 'ways of learning' – formal and informal. Have participants identify qualifications of formal learning versus informal learning that produces no qualifications or certificates.

### Facilitator Note:

Facilitator Note About 'Formal' Versus 'Informal' Learning: People may well respond differently to the exercise in how they think about 'categories'. For the purposes of the next step, the discussion should get young people to thrash out various understandings and feelings about learning. The 'qualification' category should include academic/educational-based qualifications; the 'non-qualification' category should include experiential, mentoring, reflective learning. Participants may also find that there are certain ways of learning, which can be qualification or non-qualification-based and which may be oriented around skills and information learnt from organisations, which impart such skills. For example, facilitation skills, community mobilisation, caring for the sick. Allow participants to create a middle category, which will accommodate such skills. Remind them that these skills are trainable in a formal setting and are usually set around certain guidelines. If they have acquired them without formal training and if they would like to continue with them, it

might be advisable that they try to get the necessary formal training.

#### 4.

- Divide the group randomly in half and assign the qualification-based category to one group and the non-qualification category to another group. If the group is keen to include the third category then allow this. You will then have to divide the group into three, and cut the presentation time accordingly.
- Other categories may include life experience aka street smarts, training, wisdom, family.
- Give them 10 minutes to discuss the importance of their category, the benefits of improving people's lives and livelihoods and how it helps people to feel good about their lives. They need to think about what it means to be successful, and what kinds of learning lead to success. They must address the following:
  - Why is your way of learning important in improving people's lives and ways of living? / Kwa nini njia yako ya kuifunza ni ya maana kwa kubadilisha?
  - How does your category create or contribute to people's success? / Ni njia gani katogori yako inajenga au kuchongia kwa kujenga watu wengine?
  - What important benefits you can think of? / Faida gani ya maana unaeza fikiria?
  - Think of one or two examples that support the value of your category. / Fikiria mfano moja au mbili yenyewe inasistiza katogori yako?

#### 5.

Ask participants to select a presenter. S/he will present their case in detail according to the questions. The ground rules for this discussion is that all participants must listen to the presenter and not interrupt nor ask questions until the presentation is finished.

#### 6.

- When presentations are over each group is given a turn to respond by asking questions or critiquing the other group's presentation.
- To wind down the discussion prompt participants to think critically about the following:
  - How you define success relative to education? / Unaeza fasili aje husiano wa mafanikio na masoma?
  - How education supports different roles in your community? / Masoma inasaidiaje utafuati w majukumu kutika mtaa?
  - What kinds of work you can get with different kinds of learning; long versus short term, luck versus certainty, advantages and disadvantages? / Jara gani unaeza pata kupitia njia tofauti ya masoma, za urefu na ufupi? Ubaya na uzuri?
  - Identify opportunities for learning in your own community / Tambua furssa ya masoma/kujifunza kwa mtaa wako?
  - Think about ways of learning that are more likely to open doors and leave less to 'chance' or 'luck'. / Fikiria njia unaeza tumia kujifunza na inaeza kutungua njia.

#### 7.

- Bring the group back together and give a brief summary of some of the key issues and points that emerged.
- Stress that learning can be qualifications or non-qualification, formal or less formal, and that ideas of 'success' are different for different people and are influenced by those around us.



## Exercise 2: My Learning / Kujifunza Kwangu

**AIMS:** The aim of this exercise is to make participants think critically about their own experiences of learning and how to enhance them and benefit from their experiences

**MATERIALS NEEDED:** Flipchart, markers, action reflection model

### DIRECTIONS:

#### 1.

- Ask for four volunteers who have a learning experience or process where they learnt a skill or got a certificate or got training, and they will share their learning experience with the group.
- Invite the first volunteer up. If no one volunteers, select some participants.
- Ask them to identify what they learnt (ex. Hairdressing, bead-making, maths, CRE, catering, tailoring, house-keeping, mechanics)?
- Ask them to share their experience and answer the following questions for the group:
  - What was the process of learning the skill? / Je ni nini ndio mdrakatoya kujifuna ujuzi?
  - What was difficult about the experience and why? / Je ni nini hawea kilikua kigumu kutokana na uzoefu na kwa nini?
  - What was good about the experience and why? / Je ni nini kilikua kizuri kuhusu uzoefu na kwa nini?
  - If you had to learn again what would you do differently, would you want to learn differently? / Kama itakua ujifunze tena ungefanya nini tofauti? Je ungependa ujifunze tofauti?

#### 2.

- As the facilitator, guide the group through the Action Reflection Model (Guide 1)
- Position the events in the character's life (Wafula or Njeri) in terms of the boxes of the Action Reflection cycle.
- Emphasise that this 'cycle' is one many of us follow naturally without thinking, but that sometimes it helps us to remember to apply the learning and make some changes in the way we do things based on what we have learned.

#### 3.

- Guide the group through one of the following two scenarios using the Action Reflection Model

**Scenario One:** A boy has a job carrying luggage in town, the customer's luggage gets lost or it falls and breaks.

#### **Description - What happened?**

- Carrying luggage and it gets lost or it falls and breaks

#### **Feeling – What were you thinking and feeling?**

- Fearful, a mob can come to harass you
- Tense and stressed
- Unajali
- No money from the job, means you cannot eat

#### **Evaluation – What was good and bad about the experience?**

- Don't get paid

~~~~~  
- You learn to be extra careful next time with the person's luggage → you learn from your mistake

Analysis – What sense can you make of the situation?

- The luggage was too heavy and you dropped it
- You put the luggage down and got out of the rain and forgot it
- The luggage was stolen by someone and not lost
- Your trolley got hit by a car and the luggage fell and broke

Conclusion – What else could you have done?

- If it fell because it was too heavy → weigh the luggage first and assess if you can carry it
- Forgot it someplace → Be careful and stay with the luggage always
- Hit by a car → Witness, assess situation, apologize, run away as you are Mshefa
- Stolen → guard luggage

Action Plan – If it arose again, what would you do?

- If it fell because it was too heavy → have a friend help and split the profit so it won't fall
- Forgot it someplace → Be careful and stay with the luggage always
- Hit by a car → Avoid traffic, don't use drugs or alcohol when working
- Stolen → guard luggage

Scenario Two: A girl is hired to do house-help and bleaches clothes using Jik, or burns trousers when ironing.

Description - What happened?

- A girl is hired to do house-help and bleaches clothes using Jik, or burns trousers when ironing.

Feeling – What were you thinking and feeling?

- Fearful / Unagopa
- Tense and stressed
- Unajali
- No money from the job for the day
- Verbal abuse from household

Evaluation – What was good and bad about the experience?

- Don't get paid
- You get verbally abused by the head of household or woman of household
- You learn how to use Jik properly or iron properly → learning from mistakes

Analysis – What sense can you make of the situation?

- You didn't know how to use Jik and detergents
- You left iron on trousers when you answered your phone
- You fell asleep on the job

Conclusion / Action Plan – If it arose again, what would you do?

- Buy new trousers if you can afford to replace them
- Apologise
- Be careful, concentrate and focus on job
- Ask questions for instructions from employer about how to use detergents

- Do one task at a time

4.

- Facilitator to share a personal story about getting work, using life skills and street smarts with the group to end the day.

Action Reflection Model

<p>Stage one: Description of the event Describe in detail the event you are reflecting on. Include for example, where you were; who else was there; why were you there; what were you doing; what were other people doing; what was the context of the event; what happened; what was your part in this; what part/s did other people play; what was the result?</p>	<p>Stage two: Feelings At this stage try to recall and explore the things that were going on inside your head, i.e. why does this event stick in your mind? Include how you were feeling when the event started; what you were thinking about at the time; how it made you feel; how other people made you feel; how you felt about the out- come of the event; what you think about it now?</p>
<p>Stage three: Evaluation Try to evaluate or make a judgment about what happened. Consider what was good about the experience and what was bad about the experience or what didn't go so well.</p>	<p>Stage four: Analysis Break the event down into its component parts, so they can be explored separately: what went well; what did you do well; what did others do well; what went wrong or did not turn out as it should have done; in what way did you or others contribute to this.</p>
<p>Stage five: Conclusion You now have a lot of information on which to base your judgment. It is here that you are likely to develop insight into your own and other people's behaviour in terms of how they contributed to the outcome of the event. <i>Re- member the purpose of reflection is to learn from an experience.</i> During this stage you should ask yourself what you could have done differently.</p>	<p>Stage six: Action plan Plan what you would do if you encountered the event again. Would you act differently or would you be likely to act the same? How will this incident affect your future practice? What additional knowledge and skills do you need to develop?</p>

SESSION 7: INCOME GENERATING ACTIVITIES PART 1 / JARA PART 1

PURPOSE:

- Enhance the ability to identify viable, accessible business opportunities, and the resources necessary to respond to such opportunities
- Enhance the ability to identify basic business principles, including business risks

MATERIALS AND PREPARATION:

- Flipchart
- Markers
- Prepared flipchart of Basic concepts exercise 3.





EXERCISE 1: Experiences of income generating activities / Mazoea ya IGA

AIMS: The aim of this exercise is to set the stage for participants to think about viable business opportunities and experiences and reflect on lessons learned and challenges.

MATERIALS NEEDED: Flipchart, markers

DIRECTIONS:

1.
 - Explain that this session is going to assist participants to strengthen their enterprise- related goals. This may relate to their education, or looking for work. It may be a new venture, or something that started before the workshops began.
 - Start by recalling previous sessions. Note that 'work' and income and other 'rewards' are important but do not always come through working for others.
2.
 - Ask participants to discuss their experiences in trying to generate income.
 - On a flipchart divide the paper into four columns: IGA Activity, Successes, Lessons, Challenges
 - In a circle, have participants go around one by one and tell the group about an experience they've had trying to generate income. This can be small trading like selling sweets, cigarettes, house-help, carrying luggage, selling polythenes or any 'business'-like ventures they have tried before.
 - Make a note of these activities on a flipchart under the heading 'IGA Activity'. Ask each person to also tell them about the successes, a lesson and a challenge with this experience generating income.
 - List these under the column headings
 - Say that in any enterprise you need to be aware of the important aspects of establishing and running that particular enterprise. However, most businesses run on the same principles. Say that these will be discussed throughout this exercise





Exercise 2: Basic Business Concepts / Msingi wa dhana ya biashara

AIMS: The aim of this exercise is for participants to become familiar with basic business concepts required for an income generating activity

MATERIALS NEEDED: Flipchart, markers

DESCRIPTION: This facilitator driven exercise is meant to assist and prepare participants with basic business concepts required to start an income generating activity.

DIRECTIONS:

1.

- Explain that this session will help participants understand basic business concepts that would help them when planning and starting an income generating activity.
- Ask participants to share basic ideas or concepts about business that they know. One by one have participants go around in a circle using the Maasai stick to share what they know about running/starting/maintaining a business and key concepts.
- List these on a flipchart
- Review each concept that participants share. If they are in the basic business concepts table, expand on the definition if it will increase understanding or clarify an issue.

2.

- Go through basic business concepts listed below that participants should have some knowledge of when starting an IGA
- List each one on a flipchart and have participants discuss what it means. Then give the full definition of the concept

Business Concept	Definition / Explanation
Profit	The money you made from the sale of your product or service minus your costs/expenses before tax. Your net profit is the money you made minus your costs/expenses AND tax.
Capital	Money invested in a business at the start.
Business Plan	A document that details the specifics about how a business will run.
Expenses	All money spent to operate the company that's not directly related to the sale of individual goods or services.
Inventory	The goods you have in stock. Your inventory can also be the materials you have on hand that are used to manufacture your product.

Invoice	The bill that is given to the purchaser of a product or service for money due.
Accounts Payable (AP)	The bills that you need to pay. An example of an AP is the invoice you receive for buying supplies from the manufacturer. They are considered liabilities.
Accounts Receivable (AR)	The debts owed to you. If you sell your product or service to your customers and they do not pay you at the time of sale, the money they owe you is considered an AR. They are considered resources.
Resources	Property your business owns. This includes anything that has value, such as cash, inventory, supplies, equipment, etc.
Balance sheet	The financial statement that presents a snapshot of the company's financial position as of a particular date in time. It's called a balance sheet because the things owned by the company (resources) must equal the claims against those resources (liabilities and equity).
Bad debt	A debt that is written off and deemed uncollectible or unrecoverable.
Bankruptcy	Inability to pay debts.
Cash Flow	The money that goes into and out of the business within a set amount of time.
Cost of Goods Sold (COGS)	The cost you pay for supplies, goods, labour, etc. in order to sell your product. For example, if you buy a bicycle in a second hand shop and sell it to someone else, the cost to buy the bicycle is your COGS.
Fixed Costs	The costs that do not change in relation how much you sell. Paying rent or salaries are examples of fixed costs. They do not change if your sales or income/profit increase or decrease.
Interest	The extra money a company needs to pay if it borrows money from a bank or other company. For example, when you buy a car using a car loan, you must pay not only the amount you borrowed but also interest, based on a percent of the amount you borrowed.
Gross Margin	The difference between the total amount of money you made from selling your product or service and the total amount of money your product or service cost you. For example, if it cost you R10 to make your scarf, but you sold it for R30, your gross margin is the difference - R20.



Exercise 3: Making a Plan for your IGA / Plan ya Jara

AIMS: The aim of this exercise is to share the basic concepts that need to be considered when putting together a plan for an IGA.

MATERIALS NEEDED: Flipchart, markers, prepared table on flipchart

DESCRIPTION: This facilitator driven exercise is meant to assist and prepare participants to plan for an income generating activity.

DIRECTIONS:

1.

- Have the table below of questions prepared on a flipchart.
- Explain that there is no right or wrong way to put together your plan, but it will have to answer some basic questions.
- Go over the What? Why? How? Who? Where? And When? Questions
- Ask participants to think about their IGA goals and what questions they need to answer to build their own business plan.
- Have participants share some ideas with the group.

WHAT?	WHY?	HOW?
What are you going to produce? What resources will you need? What will be the financial benefits? What will be the risks?	Why do you want to start an IGA? Why have you chosen this particular activity?	How are you going to go about it? How much income will be generated? How will you use the income?
WHO?	WHERE?	WHEN?
Who will be your customers? Who will be your competitors? Who will take part in the production (employees, family, partners)?	Where will you get the resources from? Where will your IGA be located? Where will you sell from?	When will you start? When will it become profitable?

Nini?	Mbona?	Aje?
Unakwenda kuzalisha aje? Rasilimali gani unahitaji? Nini itakua faida yafedha? Nini itakua hatari?	Mbona unataka kuanisha IGA? Mbona na umeamua kuchakua hasa hii shuguli?	Jinsi ya wewe kwenda juu yake? Ni kiasi gani itatolewa? Jinsi gani unaweza kutumia mapata?
Nani?	Wapi?	Lini?
Nani watakua customa? Nani watakua washindani wako? Nani watajihusisha na uzalishaji (Je ni wafanyi kazi, familia, ushirika)	Je ni wapi utapata rasilimali? Je ni wapi utataka IGA ikue? Je utaiuza wapi?	Utaanza lini? Lini ilianza kua na faida?

2.

- Guide participants through the following four-step process. Explain that in the next session we will work on identifying an IGA need in their community and create an IGA Plan. They will pitch their IGA plan at the end of session 8. This process and the flipchart question table will help them create an IGA plan next session.

Where to Start? / Utaanza wapi?

- **Identify Your Resources / Kutambua rasilimali zako**
- **Consider Your Environment / Kuzingatia mazingira yako**
- **Determine Possible Activities / Kuamua shuguli zinazoweza kufanyika**
- **Plan / Mpango**

Your Resources

- To succeed in generating income you need to choose an activity, which takes advantage of your strengths. You first need to identify your resources to build up a picture of where your competitive advantages lie.
- Look out for these resources:
 - Human Resources:** Your skills, skills of family members/friends/potential partners
 - Financial Resources:** Money. Running an income generating activity requires initial start-up finance. Some activities require a lot more finance – to pay for materials and equipment – than others. Part of deciding what activity to undertake will depend on whether you have enough savings for your activity or if there are local sources of finance, such as banks or microcredit programs that will be prepared to lend you money. Starting out small, and gradually demonstrating your ability to run your activity successfully, may often offer a good route to attracting financing sources where it exist, but will not offer money to a new and unproven activity.
 - Social Resources:** Family/ friends support, networks, goodwill
 - Physical Resources:** Buildings, equipment etc.
 - Natural Resources:** Land, water, trees etc.

Your Environment

Every business needs buyers. To become profitable, a sufficient number of buyers must exist. Ask yourself who:

- Who needs/wants your product in your community or outside? (If outside, think about transport costs, how far away your market is, and what transport options are available. Remember in order to maximise your profits the transport costs cannot be too high.) / Nani anahitaji au anataka bidhaa kwa jamii au nje ya jamii (kama ni nje, fikiria kuhusu usafiki, umbali gani soko iko, gharama za usafiri. Kumbuka ili uweze kuongeza faida, gharama za usafiri haitakuwa juu zaidi)
- Who can be made aware of it / Nani ndio watajulishwa kuhusu
- Who is able to access where it is sold/ Nani wanaweza kuipata mahali inauzwa
- Who has the money to buy it This will help you in deciding which types of activity are most likely to represent a good business opportunity for you. / Nani ako na pesa ya kununua hii. Inaweza kusaidia kuamua ni aina gani ya biashara ni mzuri kwako

Determine possible activities

How you assess demand, how easy it is, and how accurate, will depend on whether the product is more or

less identical to an existing product already being sold e.g. mboga, sweets, goods in a bazaar. For products similar to ones already on sale, simple observation can be enough to provide a good idea of demand.

Ask yourself:

- How much of the product is sold in an hour? / Bidhaa ngapi zinauzwa kwa saa mooja?
- At what price? / Kwa pesa nngai?
- What types of customer are buying it? / Ni makastama wangpi wananunua?

Plan

You've had a few ideas about what to IGA activity to try out, and from your research you now know which products there's a market for. It's worth reminding ourselves of some very basic economic truths before going any further.

Ask yourself:

- Which IGA activity will generate the most income? / Ni biashara gani italeti pesa mingi?
- At what sales prices? / Kwa pesa ngapi?

FOR A GOOD COMPETITIVE ADVANTAGE FOR YOUR IGA, STRIVE:

- To produce goods better than everyone else's
- To serve needs that are under met or not at all met with new or additional products and services.

Having a detailed written plan for implementing your income generating activity will:

- Help you to think through all aspects of how your project will run.
- Help to draw out uncertainties and areas where more thought or research is needed.
- Provide a tool for assessing how successful you've been at achieving your goals, as well as for learning from mistakes.

SESSION 8: INCOME GENERATING ACTIVITY 2 / SHUGULI YA KUZALISHA MAPATO

PURPOSE: The aim of this exercise is to enhance participant ability to identify viable, accessible business opportunities, and the resources necessary to respond to such opportunities. Participants will identify an IGA need in their community, draft an IGA plan and present it to the group.

MATERIALS AND PREPARATION

- Flipchart with "IGA PLAN QUESTIONS" from Session 7
- Markers
- Crayons
- Craft Paper





Exercise 1: Pitch your IGA Idea / Kushare wazo ya IGA

AIMS: The aim of this exercise is for participants to use the entire session to work on planning, developing and pitching an IGA activity based on what they learnt in the previous session.

MATERIALS NEEDED: Craft paper, pens, markers, crayons, prize for best pitch

DESCRIPTION: In this exercise participants split into groups and work for the duration of the session on planning and developing an IGA. At the end of the session each group gets 5 minutes to pitch their IGA activity to the group and facilitators using their craft paper and presentation skills. The best pitch determined by the facilitators gets a prize.

DIRECTIONS:

1.
 - Divide participants into groups according to where they live or their IGA interests.
 - Give each group a large piece of craft paper.
 - Ask them to think of an IGA idea that they would like to plan for.

Facilitator Note: You will have to go around to the different groups and ensure they are on track. Help them out if they are stuck.

2.
 - Using their craft paper, have the groups go through the following process under your guidance. They can use their craft paper to draw and answer the questions

STEP ONE – ASSESS THE COMMUNITY IGA OPPORTUNITY ASSESSMENT

- **What are the existing resources in the community? / Ni rasilimali gani inapatikana kwa mtaa?**
- **What are the existing livelihoods / IGA activities happening in your community? / Ni riziki gani zina pati kana / IGA gani zinafinya kwa mtaa?**
 - Where are these livelihood / IGA activities in your community happening (major roads/intersections)? / Riziko hizo ziko wapi?
 - What IGAs / livelihoods are successful in your community? / Ni IGAs/riziki gani zio za mafanikio?

STEP TWO – WHAT WOULD MAKE A GOOD IGA IN THE COMMUNITY

BASED ON ASSESSMENT OF WHAT EXISTS IN THE COMMUNITY, WHAT NEED MIGHT BE PRESENT, WHAT IS SATURATED, WHAT AREA IS GOOD FOR BUSINESS, WHAT RESOURCES EXIST IN THE COMMUNITY. HAVE GROUPS IDENTIFY AN IGA OF INTEREST

- What needs are not being address in the community? Why? / Ni mahitaji gani hazitafuliwi kwa mtaa? Kwa nini?
- What needs are not being addressed outside the community? / Ni mahitaji gani hazitafuliwi inje ya mtaa?
- What IGA strategy can you come up with to address these gaps? Ni makakati gani unaezaweka kufanya pengo?

STEP 3: Thinking of their IGA idea...

- What are the risks or challenges in relation to starting your IGA activity in your community?

STEP 4: IGA PLAN

- Tell them now, that they have identified and IGA they would like to try in their community. They can use the following questions below to plan their IGA.
 - What needs does your chosen business/IGA meet in your community? / Ni nini biashara yako teule inakutana na malengo ya jamii yako?
 - How will you mitigate (overcome) the risks or challenges you identified associated with your IGA idea? / Unaweza aje shinda hatari au changamoto ulitambua huhusishwa na wazo la IGA?
 - What resources (physical, human, social, financial, natural) do you need to start IGA/business? / Railimali gani (kimwili, binadamu, kijamii, fedha, asili) unahitaji ili kuanza biashara/ IGA?
 - What might make this business/IGA successful and why? / Ni nini inayoweza biashara/IGA kufanikiwa na kwa nini?
 - What might make this business fail and why? In other words, what are the risks to its survival? / Ni nini inayo fanya hi biashara kuanguka na kwa nini? Ni nini hatari kwa kuishi kwako? Mfano, ushindani, kosefu, rasilimali, ukosefu wa wateja, usimamizi mbaya ya pesa. For example, competition, loss of resources, loss of customers, bad money management, etc. (Facilitator Note: This is about getting the group to identify what makes a business work, so the aim will be to start getting at pro t, turnover, etc.)

STEP 5: PITCH YOUR IGA IDEA

- Bring the groups back together and have each group make a 5-10 minute presentation about their business/IGA idea and make sure they talk about the “need”, “resources”, “risks” and why the IGA will be successful. Tell the groups to think of it as an IGA biashara pitch to a potential sponsor
- The best pitch gets a prize

FACILITATOR DISCUSSION:

- Summarize what elements are important to consider when starting a business?
- Need, Start up capital, supplies, resources, costs, profit, marketing etc.
- Link their points to what makes an income generating activity work and to basic business concepts, looking to cover the following: start-up capital, cost, pro t, turnover, marketing and bookkeeping.

SESSION 9: SAVING AND COPING WITH SHOCKS PART A / KUSAVE NA KUCOPE NA SHOCKS PART A

PURPOSE:

- To motivate critical thinking around spending patterns and strategies for saving
- To explore causes and consequences of getting into debt and ways of overcoming debt

MATERIALS AND PREPARATION:

- Flipchart
- Markers
- Maasai Stick





Exercise 1: How we spend money / Jinsi ya kutumia pesa

AIMS: The aim of this exercise is to motivate participants to critically think about their spending patterns

MATERIALS NEEDED: Flipchart, markers, Maasai stick

DIRECTIONS:

1.

- Tell them that in this exercise time will be spent thinking about how we manage personal money.
- Ask the participants to share how they spend their money. Ensure participants are talking about themselves. Use the following questions and write their responses on the flipchart:
- Using the Maasai stick, go around one by one and have each person respond the following questions.
- Write their responses on the flipchart.
 - How often do you get money? / Unapata pesa kwa ma saa gani?
 - What do you spend it on? / Unatumia pesa yako kununua nini?
 - How do you feel about what you spend money on? / Unafeelaje kwa kile unochonunua ukitumia pesa yako?
 - What do you spend money on which give you status with friends or family? / Unanunua nini na pesa yako inachokupea sifa kati ya marafiki na familia?
 - What do you wish you could spend your money on? / Ungependa kununua nini na pesa yako?
 - Is there a connection between what you spend your money on and your image? How do you want other people to think about you? / Kuna husiano Fulani? Vile ungependa watu wengine wakuone?
 - How much money are you willing to spend on these things? / Uneza tumia pesa ngapi kwa hizi stuff?

2.

- Now on a flipchart draw two columns. In one column give it the heading 'Needs' – ie. Things you cannot do without on a daily basis for survival. In a second column write the heading 'Wants' – ie. Things you spend money on that are nice to have, that boost your status, that make you feel good about yourself, but that you can live without.
- Using the Maasai stick, go around the group one by one and have each person say one thing they spend money on that they cannot do without on a daily basis for survival and one thing they spend money on that they can live without.
- As the facilitator record these on the flipchart. Ask the group:
 - What sets the two lists apart? / Nini inaweka orodha kwa upande?
 - What would it mean having to give up any of the items mentioned? / Nini inaeza maanisha kugive up kwa hizo stuff wameorodhoshwa? Go over this per column.
 - What lessons are you learning about balancing between what you want and what you need in your life? / Ni nini unajifunza kati ya kutumia pesa yako vizuri ama vibaya?

3.

- Close the exercise by summarising: In most aspects of life we have to choose between what we need and what we want. This is not easy because it means we must always be aware of our life goals. At times it may seem important what our friends or family think of us, about what we wear, whether we have nice furniture, nice cars or homes. Remember, the decisions we take about money are ours and we are responsible for the outcomes.



Exercise 2: Getting into and dealing with debt / Kujiingiza na kupambana na deni

AIMS: The aim of this exercise is to explore causes and consequences of getting into debt and ways of overcoming debt

MATERIALS NEEDED: Flipchart, markers, Maasai stick

DIRECTIONS:

1.
 - Say that in this exercise the causes and consequences of getting into debt, and how to deal with debt, will be explored. Note that some may have their own experiences to draw on, while others may not have experienced debt.
2.
 - Divide participants into two groups (one will stay with each facilitator) and ask them to discuss issues relating to debt and its consequences. Prepare a flipchart with a spider diagram on getting into debt. This includes both small and big debt.
 - Using the Maasai stick, have participants go around one by one and say a 'cause of getting into debt'. Write these up on the upper legs of the spider.
 - Using the Maasai stick, have the participants go around again one by one and say a 'consequence of getting into debt'. Write these in a different colour on the lower half of the spider diagram.
3.
 - Have the two groups come back together and review their diagrams with the group.
 - Ask the group the following questions:
 - What are the similarities or differences in relation to the causes of getting into debt? / Ni usawa gani ama utofauti gani inafanya mtu kuingia kwa deni?
 - What are the similarities or differences in relation to the consequences of getting into debt? / Ni usawa gani ama utofauti gani ukiangali mashida ya kuingilia deni?
 - Who are the people affected when we get into debt? / Ni watu gani wanahathirika wakiinga kwa deni?
 - If someone else gets into debt on your behalf (for example, they buy things for you), what do you have to give them in return? / Kama mtu amechukua deni kwa niaba yako (mfano, kukununulia bidhaa) ni nini unawapa kulipisha?
 - What are the consequences and risks of that? / Ni nini mashida na hatari ya hiyo?
 - Do you become more dependent on them? Is that good or bad, and why? Inakuwa unawategea sana? Ni mzuri au mbaya? Kwa nini?
 - What lessons can we take from the exercise in relation to debt? / Mafunzo gani unajifunza ukiaangalia deni?
 - What are the implications for you as young people? / Inakusaidiaje kama kijana?
4.
 - Summarise by saying that we have both good and bad experiences with money. Owing other people money can cause a lot of tension, whether we owe an individual, or a group of people or a company. It is important to learn that incurring lots of debt can be damaging to our credit as well as our relationships with family and friends. Generally it is important to your peace of mind to minimise or eliminate debt.

SESSION 10: SAVINGS AND COPING WITH SHOCKS PART B / KUIFADHA NA KUPAMBANA NA MSTUKO PART B

PURPOSE:

- To enhance ability to identify different types of shocks and crises and the different ways of responding and the impact of responses
- To create awareness of the role of saving and different ways of accomplishing saving

MATERIALS AND PREPARATION:

- Flipchart
- Markers
- A flip chart of key issues from the character's story relevant to this session as a point of reference





Exercise 1: How do we cope with crises in our lives? / Tunakabiliana aje na migagoro kwa maisha yetu?

AIMS: The aim of this exercise is to create awareness around how prepared participants are to deal with financial and life crises and shocks

MATERIALS NEEDED: Flipchart, markers, Maasai stick

DIRECTIONS:

1.

- Say that even though people have ways of securing livelihoods there are crises at times that challenge us to further intensify our efforts to survive. A crisis often catches people unprepared; for example, death in the family, accidents, and ill health. Say that the purpose of this exercise is to explore how prepared we are for such events.

2.

- Ask participants to sit back, relax and close their eyes. Say that we are going to think back to those times in our lives when we had crises and we did not have the necessary money, or we were not prepared. With eyes closed, participants must think (not talk) about the following:
 - What crisis have you experienced when you needed a large sum of money and you did not have it? / Mashida gani umepitia wakati uliitaji pesa mob na ulikua kapa?
 - If you cannot think of a situation of your own, have you been involved in a situation where this happened to someone else? What happened? / Kama uwezi kufikiria kifu ka hiyo ilikufanyikia, ushaipitia shida ka iyo ambae imefanyikia msee mwingine?
 - Who did you turn to for financial help? / Uliomba nani usaidizi ya kifedha?
 - What plan did you make for returning the money that you borrowed? What kind of agreement did you make? Did you return the money? What means of recovery did you make if you did not have to return the money? / Ulijipanga age kurudisha pesa uliokodesha? Na mulielewana aje? Ulirudisha pesa? Ungelipisha aje kama aungepata hiyo fedha?
 - What were the positive spin-offs? / Mapito gani ni mazuri?
 - What were the negative spin-offs? – What risks did you take to deal with this matter and how did these risks affect your life? / Mapita gani ni mabaya? Ni njia gani ya kihatari ulideal na njio hilo? Na ngia gari ilidhuru maisha yako?

3.

- Facilitate a group discussion asking participants to share whatever is comfortable from the above exercise using the following questions as prompts. List their responses on a flipchart and put this up on the wall.
 - What crisis or problem did you have that needed money you did not have? How much money did you need?
 - What were the circumstances? / Je ilikuwa hali gani?
 - What was the money used for? / Je pesa zilitumiwa kwa nini?
 - How did the situation come about? Who else was involved? / Hiyo hali ilijuwaje nani alijumuishwa?
 - How other people feel about this? / Vile watu wengine wanahisi kuhusii hii?
 - How did you - and they - handle the situation? / Ulifanyaje ama wale kusuluisha hiyo hali
 - Was it resolved? / Je ilitatuliwa?

-
- What would you do in future to make sure you are prepared for a similar crisis? / Nini ungefanya kwa maisha ya baadaye ndio ujipange shida inayo fanana na hilo?
 - If savings have not been mentioned then prompt for a variety of ways to save money, including chamas, bank accounts, avoiding debt.

4.

- Say that saving is challenging, but if we think about it in terms of the crises and risks we have been talking about in the session, it might be worth it. Think about what might have happened differently if you had managed to save money in some way.



Exercise 2: Learning to save money / Kujifuna kusave dau

AIMS: *The aim of this exercise is to create awareness around the role of saving and different ways of accomplishing it*

MATERIALS NEEDED: Flipchart, markers, Maasai stick

DIRECTIONS:

1.

- Say that saving is a challenging practice but it can be learned no matter how much one earns or receives.
- Ask participants what behaviours are needed in order to save successfully.
- List their suggestions and key points on the flipchart. Note the areas where it is difficult to get some consensus on which behaviours would be needed for one to save successfully, as well as different ways to save. Use the following as prompts:
 - How easy is it to behave as needed? / Ni virahisi aje kubehave vile inaitajika?
 - What are the challenges? How might these be overcome? / Nini changamoo ambazo zinaitajika uzipite?
 - Were there any areas that needed to be improved? How? / Ni seham gani inaitajika kuongezwa wapi? Aje?
- Summarise by saying that saving is not easy but there are supportive behaviours that can help you save, with notable returns. It is important to keep in mind that saving needs discipline.

2.

- Remind participants that the next session is the last.

SESSION 11: REFLECTING ON LEARNING AND LOOKING AHEAD / KUFIKIRI KUHUSU UMEJIFUNZA NA KUONA MBALE

PURPOSE

- To allow time for participants to reflect on what they have learned through the intervention, and think further about their goals looking ahead

MATERIALS AND PREPARATION:

- Flipchart
- Markers
- Pens
- Craft Paper with their goals from Session Two



Exercise 1: Reflecting on our goals and what we've accomplished / Tuko wapi saa hii?

AIMS: The aim of this exercise is to reflect on what we've learnt throughout the program and what we've accomplished as a group

MATERIALS NEEDED: Flipchart, markers, Maasai stick

DIRECTIONS:

1.

- Ask each person to spend five minutes quietly reflecting on what they have learned over the last weeks.
- Ask them to share whatever they are comfortable with. Go around one by one using the Maasai stick and have each person share something. Record all the things they have learnt about livelihood resources on a flipchart.

2.

- Ask the group the following questions and record their answers:
 - What are the different kinds of resources people use to build their lives, to help them find work, to save money and generate income? / Ni matu mizi yapi ambayo watu hutumia kujenga maisha yao, kuwasaidia kupata kazi kuweka pesa na kupata riziki?
 - What do you see as the role of relationships in supporting our livelihoods? / Ni nini unaona sukumu la ushusiano wa msaada wa maisha yetu?
 - How can community participation help us build our livelihoods? / Ni jinsi ipi ushirika wa jamii husaidia kujenga miasha yetu?
 - What are some different ways of learning? What are the advantages and disadvantages of each in helping us towards our life goals? / Ni nini tafauti zipi za kusoma? Ni nini faida na hasara la kila..
 - What have you learned that has been useful in thinking about looking for work? / Umejifunza nini muhimu kuhusu kutafuta kazi?
 - What have you learned that has been useful in helping you think about setting up a small business? / Umejifunza nini muhimu katika kusaidia kuhusiana na kuanzisha biashara?
 - What have you learned regarding saving money and ways of coping with shocks? / Umejifunza nini kuhusiana na kuweka pesa na kupa mbana na change moto?

3.

- Hand out participants' goal craft paper. Ask them to think about what they have learned and the life goal they have set themselves at the beginning of the livelihoods intervention, which they have added to and changed during the workshops.
- Ask them to think about or write down or draw on their craft paper, responses to the following:
 - What progress have you made in working towards your goal? / Maendeleo gani umefanya ili kupata lengo lako?
 - What progress have you made in each of the following areas? How does it link to your goal? / Maendeleo gani umefanya katika kila malengo? Inaunganaje na lengo lako? How will it help

~~~~~  
you achieve your goal? / Itaweza kukusaidia aje kutumiza lengo lako?

- Getting work. / Kupata jara
- Saving money and preparing to cope with shocks. / Kusave na kucope na shocks
- Developing an income generating activity. / Kuendeleza shuguli za kuzalisha mapato
- What are your plans for your next steps in working towards your goal? / Umejipanga aje kuchukukua mkondo wa kufikia matakwa yako?
- Where do you need help with planning? / Kwa nini tunaitali usaidizi na mipangilio?

**4.**

- Ask them to prepare a short presentation (no more than 5 minutes) presented in any way they like – drawing, writing, acting, talking or singing on:
  - What you have learned during this intervention? / Nini umejifunza kwenye hihi mafunza?
  - What progress you have made towards your goals during the intervention? / Ni hatua gani umeunda mbele ya malengo yako kutokana na haya mafunza?
  - The next steps you aim to take / Hatua nyingine ya kuchakua
  - Your questions, your areas of concern or where you would like help with planning. / Mawali kugependa kusaidiwa kujipanga?
  - After each presentation the other participants can ask questions or offer suggestions. / Baada ya kila maswali kila mtu anaweza uliza maswali ama angepende lea nini



## Exercise 2: Closing the matched-savings chamas / Mwisho ya kudouble savings

**AIMS:** The aim of this exercise is to close the workshop and redistribute matched-savings

**MATERIALS NEEDED:** Flipchart, markers, Maasai stick, savings accounting workbook

### DIRECTIONS:

1.
  - Ask participants to reflect on what they are going to use their savings for
  - Have participants go around one by one using the Maasai stick, sharing what they are going to use their savings for.
2.
  - Have the group sing a closing song
3.
  - Have each matched-savings chamas leader coordinate with the program banker for their group. Have participants meet with the program banker who will ensure each participant receives their savings based on their attendance and deposits throughout the whole program.



## APPENDIX IV: DATA COLLECTION TOOLS

### 1.0 BASELINE AND ENDLINE SURVEY

**Interviewer:** Please fill in the details below before commencing the interview.

|                                    |
|------------------------------------|
| Interviewer name:                  |
| Date: (dd/mm/yy):                  |
| Participant Identification number: |

#### Introduction

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#### Interviewer Introduction

My name is (interviewer name). You've agreed to participate in an HIV prevention intervention that involves a questionnaire about HIV knowledge, gender equity, and sexual practices. There are no right or wrong answers to the questions and you may decline to answer any questions throughout the survey. Your information will remain confidential, and will be combined with others to better understand how to prevent HIV among street-connected young people in Kenya. We appreciate your participation in this project and value your contribution to this research.

**PART ONE: SOCIO-DEMOGRAPHICS**

**Interviewer:** I'm now going to ask you some questions about yourself. All of your answers will remain confidential. You may refuse to answer any question.

- 1.0 **What is your current age:** \_\_\_\_\_ (Years)
- 1.1 **What year were you born?:** \_\_\_\_\_ (YYYY) \_\_\_ Don't Know \_\_\_ Refuse to Answer
- 1.2 **Sex:**  
\_\_\_ Male  
\_\_\_ Female
- 1.3 **Have you ever attended school?**  
\_\_\_ Yes  
\_\_\_ No  
\_\_\_ Don't know  
\_\_\_ Refuse to Answer

If yes, what was the last level and class completed?  
If no, Skip to 1.5

- 1.4 **Education level:**  
\_\_\_ Primary / Standard \_\_\_\_\_  
\_\_\_ Secondary / Form \_\_\_\_\_  
\_\_\_ Vocational  
\_\_\_ Refuse to Answer  
\_\_\_ Other, Specify: \_\_\_\_\_

- 1.5 **How would you describe your current relationship status?**  
\_\_\_ Single  
\_\_\_ Have a boyfriend or girlfriend  
\_\_\_ Married  
\_\_\_ Divorced  
\_\_\_ Widowed  
\_\_\_ Other, Specify: \_\_\_\_\_

- 1.6 **How long have you been street-involved?**  
\_\_\_ 6 months to 1 year  
\_\_\_ 1 to 2 years  
\_\_\_ 2 to 5 years  
\_\_\_ More than 5 years  
\_\_\_ Refuse to Answer  
\_\_\_ Don't Know

- 1.7 **How often are you on the streets?**  
\_\_\_ Day & Night  
\_\_\_ Day Only  
\_\_\_ Varies

- Refuse to Answer
- Don't know

**1.8 Where do you typically (the majority of nights of the week) sleep at night?**

- In a shelter I share with friends (small room in Langas, Kipkaren, Kamukunji etc)
- In my own rented house
- On the streets (verandah, market, other)
- In the barracks
- At my parent(s)/guardian(s) house
- Someplace different every night
- Refuse to Answer

**1.9 Are you a member of a 'barracks/base'?**

- Yes
- No
- Don't know
- Refuse to Answer

**1.10 Are your parents alive? (tick all that apply)**

- Mother dead
- Father dead
- Both parents dead
- Mother Alive
- Father Alive
- Both parents alive
- Mother's vital status unknown
- Father's vital status unknown

**1.11 How do you get money? (Tick all that apply)**

- Begging
- Stealing / Pick-pocketing/snatching/robbing
- Collecting Recycling (Plastics, Paper, Metals)
- Selling plastic ('paper') bags in the market
- Selling drugs (glue, bhang, pombe)
- Watching cars (Parking)
- Carrying luggage/bags (Trolley)
- Commercial Sex Work
- Casual/Informal labor, Specify: \_\_\_\_\_
- Other, Specify: \_\_\_\_\_
- Employed, Specify: \_\_\_\_\_
- Refuse to Answer

**1.11 How much money do you earn per day?**

- < 50 KSH
- 50-100 KSH
- 100-500 KSH
- >500 KSH
- Don't know
- Refuse to Answer

**1.12 Which of the following personal items do you own? (Tick all that apply)**

- Slippers
- Shoes
- Jacket / Jumper
- Mattress
- Blanket
- A second pair of clothing
- Jiko
- Cellular Phone
- Radio
- TV
- None of the above
- Refuse to Answer

**PART TWO**

**Interviewer:** I’m now going to ask you some questions about what you know about HIV. All of your answers will remain confidential. You may refuse to answer any questions you do not wish to answer. For each statement, please tell me if it is “True”, “False”, or “I don’t know”. If you do not know, please do not guess; instead, please tick “Don’t know.”

**HIV KNOWLEDGE - HIV-KQ-18**

| Question                                                                                                                   | True | False | Don't Know |
|----------------------------------------------------------------------------------------------------------------------------|------|-------|------------|
| 2.0 Coughing and sneezing DO NOT spread HIV.                                                                               |      |       |            |
| 2.1 A person can get HIV by sharing a glass of water with someone who has HIV                                              |      |       |            |
| 2.2 Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.                            |      |       |            |
| 2.3 A woman can get HIV if she has anal sex with a man.                                                                    |      |       |            |
| 2.4 Showering, or washing one’s genitals/private parts, after sex keeps a person from getting HIV.                         |      |       |            |
| 2.5 All pregnant women infected with HIV will have babies born with AIDS.                                                  |      |       |            |
| 2.6 People who have been infected with HIV quickly show serious signs of being infected.                                   |      |       |            |
| 2.7 People are likely to get HIV by deep kissing, putting their tongue in their partner’s mouth, if their partner has HIV. |      |       |            |
| 2.8 A woman cannot get HIV if she has sex during her period.                                                               |      |       |            |
| 2.9 There is a female condom that can help decrease a woman’s chance of getting HIV .                                      |      |       |            |
| 2.10 A polythene bag works better against HIV than does a latex condom.                                                    |      |       |            |
| 2.11 A person will NOT get HIV if she or he is taking antibiotics.                                                         |      |       |            |
| 2.12 Having sex with more than one partner can increase a person’s chance of being infected with HIV.                      |      |       |            |
| 2.13 Taking a test for HIV one week after having sex will tell a person if she or he has HIV.                              |      |       |            |
| 2.14 A person can get HIV by sitting next to a person who has HIV.                                                         |      |       |            |
| 2.15 A person can get HIV from oral sex.                                                                                   |      |       |            |
| 2.16 There is a vaccine that can stop adults from getting HIV.                                                             |      |       |            |
| 2.17 Using Vaseline or baby oil with condoms lowers the chance of getting HIV                                              |      |       |            |

**PART THREE: Gender Equity**

**Interviewer:** I’m now going to read you a series of statements about how you think and feel about relationships between a man and a woman and how men and women interact in relationships, including sexual relationships. I would like you to tell me for each statement I read to you, if you agree, partially agree or do not agree. All of your answers will remain confidential. You may refuse to answer any questions you do not wish to answer.

| Domain                                                                                                    | Agree | Partially Agree | Do not Agree |
|-----------------------------------------------------------------------------------------------------------|-------|-----------------|--------------|
| <b>Violence domain items</b>                                                                              |       |                 |              |
| There are times when a woman deserves to be beaten.                                                       |       |                 |              |
| A woman should tolerate violence to keep her family together.                                             |       |                 |              |
| It is alright for a man to beat his wife if she is unfaithful.                                            |       |                 |              |
| A man can hit his wife if she won’t have sex with him.                                                    |       |                 |              |
| If someone insults a man, he should defend his reputation with force if he has to.                        |       |                 |              |
| A man using violence against his wife is a private matter that shouldn’t be discussed outside the couple. |       |                 |              |
| <b>Sexual relationships domain Items</b>                                                                  |       |                 |              |
| It is the man who decides what type of sex to have.                                                       |       |                 |              |
| Men are always ready to have sex.                                                                         |       |                 |              |
| Men need sex more than women do.                                                                          |       |                 |              |
| A man needs other women even if things with his wife are fine.                                            |       |                 |              |
| You don’t talk about sex, you just do it.                                                                 |       |                 |              |
| It disgusts me when I see a man acting like a woman.                                                      |       |                 |              |
| A woman should not make the first move for sex                                                            |       |                 |              |
| A woman who has sex before she marries does not deserve respect                                           |       |                 |              |
| <b>Reproductive health and disease prevention domain items</b>                                            |       |                 |              |
| Women who carry condoms on them are easy.                                                                 |       |                 |              |
| Men should be outraged if their wives ask them to use a condom.                                           |       |                 |              |
| It is a woman’s responsibility to avoid getting pregnant.                                                 |       |                 |              |
| Only when a woman has a child is she a real woman.                                                        |       |                 |              |
| A real man produces a male child.                                                                         |       |                 |              |
| <b>Domestic chores and daily life domain Items</b>                                                        |       |                 |              |
| Changing diapers, giving a bath, and feeding kids is the mother’s responsibility.                         |       |                 |              |
| A woman’s role is taking care of her home and family.                                                     |       |                 |              |
| The husband should decide to buy the major household items.                                               |       |                 |              |
| A man should have the final word about decisions in his home.                                             |       |                 |              |
| A woman should obey her husband in all things.                                                            |       |                 |              |

**PART FOUR: Condom Use Self-Efficacy**

**Interviewer:** I'm now going to read you a series of statements about condom use. I would like you to tell me for each statement I read to you, if you strongly agree, agree, disagree, strongly disagree or are undecided. All of your answers will remain confidential. You may refuse to answer any questions you do not wish to answer.

| Domain                                                                                                                                                 | Strongly Agree | Agree | Undecided | Disagree | Strongly Disagree |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------|-----------|----------|-------------------|
| I feel confident in my ability to discuss condom usage with any partner I might have                                                                   |                |       |           |          |                   |
| I feel confident in my ability to suggest using condoms with a new partner                                                                             |                |       |           |          |                   |
| I feel confident I could suggest using a condom without my partner feeling "diseased"                                                                  |                |       |           |          |                   |
| I feel confident in my ability to persuade a partner to accept using a condom when we have sex                                                         |                |       |           |          |                   |
| I wouldn't feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I've had a homosexual experience |                |       |           |          |                   |
| I wouldn't feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have STD                       |                |       |           |          |                   |
| I wouldn't feel confident suggesting using condoms with a new partner because I would be afraid he/she would think I thought they had STD              |                |       |           |          |                   |
| I feel confident that I would remember to use a condom even after I have been drinking.                                                                |                |       |           |          |                   |
| I feel confident that I would remember to use condom even if I were high                                                                               |                |       |           |          |                   |

**PART FIVE: SEXUAL PRACTICES**

**Interviewer:** I'm now going to ask you some questions about your sexual practices. All of your answers will remain confidential. You may refuse to answer any questions you do not wish to answer.

**4.0 Have you ever had vaginal sex?**

- Yes
- No
- Refuse to answer

***If NO, REFUSE TO ANSWER or DON't KNOW skip to 4.3***

**4.1 How old were you when you first had vaginal sex \_\_\_\_\_years**

**4.2 The first time you had vaginal sex, was it voluntary (not forced or coerced)?**

- Yes
- No
- Don't Know
- Refuse to answer

**4.3 Have you ever had anal sex?**

- Yes
- No
- Refuse to answer

***If No, Refuse to Answer or Don't Know Skip to***

**4.4 How old were you when you first had anal sex \_\_\_\_\_years**

**4.5 The first time you had anal sex, was it voluntary (not forced or coerced)?**

- Yes
- No
- Don't Know
- Refuse to answer

**\*\*\*\*\* If Respondent has Responded No, Don't Know or Refuse to Answer to BOTH Vaginal and Anal sex questions 4.0 and 4.3 Proceed to Question 4.19 \*\*\*\*\***

**4.6 Are you sexually active now?**

- Yes
- No
- Refuse to answer

***If No or Refuse to answer, skip to 4.8***

**4.7 If yes, do you have sex with:**

- Men/boys
- Women/girls
- Both
- Refuse to Answer

**4.8** When is the last time you had vaginal sex?

- Within past 1 week
- Within past 1 month
- 1-6 months ago
- More than 6 months ago
- Never

*If never skip to question 4.12*

**4.9** The last time you had vaginal sex did you (or the person you had sex with) use a condom?

- Yes
- No
- Refuse to answer
- Don't Know

**4.10** How often do you (or the person you have sex with) use condoms for vaginal sex?

- Always
- Most of the time
- 50% of the time
- Sometimes
- Never

**4.11** How many different people have you had vaginal sex with in the last month?

- 0
- 1
- 2-5
- 5-10
- >10

**4.12** When is the last time you had anal sex?

- Within past 1 week
- Within past 1 month
- 1-6 months ago
- More than 6 months ago
- Never

*If never skip to question 4.16*

**4.13** The last time you had anal sex did you (or the person you had sex with) use a condom?

- Yes
- No
- Refuse to answer
- Don't Know

**4.14** How often do you (or the person you have sex with) use condoms for anal sex?

- Always
- Most of the time
- 50% of the time
- Sometimes

Never

**4.15 How many different people have you had anal sex with in the last month?**

0

1

2-5

5-10

>10

**4.16 Have you EVER exchanged sex for money, shelter, food, protection, or anything else?**

Yes

No

Refuse to answer

If NO or REFUSE TO ANSWER Skip to Question 4.19

**4.17 In the past month, have you ever exchanged sex for money, shelter, food, protection, or anything else?**

Yes

No

Refuse to answer

**4.18 How often do you typically exchange sex for money, shelter, food, protection or anything else?**

Daily

Weekly

Once a month

I have in the past, but not in the past six months.

Don't Know

Refuse to Answer

**4.19 Have you ever been tested for HIV?**

Ever, Yes

Never

Don't know

Refuse to answer

If NEVER, DON'T KNOW or REFUSE TO ANSWER → End of Survey

**4.20 When the was the last time you were tested for HIV**

0-1 months

> 1 month - < 3 months

> 3 months - < 6 months

> 6 months

Don't Know

Refuse to Answer

## 2.0 Socio-demographic data collected from FGD participants:

Age: \_\_\_\_\_ (Years)

Sex:

Male

Female

Education level:

None

Primary

Secondary

Vocational

Refuse to Answer

Other – Specify: \_\_\_\_\_

### ADAPTATION FOCUS GROUP DISCUSSION GUIDE

The research team will give an overview and presentation of the Stepping Stones program, its curriculum, and how the sessions are intended to work. After this overview participants will be invited to participate in a guided discussion about the proposed intervention.

1. Tell me about your thoughts about the Stepping Stones program you just heard about

Follow-up questions:

a. What about the program did you like?

b. Is the proposed program acceptable to you? Do you think it's appropriate for you and your peers connected to the streets? Why/Why not?

c. What about the program did you not like?

d. What parts of the program are not acceptable to you? What components of the program do you think are inappropriate for you and your peers connected to the streets?

e. What would you add to the program?

f. What would you take away from the program?

g. What time of day and days of the week would you like the program to run?

h. How many days of the week would you be willing to come to the program?

2. Is there anything else you would like to tell me about in relation to this program?

The research team will give an overview and presentation of the proposed combined livelihood-strengthening program (Creating Futures and matched-savings GISE Groups), its curriculum, and how the sessions are intended to work. After this overview participants will be invited to participate in a guided discussion about the proposed intervention.

1. Tell me about your thoughts about the livelihood-strengthening program you just heard about.

a. What about the program did you like?

b. Is the proposed program acceptable to you? Do you think its appropriate for you and your peers connected to the streets? Why/Why not?

- c. What about the program did you not like?
- d. What parts of the program are not acceptable to you? What components of the program do you think are inappropriate for you and your peers connected to the streets?
- e. What would you add to the program?
- f. What would you take away from the program?
- g. How do you think GISE groups will best function for you?

2. Is there anything else you would like to tell me about in relation to this portion of the HIV prevention program?

### **3.0 EVALUATION IN-DEPTH INTERVIEW GUIDE**

I would like to ask you questions regarding your experiences facilitating the adapted? HIV prevention program over the past 16 weeks.

1. Tell me about your experiences facilitating and participating in the program?

Follow-up questions

- a. What did you think worked well in the program? And Why?
- b. What did not work well? And why?
- c. What did you learn while facilitating the program?
- d. What could be improved about the program based on your experience facilitating the program?
- e. What was unexpected about facilitating the program?
- f. Would you be a program facilitator again?

2. What were some challenges you encountered as a facilitator?

- a. If you were going to facilitate this program again, what do you think are some solutions to mitigate these challenges?

3. Tell me about what you enjoyed the most about being a facilitator?

4. How did the experience of facilitating this program impact you personally? Others??

5. I would like to invite you to share anything else you would like about your experience facilitating the program.

#### 4.0 EVALUATION FOCUS GROUP DISCUSSION GUIDE

I would like to ask you questions regarding your experiences participating the HIV prevention program over the past 16 weeks.

1. Tell me about your experience participating in the program as a street-connected young person?

Follow-up questions

a. What did you learn while participating the program?

b. What did you learn about sexual health? How did this change your sexual practices?

c. What did you learn about how men and women live and relate to each other? How did this change how you interact and relate to boys/men/girls/women?

d. What was your experience like with the matched-savings GISE Groups? How did this change your economic status?

e. Would you participate in it again?

2. What did you think worked well for you as a program participant? And Why?

a. What did not work well as a program participant? And why?

b. What could be improved based on your experience participating the program?

3. What was unexpected about participating the program?

4. What were some challenges you encountered as a participant?

a. What do you think are some solutions to mitigate these challenges?

3. Tell me about the positive aspects (if any) about being a participant in the program.

a. Tell me about the negative aspects (if any) about being a participant in the program.

4. I would like to invite you to tell me anything else about how the experience of participating this program impacted your life?

5. I would like to invite you to share anything else you would like to tell me.

## Translated Documents

### MAHOJIANO YA KUANZA NA YA KUMALIZIA

**Anayehoji:** Tafadhali jaza maelezo hapa chini kabla ya kuanza mahojiano.

|                      |
|----------------------|
| Jina ya Anayehoji:   |
| Tarehe: (dd/mm/yy):  |
| Nambari ya utafiti : |

### Utangulizi

---

#### Anayehoji

#### Kuanza

Jina langu ni (Jina la anayehoji). Umekubali kushiriki kwa hii mbinu ya kuzuia virus vya ukimwi ambayo inahusisha maswali kuhusu ufahamu wa virusi vya ukimwi, usawa wa jinsia, na namna ya kushiriki ngono. Hakuna jibu lililo sawa au lisilo sawakwa maswali na unaweza kukosa kujibu maswali yoyote katika utafiti huu. Taarifa yako itabaki kua siri, na itachanganywa na ya wale wengine kueleza vizuri zaidi jinsi ya kuzuia virusi vya ukimwi kati ya vijana wa mtaani nchini Kenya. Tunashukuru ushirikiano wako katika mradi huu na kuthamini mchango wako katika utafiti huu.

## SEHEMU YA KWANZA: Maswali kujihusu wewe

**Anayehoji:** Sasa nitaenda kukuuliza maswali kujihusu wewe mwenyewe. Majibu yako yote itabaki kua siri. Unaweza kataa kujibu swali yoyote.

**1.0 Je, umri wako kwa sasa ni?:**(Miaka) \_\_\_\_\_

**1.1 Je, wewe ulizaliwa mwaka gani?:** \_\_\_\_\_ (Mwaka) \_\_\_\_ Sijui \_\_ kataa kujibu

**1.2 Jinsia:**  
\_\_ Mwanaume  
\_\_ Mwanamke

**1.3 Je, umewahi enda shule?**  
\_\_ Ndio  
\_\_ La  
\_\_ Sijui  
\_\_ Kataa kujibu

Ikiwa ndio, darasa la mwisho kukamilisha ilikua ipi?  
Ikiwa La, ruka hadi 1.5

**1.4 Kiwango cha elimu:**  
\_\_ Shule ya Msingi / Darasa la \_\_\_\_\_  
\_\_ Shule ya Upili / Kidado cha \_\_\_\_\_  
\_\_ Shule ya Ujuzi  
\_\_ Kataa kujibu  
\_\_ Nyingine, Taja: \_\_\_\_\_

**1.5 Je, unaweza kuelezea aje hali ya uhusiano wako kwa sasa?**  
\_\_ Pekee/solo  
\_\_ Na mpenzi wa kike au wa kiume  
\_\_ Umeoa  
\_\_ Umetalaki/Mumeachana  
\_\_ Mjane  
\_\_ Nyingine, Taja: \_\_\_\_\_

**1.6 Je, muda gani umehusika kuwa wa mtaani?**  
\_\_ Miezi 6 hadi mwaka mmoja  
\_\_ Mwaka 1 hadi 2  
\_\_ Miaka 2 hadi 5  
\_\_ Zaidi ya miaka 5  
\_\_ Kataa kujibu  
\_\_ Sijui

**1.7 Je, wewe huwa mitaani wakati gani?**  
\_\_ Usiku na mchana  
\_\_ Mchana pekee  
\_\_ Inatofautiana

- Kataa kujibu
- Sijui

**1.8 Je, Kwa kawaida wewe (Wingi wa usiku kwa wiki) hulala wapi usiku?**

- Kwa nyumba, Kulala na marafiki (Kwa nyumba ndogo eneo ya Langas, Kipkaren, Kamukunji na kadhalika)
- Kwa nyumba yangu ya kukodisha
- Katika mitaani (veranda, Sokoni, Nyinginezo)
- Kwa base/Barracks
- Kwa nyumba ya wazazi/walezi wangu
- Mahali tofauti tofauti kila usiku
- Kataa kujibu

**1.9 Je, wewe ni muhusika wa barracks/base'?**

- Ndio
- La
- Sijui
- Kataa kujibu

**1.10 Je, wako hai wazazi wako? (Weka alama kwa yote inayofaa)**

- Mama amefariki
- Baba amefariki
- Wazazi wote wamefariki
- mama yuko uhai
- baba yuko uhai
- Wazazi wote wako huai
- Mama hajulikani aliko
- Baba hajulikani aliko

**1.11 Je, Wewe hupata pesa kwa njia gani? (Weka alama kwa yote inayofaa)**

- Kuomba
- Kuiba/Kunyakua mifukoni/
- Kusanya (plastiki, Makaratasi, vyuma)
- Kuuza plastiki (Makaratasi) ya kubebea mizigo sokoni
- Kuuza madawa (Biere/Gundi, Bangi, Pombe)
- Kuchunga magari (Kuegeza)
- Kubeba mizigo/Mifuko (Trolis)
- Biashara ya kufanya ngono ili kulipwa
- Kazi ya kawaida/rasmi, Taja: \_\_\_\_\_
- Nyinginezo, Taja: \_\_\_\_\_
- Kuajiriwa, Taja: \_\_\_\_\_
- Sijui
- Kataa kujibu

**1.11 Je, Wewe hupata pesa ngapi kwa siku?**

- < Chini ya shilingi 50
- Shilingi 50-100
- Shilingi 100-500
- > Zaidi ya shilingi 500
- Sijui

Kataa kujibu

**1.12 Je, Ni ipi kati ya zifuatazo wewe umiliki kama yako? (Weka alama kwa yote inayofaa)**

Champari/Slippers

Viatu

Koti/Jampa

Godoro

Blanketi

Jozi ya pili ya nguo

Jiko

Simu ya mkononi

Radio

Runinga

Hakuna yeyote kwa haya

Kataa kujibu

## SEHEMU YA PILI

**Anayehoji:** Ninaenda kukuuliza maswali kuhusu yale unayofahamu kuhusu virusi vya ukimwi. Majibu yako yote itabaki kua siri. Unaweza kataa kujibu swali yoyote ambayo haujihisi kujibu. Kwa kila taarifa, Tafadhali weka alama “Kweli”, “Si kweli”, au “Sijui”. Ikiwa haujui, tafadhali usikisie,badala yake,tafadhali weka alama “Sijui.”

### Unayofahamu kuhusu virusi vya ukimwi- HIV-KQ-18

| Maswali                                                                                                                                                       | Kweli | Si kweli | Sijui |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------|-------|
| 2.0 Kukohoa na kupiga chafya HAIWEZI sambaza virusi vya ukimwi.                                                                                               |       |          |       |
| 2.1 Mtu anaweza kuambukizwa virusi vya ukimwi kwa kutumia kwa pamoja glasi ya maji na mtu ambaye ana virusi vya ukimwi.                                       |       |          |       |
| 2.2 Kutoa mboro nje kabla ya mwanaume kumwaga inazuia mwanamke kutopata virusi vya ukimwi wakati wa ngono.                                                    |       |          |       |
| 2.3 Mwanamke anaweza kupata virusi vya ukimwi wakati anafanya ngono ya mukundu na mwanaume.                                                                   |       |          |       |
| 2.4 Kuoga, au kuosha sehemu za siri ya mtu, baada ya ngono inazuia mtu kutopata virusi vya ukimwi.                                                            |       |          |       |
| 2.5 Wanawake wote wajawazito ambao wana virusi vya ukimwi watajifungua watoto walio na ukimwi                                                                 |       |          |       |
| 2.6 Watu ambao wana virusi vya ukimwi kwa haraka wanaonyesha dalili ya kuadhiriwa.                                                                            |       |          |       |
| 2.7 Kuna uwezekano ya watu kupata virusi vya ukimwi kwa kubusiana, kuweka ulimi wao ndani ya mdomo ya mpenzi wake, Ikiwa wapenzi wao wana virusi vywa ukimwi. |       |          |       |
| 2.8 Mwanamke hawezi kuambukizwa virusi vya ukimwi akifanya ngono wakati ako kwa kipindi chake ya damu ya mwezi.                                               |       |          |       |
| 2.9 Kuna kondomu ya wanawake ambayo inasaidia kupunguza nafasi ya wanawake kupata virusi vya ukimwi.                                                          |       |          |       |
| 2.10 juala hutumika viruzi dhidi ya virusi vya ukimwi kuliko mpira wa kondomu.                                                                                |       |          |       |
| 2.11 Mtu hawezi kupata virusi vya ukimwi ikiwa anatumia madawa ya antibiotiki.                                                                                |       |          |       |
| 2.12 Kushiriki ngono na mpenzi zaidi ya mmoja inaweza ongeza nafasi ya mtu kuambukizwa virusi vya ukimwi.                                                     |       |          |       |
| 2.13 Kupimwa hali ya virusi vya ukimwi wiki moja baada ya kushiriki ngono itaongesha ikiwa mtu ana virusi vya ukimwi.                                         |       |          |       |
| 2.14 Mtu anawezapata virusi vya ukimwi kwa kutumia besheni moja ya kuogea na mtu ambaye ana virusi vya ukimwi.                                                |       |          |       |
| 2.15 Mtu anawezapata virusi vya ukimwi kutokana na ngono ya kunyonyana.                                                                                       |       |          |       |
| 2.16 Kuna chanjo ambayo inaweza zuia watu wazima wasipate virusi vya ukimwi.                                                                                  |       |          |       |
| 2.17 Kutumia mafuta ya vaselin au mafuta ya kujipaka ya mtoto kwa kondomu inapunguza nafasi ya kupata virusi vya ukimwi                                       |       |          |       |

**SEHEMU YA TATU: Usawa wa kijinsia**

**Anayehoji:** Sasa ninaenda kukusomea mfululizo wa taarifa kuhusu jinsi unavyofikiria na kuhisi kuhusu uhusiano baina ya mume na mke na jinsi ambavyo wanaelewana katika uhusiano, ikiwa ni pamoja na uhusiano wa ngono. Ningependa wewe unieleze kwa kila taarifa ninayo kusomea, ikiwa unakubali, ikiwa unakubali kwa kiasi fulani, au haukubali. Majibu yako yote itabaki kua siri. Unaweza kataa kujibu swali yoyote ambayo haujihisi kujibu.

| Kitengo                                                                                        | unakubali | Unakubali<br>kwa kiasi<br>fulani | Haukubali |
|------------------------------------------------------------------------------------------------|-----------|----------------------------------|-----------|
| <b>Kitengo cha vurugu</b>                                                                      |           |                                  |           |
| Kuna wakati mwanamke anastahili kupigwa.                                                       |           |                                  |           |
| Mwanamke anapaswa kuvumiliza vurugu ili kuweka familia yake pamoja.                            |           |                                  |           |
| Ni sawa kwa mume kupiga mke wake ikiwa yeye si mwaminifu.                                      |           |                                  |           |
| Mume anaweza kumgonga mke wake ikiwa hawezi kushiriki ngono na yeye.                           |           |                                  |           |
| Ikiwa mtu atatusi mwanaume , anapaswa kuilinda sifa yake kwa nguvu ikiwa anapaswa hivyo.       |           |                                  |           |
| Mume kutumia vurugu dhidi ya mke wake ni swala binafsi ambayo haipaswi kujadiliwa nje ya ndoa. |           |                                  |           |
| <b>Kitengo cha uhusiano wa kimapenzi</b>                                                       |           |                                  |           |
| Ni mwanaume ambaye anaamua ni ngono aina gani mtafanya.                                        |           |                                  |           |
| Mwanaume yuko tayari kila wakati kushiriki ngono.                                              |           |                                  |           |
| Mwanaume anahitaji ngono zaidi kuliko vile wanawake wanavyohitaji.                             |           |                                  |           |
| Mwanaume anahitaji wanawake wengine hata kama vitu baina yake na mke wake yako sawa.           |           |                                  |           |
| Hauwezi kuzungumza kuhusu ngono , wewe hufanya tuu.                                            |           |                                  |           |
| Inanichukiza wakati ambapo naona mwanaume anajifanya kama mwanamke.                            |           |                                  |           |
| Mwanamke hafai kuwa wa kwanza kuulizia ngono.                                                  |           |                                  |           |
| Mwanamke ambaye anashiriki ngono kabla aolewe hastahili heshima.                               |           |                                  |           |
| <b>Kitengo cha afya ya uzazi na kuzuia magonjwa.</b>                                           |           |                                  |           |
| Wanawake ambao hubeba kondomu ni warahisi.                                                     |           |                                  |           |
| Wanaume wanapaswa kuwa na hasira ikiwa wake wao wanawahimiza watumie kondomu.                  |           |                                  |           |
| Ni wajibu wa mwanamke kujizuia kupata mimba.                                                   |           |                                  |           |
| Wakati mwanamke ana mtoto pekee yeye ni mwanamke wa kweli.                                     |           |                                  |           |

|                                                                          |  |  |  |
|--------------------------------------------------------------------------|--|--|--|
| Mwanaume kamili anazalisha mtoto wa kiume.                               |  |  |  |
| <b>Kitengo cha kazi za nyumbani na maisha ya kila siku</b>               |  |  |  |
| Kubadilisha nepi, Kuosha na Kulisha watoto ni jukumu la mama.            |  |  |  |
| Jukumu la mwanamke ni kuchunga nyumba na familia yake.                   |  |  |  |
| Mume anapaswa kuamua kununua vitu/bidhaa kuu za nyumba.                  |  |  |  |
| Mwanaume anapaswa kusema jambo la mwisho kuhusu maamuzi kwa nyumba yake. |  |  |  |
| Mwanamke anapaswa kutii mume wake kwa mambo yote.                        |  |  |  |

**SEHEMU YA NNE: Matumizi ya kondomu kibinafsi kwa ufanisi**

**Anayehoji:** Sasa ninaenda kukusomea mfululizo wa taarifa kuhusu matumizi ya kondomu. Ningependa wewe unieleze kwa kila taarifa ninayo kusomea, ikiwa unakubali kabisa, unakubali, haukubali, unapinga vikali au haujaamua. Majibu yako yote itabaki kua siri. Unaweza kataa kujibu swali yoyote ambayo haujihisi kujibu

| Kitengo                                                                                                                                                                    | Unakubali kabisa | Unaku bali | Hujaamua | Haukubali | Unapinga Vikali |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------|----------|-----------|-----------------|
| Najihisi mjasiri kwa uwezo wangu kujadili matumizi ya kondomu na mpenzi yeyote ninaye.                                                                                     |                  |            |          |           |                 |
| Najihisi mjasiri kwa uwezo wangu kupendekeza matumizi ya kondomu na mpenzi ambaye nimempata kwa mara ya kwanza.                                                            |                  |            |          |           |                 |
| Najihisi mjasiri naweza pendekeza kutumia kondomu bila ya mpenzi wangu kujihisi 'Mgonjwa'                                                                                  |                  |            |          |           |                 |
| Najihisi mjasiri kwa uwezo wangu kumshawishi mpenzi kukubali kutumia kondomu tukishiriki ngono.                                                                            |                  |            |          |           |                 |
| Siwezi jihisi jasiri kupendekeza matumizi ya kondomu na mpenzi niliyempata kwa mara ya kwanza kwa sababu nahofia anaweza fikiria ninauzoefu ya ushoga.                     |                  |            |          |           |                 |
| Siwezi jihisi jasiri kupendekeza matumizi ya kondomu na mpenzi niliyempata kwa mara ya kwanza kwa sababu nahofia anaweza fikiria nina ugonjwa ya zinaa.                    |                  |            |          |           |                 |
| Siwezi jihisi jasiri kupendekeza matumizi ya kondomu na mpenzi niliyempata kwa mara ya kwanza kwa sababu nahofia anaweza fikiria kwamba mimi nafikiria anaugonjwa ya zinaa |                  |            |          |           |                 |
| Najihisi mjasiri ninaweza kumbuka kutumia kondomu hata baada ya mimi kunywa pombe.                                                                                         |                  |            |          |           |                 |
| Najihisi mjasiri ninaweza kumbuka kutumia kondomu hata baada ya mimi kutumia madawa ya kulevya.                                                                            |                  |            |          |           |                 |

## SEHEMU YA TANO: Namna ya kushiriki ngono

**Anayehoji:** Ninaenda kukuuliza maswali kuhusu namna unavyoshiriki ngono. Majibu yako yote itabaki kua siri. Unaweza kataa kujibu swali yoyote ambayo haujihisi kujibu.

### 4.0 Je, umewahi shiriki ngono ya uke?

- Ndio
- La
- Sijui
- Kataa kujibu

*Ikiwa la, Kataa kujibu au sijui ruka hadi 4.3*

### 4.1 Je, ulikuwa una umri gani uliposhiriki ngono ya uke kwa mara ya kwanza Miaka \_\_\_\_\_

### 4.2 Kwa mara ya kwanza uliposhiriki ngono ya uke, Je, Ilikua kwa hiari (si kwa nguvu au kulazimishwa)?

- Ndio
- La
- Sijui
- Kataa kujibu

### 4.3 Je, Umewahi shiriki ngono ya mkundu?

- Ndio
- La
- Sijui
- Kataa kujibu

*Ikiwa la, Kataa kujibu au sijui ruka hadi 4.6*

### 4.4 Je, ulikuwa una umri gani uliposhiriki ngono ya mkundu kwa mara ya kwanza Miaka \_\_\_\_\_

### 4.5 Kwa mara ya kwanza uliposhiriki ngono ya mkundu, Je, Ilikua kwa hiari (si kwa nguvu au kulazimishwa)?

- Ndio
- La
- Sijui
- Kataa kujibu

*\*\*\*\*\* Ikiwa mhojiwa amejibu La, Sijui au kataa kujibu kwa maswali YOTE MBILI ya ngono ya uke na mkundu 4.0 na 4.3 endelea na swali 4.19\*\*\*\*\**

### 4.6 Je, wewe hushiriki ngono kwa sasa?

- Ndio
- La
- Kataa kujibu

*Ikiwa la au Kataa kujibu ruka hadi 4.8*

### 4.7 Ikiwa ndio, wewe hufanya ngono na nani:

- Wanaume/wavulana

- wanawake/wasichana
- Wote
- Kataa kujibu

**4.8 Je, Mara ya mwisho wewe kushiriki ngono ya uke ilikua?**

- Kati ya wiki moja iliyopita
- Kati ya mwezi moja iliyopita
- Mwezi 1-6 iliyopita
- Zaidi ya miezi 6 months iliyopita
- Kamwe Sijawahi

***Ikiwa kamwe sijawahi, ruka hadi 4.12***

**4.9 Kwa mara ya mwisho wewe kushiriki ngono ya uke, je, wewe (au mtu uliyeshiriki naye ngono) ulitumia kondomu?**

- Ndio
- La
- Sijui
- Kataa kujibu

**4.10 Je, Kwa mara ngapi wewe (au mtu uliyeshiriki naye ngono) hutumia kondomu kwa ngono ya uke?**

- Kila mara
- Mara nyingi
- Mara 50%
- Mara nyingine
- Kamwe sijawahi

**4.11 Je, Ni watu wangapi tofauti umeshiriki nao ngono ya kike kwa mwezi iliyopita?**

- 0
- 1
- 2-5
- 5-10
- >10

**4.12 Je, Mara ya mwisho wewe kushiriki ngono ya mkundu ilikua?**

- Kati ya wiki moja iliyopita
- Kati ya mwezi moja iliyopita
- Mwezi 1-6 iliyopita
- Zaidi ya miezi 6 months iliyopita
- Kamwe Sijawahi

***Ikiwa kamwe sijawahi, ruka hadi 4.16***

**4.13 Kwa mara ya mwisho wewe kushiriki ngono ya mkundu, je, wewe (au mtu uliyeshiriki naye ngono) ulitumia kondomu?**

- Ndio
- La
- Sijui
- Kataa kujibu

**4.14 Je, Kwa mara ngapi wewe (au mtu uliyeshiriki naye ngono) hutumia kondomu kwa ngono ya mkundu?**

- Kila mara
- Mara nyingi
- Mara 50%
- Mara nyingine
- Kamwe sijawahi

**4.15 Je, Ni watu wangapi tofauti umeshiriki nao ngono ya mkundu kwa mwezi iliyopita?**

- 0
- 1
- 2-5
- 5-10
- >10

**4.16 Je, umewahi shiriki ngono ilikupata pesa, makao, chakula, ulinzi, au kitu kingine chochote?**

- Ndio
- La
- Kataa kujibu

Kama umejibu la ama kataa kujibu enda kwa 4.19

**4.17 Kwa mwezi iliyopita, je, wewe umewahi shiriki ngono ilikupata pesa, makao, chakula, ulinzi, au kitu kingine chochote?**

- Ndio
- La
- Kataa kujibu

**4.18 Ni kwa mara ngapi wewe huwa unashiriki ngono ilikupata pesa, makao, chakula, ulinzi, au kitu kingine chochote?**

- Kila siku
- Kila wiki
- Mara moja kwa mwezi
- Nimewahi kwa muda iliyopita, lakini sio kwa miezi sita iliyopita.
- Sijui
- Kataa kujibu

**4.19 Je, umewahi pimwa virusi vya ukimwi?**

- Ndio Nimewahi
- Kamwe sijawahi
- Sijui
- Kataa kujibu

Kama umejibu kamwe sijawahi, sijui au kata kujibu. Asante kwa kushiriki kwa utafiti huu

**4.20 Mara ya mwisho wewe kupimwa virusi vya ukimwi ilikua?**

- 0-1 months
- > 1 month - < 3 months
- > 3 months - < 6 months
- > 6 months

\_\_ Sijui  
\_\_ Kataa Kijibu

**Maswali kujihusu binafsi kutoka kwa washiriki wa vikundi vya majadiliano:**

**Umri:** \_\_\_\_ (Miaka)

**Jinsia:**

- Mwanaume
- Mwanamke

**Kiwango cha elimu:**

- Hakuna
- Shule ya msingi
- Shule ya upili
- Shule ya ujuzi/ufundi
- Kataa kujibu
- Nyinginezo - Taja: \_\_\_\_\_

**MWONGOZO WA KUKABILIANA NA VIKUNDI VYA MAJADILIANO.**

Timu ya utafiti itatoa maelezo na kuwasilisha mpangilio wa jiwe la kupigia hatua, Vipengele vyake na vile vikao vyake inakusudiwa kufanya kazi. Baada ya maelezo haya washiriki wataalikwa kushiriki katika majadiliano ya kuongozwa kuhusu mapendekezo ya kuingilia.

1. Tafadhali nieleze maoni yako kuhusu mradi wa jiwe la kupigia hatua ambayo umesikia kuihusu.

Maswali ya kufuatilia:

- a. Je, Ulipenda mpangilio wake?
- b. Je, Mradi iliyopendekezwa inakubalika kulingana na wewe? Unafikiria ni sahihi kwako na wenzako wa mitaani? Kwanini/Kwanini sivyo?
- c. Je, Nini kuhusu huu mradi haikukupendeza?
- d. Je, Sehemu gani ya mradi haikubaliki kulingana na wewe? Kitengo/sehemu gani unafikiria haifai kwako na kwa wenzako wa mitaani?
- e. Je, Nini ungependelea kuongeza kwa mradi huu?
- f. Je, Nini ungependa kupunguza kutoka kwa mradi huu?
- g. Je, Ni wakati gani ya siku na wakati gani ya wiki ungependa huu mradi hufanyike?
- h. Je, Ni siku ngapi kwa wiki ungependa kushiriki katika mradi huu?

2. Je, Kuna kitu kingine chochote ungependa kuniambia kuhusiana na mradi huu?

Timu ya utafiti itatoa maelezo na kuwasilisha mradi kuhimarisha Maisha (Kupeana mapendekezo na kuweka akiba kwa vikundi - chama), Vipengele vyake na vile vikao vyake inakusudiwa kufanya kazi. Baada ya maelezo haya washiriki wataalikwa kushiriki katika majadiliano ya kuongozwa kuhusu mapendekezo ya kuingilia.

1. Tafadhali nieleze maoni yako kuhusu mradiya kuhimarisha Maisha ambayo umesikia kuihusu.

- a. Je, Ulipenda mpangilio wake?
  - b. Je, Mradi iliyopendekezwa inakubalika kulingana na wewe? Unafikiria ni sahihi kwako na wenzako wa mitaani? Kwanini/Kwanini sivyo?
  - c. Je, Nini kuhusu huu mradi haikukupendeza?
  - d. Je, Sehemu gani ya mradi haikubaliki kulingana na wewe? Kitengo/sehemu gani unafikiria haifai kwako na kwa wenzako wa mitaani?
  - e. Je, Nini ungependelea kuongeza kwa mradi huu?
  - f. Je, Nini ungependa kupunguza kutoka kwa mradi huu?
  - g. Je, unafikiria chama ya vikundi itafanya vizuri kulingana na wewe?
2. Je, Kuna kitu kingine chochote ungependa kuniambia kuhusiana na mpangilio huu kuzuia virusi vya ukimwi?

### **MWONGOZO WA KUTATHMINI MAHOJIANO YA KINDANI**

Ningependa kukuuliza maswali kuhusiana na uzoefu wako kuongoza mapendekezo?Mpangilio wa kuzuia virusi vya ukimwi kwa wiki 16 zilizopita.

1. Ningependa unieleze kuhusu uzoefu wako kuongoza na kushiriki kwa mradi huu?

Maswali ya kufuatilia

- a. Je, unafikiria nini kilifanyika vizuri kwa mpangilio? Na kwanini?
- b. Je, Ni nini haikufanyika vizuri? Na kwanini?
- c. Je, ulijifunza nini wakati ulikua unaongoza huu mradi?
- d. Je, Ni nini inaweza kuboreshwa kuhusu mradi huu kulingana na uzoefu wako wa kuongoza mradi?
- e. Je, ni nini haikutarajiwa kuhusu kuongoza mradi?
- f. Je, Utakua mwendeshaji wa mradi tena?

2. Je, Ni nini baadhi ya changamoto ulipata wewe kama mwendeshaji?

- a. Ikiwa ulikuwa uongoze mradi huu tena, Je, unafikiria ni nini baadhi ya suluhisho kukabiliana na changamoto hizi?

3. Nieleze ni nini ulifurahia zaidi kuhusu wewe kua mwongozaji?

4. Je, uzoefu wa kuongoza mradi huu ilikujenga kivi wewe binafsi? Na wengine?

5. Ningependa nikukukaribisha wewe kujadili na wengine kitu kingine chochote ungependa kuhusu uzoefu wako kuongoza mradi.

## MWONGOZO WA MTAZAMO WA MAJADILIANO YA VIKUNDI

Ningependa kukuuliza maswali kuhusiana na uzoefu wako kuongoza mapendekezo? Mpangilio wa kuzuia virusi vya ukimwi kwa wiki 16 zilizopita.

1. Ningependa unieleze kuhusu uzoefu wako kushiriki katika mradi huu kama “mshefa” mradi huu?

Maswali ya kufuatilia

a. Je, Umejifunza nini wakati umeshiriki kwa mradi huu?

b. Je, umejifunza nini kuhusu afya ya ngono? Je, hii imebadilisha kiviipi nanma yako ya kushiriki ngono?

c. Je, Umejifunza nini kuhusu jinsi wanaume na wanawake wanavyoishi na kuhusiana na kila mmoja? Je, haya yamebadilisha kiviipi jinsi wewe unavyozungumza na kuhusiana na wavulana/wanaume/wasichana/wanawake?

d. Je, uzoefu wako imekuaje na chama cha kikundi? Je, hii imebadilisha kiviipi hali yako ya uchumi?

e. Je, unaweza shiriki tena kwa chama cha kikundi?

2. Je, Ni nini ilifanyika vizuri kulingana na wewe kama mshiriki wa mradi? Na kwanini?

a. Je, Ni nini haikufanyika vizuri kwako kama mshiriki wa mradi? Na kwanini?

b. Je, Ni nini inaweza kuboreshwa kulingana na uzoefu wako ukishiriki kwa mradi?

3. Je, ni nini haikutarajiwa kuhusu wewe kushiriki kwa mradi?

4. Je, Ni nini baadhi ya changamoto ulipata wewe kama mshiriki?

a. Je, unafikiria ni nini baadhi ya suluhisho kukabiliana na changamoto hizi?

3. Niambie kuhusu mambo mazuri (kama ipo) kuhusu kuwa mshiriki katika mradi.

a. Niambie kuhusu mambo yasisofaa (kama ipo) kuhusu kuwa mshiriki katika mradi.

4. Ningependa kukuaribisha wewe kujadili na wengine kitu kingine chochote ungependa kuhusu uzoefu wako kuwa mshiriki katika mradi.

5. Ningependa kukuaribisha wewe kujadili na wengine kitu kingine chochote ambacho ungependa kunieleza.

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