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Addressing early marriage in areas of high HIV prevalence: A program to delay marriage and support married girls in rural Nyanza, Kenya

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Married adolescent girls form a large segment of Kenyan youth, yet they are largely overlooked by researchers and programmers concerned with the lives of adolescents. As evidence demonstrates, this neglected population of married girls is likely to be vulnerable and in need of support. HIV infection is much higher among adolescent girls in sub-Saharan Africa than among boys. In settings such as Nyanza Province, Kenya, rates of HIV infection are extremely high, and evidence is increasing in some settings that girls who are married are much more likely to be infected with HIV, compared with their unmarried counterparts who are sexually active.

This brief describes a program addressing the problem of early marriage, the reproductive risks associated with early marriage, and the risk of HIV infection transmission within marriage. The program was based on the Population Council's analysis of the 2003 Kenya Demographic and Health Survey (KDHS) as well as on formative research within the rural Nyanza community.

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Background

Early marriage in Kenya[1]

In Kenya, the minimum legal age at marriage is 18 for both sexes. Twenty-five percent of Kenyan adolescent girls are married before age 18, however, and 5 percent are married during early adolescence, that is, before age 15. Considerable variation in marriage rates occurs by region; girls in rural areas are significantly more likely than those living in urban areas to be married during adolescence.

[1] The statistics in this section are drawn from the Population Council's analysis of the 2003 KDHS.

Percentage of Kenyan girls aged 15–24 who were married by age 18, by province

Urban	18
Rural	29
Central	15
Coast	34
Eastern	16
Nairobi	12
Northeastern	56
Nyanza	34
Rift Valley	35
Western	32

Life-table analysis based on responses from girls aged 15–24; data drawn from the Population Council's analysis of the 2003 KDHS.

A considerable proportion of Kenyan girls do not choose their husbands; their husbands are chosen for them, although rates of arranged marriages in Kenya are not as high as in South Asia, West Africa, and parts of Ethiopia. Among married girls aged 15–24, 12 percent of urban girls and 19 percent of rural girls had arranged marriages. The highest rates of arranged marriages among adolescent girls are found in Northeastern (73 percent), Rift Valley (22 percent), and Coast (21 percent) provinces. A strong relationship is found between age at marriage and the likelihood that the marriage was arranged. Among Kenyan girls married at age 14 or 15, 33 percent had arranged marriages, compared with 13 percent of girls who married at 18 or 19. A considerable number of married adolescents and young women are in polygamous unions; nearly one in five married girls in Coast, Northeastern, and Rift Valley provinces are in such unions.

The younger a girl is when she marries, the larger the age difference between her and her spouse. Kenyan girls who married at age 14 or 15 were, on average, 11 years younger than their spouses. Girls who married at 16 or 17 were nine years younger, whereas those who married at 18 or 19 were seven years younger than their husbands. Age differences between spouses have important implications for the division of power and decisionmaking in the household, especially when the wife is very young and her spouse is considerably older.

Early marriage and the risk of acquiring HIV

Evidence is emerging that married adolescent girls in some settings are at increased risk of acquiring HIV infection, compared with their counterparts who are unmarried and sexually active. A study using biological markers conducted in four African cities revealed that 33 percent of married adolescent girls in Kisumu, Nyanza Province, are HIV-positive, compared with 22 percent of unmarried sexually active girls (Glynn et al. 2001; Clark 2004; Clark et al. 2006). Once a girl is married, she experiences intercourse much more frequently than before she was married, and condom use is virtually nonexistent. Moreover, the husbands of adolescents in Kisumu are considerably older and more likely to be HIV positive, compared with the boyfriends of unmarried girls. Analysis reveals that the age and HIV profile of adolescent girls' husbands and the frequency of intercourse are HIV risk factors that override the risk of infection related to multiple partnerships that characterize some unmarried girls' relationships.

For girls living in traditional rural settings, marriage or engagement often marks the beginning of their sexual life and of their risk of acquiring HIV infection. Likewise, parents who assume, incorrectly, that marriage protects their daughters from HIV infection frequently arrange girls' marriages. Traditionally, young brides move to their husbands' homes where they have low status, are kept relatively isolated, and lack the power to make decisions, including sexual decisions.

Although they may be at increased risk of acquiring HIV infection, married girls may be less knowledgeable and have less access than single girls to information and services related to the virus. Among married girls aged 15–24, 19 percent do not know how to avoid becoming infected with HIV, compared with 11 percent of their unmarried sexually active counterparts. The latter are significantly more likely than married girls to have acquired information about HIV from the radio, newspapers, or magazines and are more likely to have heard about voluntary counseling and training (VCT) and to know where to obtain such services.

Adolescent marriage and risk to reproductive health

Married girls in Kenya are significantly more likely to have children, compared with unmarried girls of the same age. Among Kenyan girls aged 15–24, 83 percent of married adolescents have given birth, compared with 33 percent of unmarried sexually active girls. The earlier a girl is married, the earlier she gives birth. The median age at first birth is 16 for girls

Prenatal care and assistance during first delivery among Kenyan girls aged 15–29, by age at first birth

Care provider/assistant	First birth before age 20 (n = 1,542)	First birth at age 20+ (n = 904)
Provider for prenatal care		
Doctor	17.6	20.6*
Nurse/midwife	73.6	78.0*
No one	13.2***	7.4
Assistance during delivery		
Doctor	10.5	19.1***
Nurse/midwife	32.8	49.9***
Trained birth assistant	31.4***	19.6
Relative / friend	25.9***	17.7
No one	6.0***	2.6

*Differences between groups significant at p≤0.05; ***p≤0.001.
Source: Population Council tabulations of data from the 2003 KDHS.

married at 14 or 15, 18 for girls married at 16 or 17, and 19 for girls married at 18 or 19.

Early first births are the riskiest; many girls are not prepared for pregnancy and do not receive adequate support, including medical attention. Girls who experience a first birth during adolescence are less likely to receive prenatal care from a medical professional and less likely to be assisted during delivery, compared with those who are adults when they give birth for the first time. Moreover, compared with other regions in Kenya, Nyanza Province has higher levels of maternal and infant mortality and other poor pregnancy outcomes at all ages and parities (Magadi 2004).

Patterns of marriage in rural Nyanza, Kenya

Marriage among the Luo is exogamous; women move outside their home area when they marry. Population Council formative research in rural Nyanza[2] revealed that girls in this setting often marry through arrangements made by a go-between or *jagam* who is frequently a married woman from the extended family seeking companionship in her distant marital home. Although such marriages are not considered arranged, adolescent girls are often convinced by the jagam to marry as a pathway to better their circumstances. Many girls chose to marry either because they could not progress in school or because their parents were extremely poor or had died (see quote below).

> *My mum's health was not good. My dad had passed away when we were still young. So I told myself that if I get someone who is going to help me, why not go and reduce my mum's burden. And that's why I left home [and got married].*
>
> —Girl aged 18, married at age 15, three children

Perception of HIV and VCT

The findings from the qualitative research suggest low levels of risk perception. Many respondents felt that married girls were at least risk of HIV infection, largely because their husbands represented their only source of risk.

> Interviewer: *Who do you think is at least risk [of HIV infection]?*
>
> Respondent: *Women. This is because women may only get it from their husbands as they don't have affairs outside marriage as often as men do.*
>
> —Married girl, aged 17, seven years of education

Among residents in the project site, Rachuonyo District, barriers to voluntary counseling and testing included distance to the facility and cost of transportation to the facility, as well as fear and stigma associated with a positive result. When asked about couples' VCT, respondents expressed approval of being tested as a couple:

> *I think it's good if they go together [for VCT]. If they are tested and the results show that one is infected and the other is not, they can be advised on what to do. You may go alone and they tell you that you are infected, and because of fear you may not tell your partner, and so it's better to go as a couple.*
>
> —Married girl, aged 20, seven years of education

[2] In-depth interviews were conducted in mid-2005 among eight married adolescent girls, eight husbands of adolescent girls, eight in-laws of adolescent girls, and eight parents of adolescents.

A Program to Delay Marriage and Support Married Adolescents

Based on this research among married girls and their families in Nyanza Province, a program was designed to support three categories of adolescent girls: (1) those who are not yet married but may be contemplating marriage; (2) those who are in the process of getting married; and (3) those who are already married. Activities designed to sensitize the community about delaying marriage include airing radio spots on the local-language station, training drama troupes to present messages about early marriage, and training church leaders to foster awareness within their congregations. Radio, drama troupes, and church leaders also promote premarital VCT to support girls who are in the process of marriage and to advocate for couples' learning each other's serostatus before marriage. Prominent local women are trained as mentors to lead groups of married adolescent girls, providing HIV and reproductive health information and referrals, and trained to raise awareness of gender-based violence and encourage spousal communication.

The project site, Rachuonyo District, partly borders Lake Victoria. This rural district lies south of the provincial capital, Kisumu; its economy is largely based on agriculture and fishing. In 2007, the project is expanding to a nearby rural district, Homa Bay, with a similar economy.

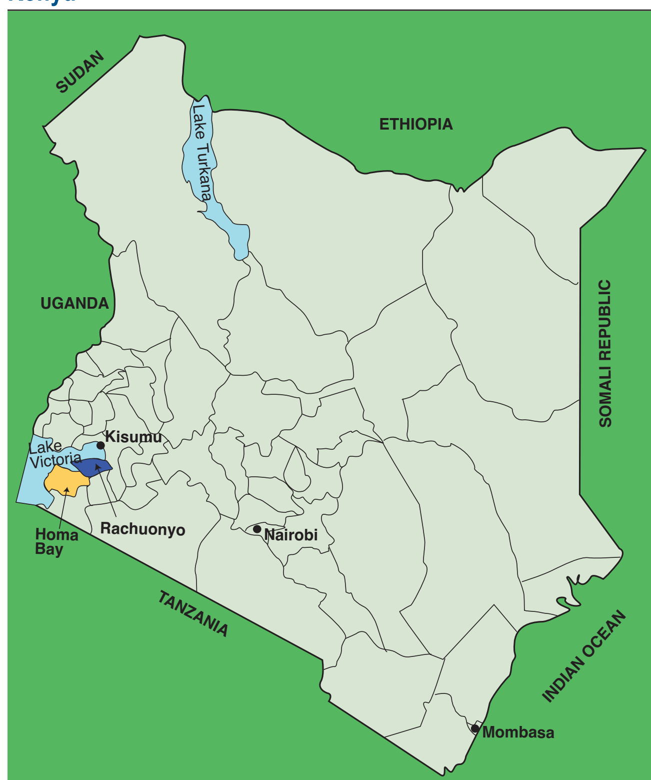
Rates of HIV are extremely high in the province in both urban and rural areas. Adolescent girls and young women are

Percentage of young people infected with HIV, Nyanza Province, Kenya

Age group	Male	Female
All Kenya		
15–19 (n = 1,463)	0.6	3.6
20–24 (n = 1,255)	2.5	8.4
Nyanza Province		
15–19 (n = 267)	0.7	7.0
20–24 (n = 164)	6.1	25.5

Source: Population Council tabulations of data from the 2003 KDHS.

Kenya



Summary of beneficiary groups and related interventions

Beneficiary group	Objective	Program component
Adolescent girls who are not yet married	To raise awareness of the risks of early marriage among community members, including girls, matchmakers, and prospective husbands	• Radio spots aired by local-language station • Drama troupes • Church leaders
Adolescent girls in the process of getting married	To foster safer marriages and encourage long-term marital fidelity	• Promotion of couples' VCT through radio, drama, and churches • Referral and linkage to existing VCT facilities
Adolescent married girls	To support girls who are already married	• Married girls' support groups led by adult female, giving HIV and reproductive health information and referrals

Translation of radio spot aired on Radio Ramogi

[Background music from traditional Luo song] "Nde, Step and walk slowly, Nde tunde, Nde, Step and walk slowly . . ."

Announcer:

My brothers and sisters, those who do things in a hurry end up eating nyoyo (beans and maize) mixed with sand. Before you agree to marry, please walk and step slowly and go for a test to confirm your HIV status. Agreeing quickly *[to marry without an HIV test]* will make you cry that you wish you had known . . .

particularly affected; one-fourth of young women aged 20–24 are HIV positive, compared with 6 percent of young men in the same age group, resulting in a female-to-male ratio of about four to one.

Radio spots

Drawing upon the Population Council's research, the Program for Appropriate Technology in Health (PATH) developed four radio spots aired on Radio Ramogi, the only Luo-language radio station, with coverage throughout Kenya. The station is particularly popular in Nyanza, having an estimated audience of 70 percent of the population. The radio spots have been aired since January 2006. They are designed to encourage listeners to wait for the right time to marry, to know their own and their partner's serostatus before marriage, and to use condoms within marriage. These 30-second spots draw on Luo proverbs and popular local songs in crafting their messages. Each of the four spots is aired once per week. The spots air just before the most popular programs on the local station and are popular with listeners because of their local relevance, humor, and plays on Luo words.

In 2007, PATH will develop three more radio spots, again addressing early marriage and HIV and premarital VCT, but also will include messages about family planning. Program managers are also considering airing messages on additional radio stations, including Radio Victoria, which is increasingly popular in the project area.

Magnet Theater Drama Troupes

Magnet Theater is a drama technique developed by PATH. The technique employs episodic dramas that are participatory, engaging the audience in problem solving and conflict resolution. Drama troupes perform at the same venue each week, attempting to draw the same audience in much the same way that a television series seeks to retain loyal viewers over time.

An inventory of existing drama groups in the project site was compiled. Project staff visited drama groups to determine their willingness and ability to deliver messages related to early marriage and HIV and reproductive health risk. Seven drama troupes were selected according to their areas of operation, membership, organizational structure, and interest in the project. The selected troupes participated in a five-day workshop. Findings were shared, and participants brainstormed emerging themes and possible story lines. Themes included the transition to marriage, including jagam-arranged unions; motivations for marriage, including marriage as a problem-solving strategy; and premarital VCT, among other topics. By the end of the training, each troupe had developed at least one serialized play on the themes identified through the research.

Trained drama troupes perform magnet theater in places where people congregate, including marketplaces, beaches,

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shopping centers, and churches. Typically, the seven troupes hold six to eight performances a month, about 42 performances in all. At the end of performances, open discussions are held with audience members on the topics introduced during the drama. Troupe members also refer those interested in VCT and reproductive health services to collaborating centers.

Church and civic leaders as advocates

Project managers undertook an inventory of well-attended churches of all denominations in the project area. From the inventory, 40 religious leaders were selected according to predefined criteria, including literacy, interest in the project themes, and area of operation. Training of religious leaders was conducted in April 2006 by the Population Council, PATH, and the Kendu Adventist Hospital Community Health Workers Department, and results were shared with the trainees. Themes were related to texts from the Bible and the Koran. The religious leaders formulated action plans and agreed that messages related to early marriage, HIV, or reproductive health would be given at least every two weeks.

Mentors for married girls and peer families

Trained church leaders and staff from Kendu Adventist Hospital identified mentors to mobilize and support groups of married adolescent girls. Female mentors were selected who were literate, well known and respected in their communities, and old enough to exert influence over adults as well as young people. In June 2006, these mentors received training on a number of topics, including HIV/AIDS, sexually transmitted infections, prevention of mother-to-child transmission (PMTCT) of HIV, spousal communication, and family planning, as well as group-facilitation skills. Before mobilizing girls' groups, the Population Council devised a simple format that mentors can use for a house-to-house approach to identify girls who may be eligible for the girls' groups. Using this methodology, married adolescent girls who otherwise would have remained isolated in their households were identified and invited to join the weekly meetings.

To date, each mentor has formed two groups of approximately 20 married girls who meet once a week, often on Sundays after church, either on the church premises or at a school. Married girls' meetings include educational sessions, group discussions, and debates on issues such as HIV/AIDS, family planning, PMTCT, safe motherhood, and VCT. A key concern among the groups is livelihoods, and plans are underway to extend education in financial literacy to participating girls.

UNICEF Kenya: George Mulala

A major challenge in convening married girls' groups was the role and attitudes of husbands—how to respond to their questions and concerns about the groups and whether and how to involve them in a constructive manner.

The term "peer families" describes an approach developed by PATH in which girls and their extended family members meet to discuss issues affecting the whole family. This methodology has been adapted for use by the participants in the married girls' groups. Relatives of the group members meet periodically to discuss issues that arise in the group meetings. Although peer families started to meet only recently, the meetings include lively debates on the issues presented including gender issues.

VCT and other reproductive health services

One of the main messages of the program is to encourage engaged couples to undergo premarital VCT, including joint disclosure of HIV serostatus, so that couples are aware of

each other's status before committing to a marital union. Drama troupes, church leaders, and mentors refer interested individuals and couples for VCT. In order to promote the idea of couples' being tested jointly, a referral coupon is offered by outreach workers that subsidizes the cost of transport for participants from their rural home to the site of a testing service. The Population Council identified and established partnerships with the 11 existing VCT centers in the project site. Providers at these clinics have been trained in "youth friendly" counseling; additional training in counseling couples is planned for early 2007.

Demand for couples' VCT has been far greater than anticipated. To date, 1,835 couples have been tested. Premarital couples' VCT presents an excellent opportunity for discussing a range of reproductive health issues. In 2007, the Population Council will provide VCT counselors with training in additional skills for family planning and other reproductive health counseling and education.

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