ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH

TAKING STOCK IN KENYA

A Report from FHI 360/PROGRESS and the Ministry of Health, Kenya

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TABLE OF CONTENTS

ACRONYMS iii

EXECUTIVE SUMMARY iv

INTRODUCTION 1

METHODS 3

Desk Review 3

Mapping of YSOs and Interview with Stakeholders 4

LITERATURE REVIEW 5

Status of Adolescent and Youth SRH 5

MAPPING OF YOUTH SERVING ORGANIZATIONS AND STAKEHOLDER INTERVIEW FINDINGS 9

The Policy Environment 9

Program Coverage 10

Program Approaches 11

Important Aspects for Implementation of SRH Interventions 15

Gaps in AYSRH – Stakeholders' Perspectives 16

Stakeholder Recommendations 18

EVIDENCE-BASED INTERVENTIONS 18

CONCLUSIONS 22

APPENDIXES 24

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent sexual and reproductive health
AYSRH	Adolescent and youth sexual and reproductive health
CBO	Community based organization
CPR	Contraceptive prevalence rate
DRH	Division of Reproductive Health
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	Faith based organization
HIV	Human Immunodeficiency Virus
ICT	Information and communication technology
IDU	Injecting drug users
KDHS	Kenya Demographic and Health Survey
MCH/FP	Maternal child health/Family Planning
MDG	Millennium development goals
MOE	Ministry of Education
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOYAS	Ministry of Youth Affairs and Sports
NCAPD	National Coordinating Agency for Population and Development
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
RH	Reproductive health
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TWG	Technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
YFS	Youth-friendly services
YSO	Youth serving organization

EXECUTIVE SUMMARY

The Division of Reproductive Health (DRH) within the Ministry of Public Health and Sanitation (MOPHS) with assistance from FHI 360 and financial support from United States Agency for International Development (USAID) undertook a review of adolescent and youth reproductive health programs in the country through a desk review, a mapping of youth serving organizations (YSOs), and interviews with stakeholders from the YSOs and development partners. The goal was to identify the key organizations involved in adolescent and youth sexual and reproductive health (AYSRH), compile a general inventory of their activities, and begin to assess the degree to which they are using evidenced-based interventions that are ready for national scale-up. This review was designed to enhance the DRH's ability to coordinate AYSRH activities in the country.

Kenya has multiple policies and guidelines that favor provision of information and services to young people, but these documents are not integrated well into services. Multiple ministries are involved in the process, adding to the challenges in this field. In addition to the MOPHS, the key ministries and government agencies with interest in AYSRH are Ministry of Medical Services (MOMS), Ministry of Youth Affairs and Sports (MOYAS), Ministry of Education (MOE), National Coordinating Agency for Population and Development (NCAPD), National AIDS and STD Control Program (NASCOP), and Kenya Institute of Education (KIE) among others.

Out of the 67 YSOs and 13 development partners identified in the review, 45 organizations and nine development partners responded with information through a telephone interview or email. The findings reiterated the fact that many young people are sexually active and are at risk of adverse reproductive health outcomes that subsequently affect achievement of life goals and optimum contribution to national development. Many youth initiate sexual intercourse early, have multiple partners and often do not use protection during sex. In general, young people are unlikely to seek health services, and when they do they are likely to get inadequate services. This health system has been slow to evolve to accommodate the needs of this age group both from program and service delivery perspectives. Some service providers lack the skills and positive attitudes needed to serve youth.

Most YSOs operate within the highly populated areas of the country with Nairobi having the highest concentration of implementers (26 out of the 45 interviewed). They mainly target in- and out-of-school youth aged 10-24 years, in both rural and urban areas. The main program approaches they use to reach youth include peer education, edutainment, service delivery (including outreach services), youth support structures, mass media, ICT, edusports, life skills education, mentorship, adult influencers, and advocacy for policy review or change. These approaches are usually not implemented singly but in combination, such as peer education with mass media and service delivery.

In the survey, the YSOs identified the following main gaps in AYSRH in terms of program and service delivery.

Program level:

- Inadequate dissemination and utilization of policies and guidelines and coordination of AYSRH activities nationally.
- Inadequate distribution of AYSRH activities in the country; some areas or target groups are over served while others hardly have any activities.
- Insufficient involvement of youth and communities in youth activities and programs.
- Inadequate human and financial resources.
- Programs not incorporating the social and cultural context into the interventions.
- Insufficient scale-up of evidence-based interventions.
- The emerging ICT platform has not been fully embraced by programs to reach youth with information.

Service delivery level

- Youth-friendly services (YFS) are poorly defined leading to various interpretations. Most facilities do not have YFS.
- Inadequate training and orientation of service providers to provide SRH services to youth.
- Awareness creation of available youth SRH services is inadequate.
- Frequent shortage of commodities and supplies.
- Peer educators are not fully utilized.

In the interviews, stakeholders recommended the following:

- Improved coordination of AYSRH activities.
- Dissemination and monitoring of policies and guidelines.
- Application of multi-sectoral approaches to address AYSRH holistically.
- Integrating AYSRH into other health and non-health related activities involving youth.
- Re-definition and standardization of YFS.
- Training and orientation of service providers on youth sexuality and service delivery.
- Evaluation of promising interventions to provide evidence for scale-up.
- National scale-up of evidence-based interventions.

Four projects were identified that are utilizing evidence-based interventions:

- Kenya adolescent reproductive health program (KARHP)
- Friends of youth (FOY)
- Primary school action for better health (PSABH)
- Families Matter!

AYSRH in Kenya needs to be better coordinated and monitored to effectively utilize the existing resources and support the replication of evidence-based interventions. This report is a first step towards strengthening DRH's coordination function and developing systems to support this coordination including development of an AYSRH strategy, review of the current youth policy (being led by NCAPD) and better evaluation of promising interventions for evidence.

INTRODUCTION

In Kenya, the pendulum is steadily swinging back from focusing on risks of HIV and AIDS for youth to a broader approach to youth development, including the pivotal issues related to sexual and reproductive health (SRH). Donors, government agencies, programs and service providers are increasingly moving towards such a holistic approach to addressing youth issues. Meanwhile, government agencies have expressed the need for better coordination of the multiple SRH youth programs being implemented by partners, often in "silos" around particular issues. As a result, the Division of Reproductive Health (DRH) is beginning to explore these issues with special regard to reproductive health for youth.

The DRH, a division within the Ministry of Public Health and Sanitation (MOPHS), has the task of coordinating adolescent sexual and reproductive health (ASRH) through the ASRH program manager and ASRH technical working group (TWG), which meets quarterly. Other government ministries and agencies with key roles in coordination, working in collaboration with DRH, include the Division of Child and Adolescent Health within MOPHS, the National Coordinating Agency for Population and Development (NCAPD), the National STD and AIDS Control Program (NASCOP) with the Ministry of Medical Services (MOMS), the Ministry of Education (MOE) and the Ministry of Youth Affairs and Sports (MOYAS). The ministries and agencies work closely with development partners such as UN agencies, bi-lateral organizations, implementing local and international non-governmental organizations (NGOs), faith-based organizations (FBOs) and community-based organizations (CBOs).The partners operate at the national, provincial and district levels depending on area of coverage.

Why Youth SRH?

Kenya is faced with a rapidly growing population with an annual growth rate of 3% per annum[1] (2009 National Census). According to the recent Kenya Demographic and Health Survey – KDHS (2008-09) and the 2009 Census, Kenya has a broad based (pyramid shaped) population structure with 63% of the population below 25 years. Similarly, 32% of the population is aged between 10-24 years; also 41% of women and 43% of men of reproductive age (15-49) are below 25 years of age. The rapid population growth coupled with large proportion of young people in the country puts great demands on health care, education, housing, water and sanitation and employment. With inadequate attention to the SRH needs of this age group of the population, Kenya is unlikely to achieve the Millennium Development Goals (MDG) or Vision 2030.

Youth in Kenya, as in other developing countries, face numerous social, economic and health issues. Youth are at a stage in their lives when they are exploring and establishing their identity in society. They need to develop life skills that prepare them to be responsible adults and socially fit in society. Due to their large population, poverty and inadequate access to health care

[1] Kenya National Bureau of Statistics (2009). National Population Census

some youth do not get an opportunity to acquire life skills and consequently involve themselves in risky behaviors that expose them to social, economic and adverse health events such as substance abuse, school dropout, crime, social unrest, unemployment, unintended pregnancy and life threatening sexually transmitted diseases and infections. A recent assessment conducted by the HIV Free Generation project in Kenya found that the top three fears of young people were unemployment, unintended pregnancy and HIV and AIDS[2].

The 1994 Cairo Plan of Action highlighted the importance of holistic action regarding ASRH. Even so, just seven years later, at the 2001 International AIDS Conference in Barcelona, the "Barcelona Youth Force" helped put the risk of HIV among youth prominently on the world stage. This youth advocacy, supported by the UNAIDS director and others, along with the creation of PEPFAR and many other factors, pushed the urgency of HIV awareness raising and action among youth to the fore of youth SRH. In 1999, Kenya declared HIV/AIDS a national disaster and almost all resources were channeled towards responding to the disaster. A decade later, after a lot of successful awareness-raising on HIV/AIDS, development of sex education curriculum, and other actions, the pendulum appears to be swinging back. Perhaps, the rise of the international youth culture, promoted through multimedia and cell phone technology has contributed to a broader picture. Or maybe the rise of sexual education programs has contributed to the slowing of the HIV infection rates. Whatever the complex reasons, a more holistic approach appears to be on the rise.

As part of its quest to better coordinate AYSRH, the DRH organized an ASRH Conference in May 2011 in Nairobi to share knowledge and experiences on addressing the RH needs of young people and promote evidence-based programming[3]. Again in September 2011, the DRH with technical assistance from FHI 360 and financial support from USAID organized a stakeholders' forum to discuss and validate the preliminary findings of a review of adolescent and youth sexual and reproductive health (AYSRH) programs and services conducted by FHI 360 and to validate the findings of the review. At both meetings, the DRH identified insufficient coordination of and collaboration with and among partners as one of the main challenges that require attention in order to adequately address AYSRH in the country. The term AYSRH was adopted at the stakeholder meeting to include youth who are past adolescence but still within the age bracket of 10-24 years[4].

Other challenges identified during the meetings included low budget allocation in the MOH budget, limited resources for better programming, inadequate physical infrastructure for provision of services, and inadequate reproductive health (RH) information for youth. The DRH

[2] Unpublished HIV Free Generation presentation (2011). Creating partnership for a HIV-Free Generation in Kenya
[3] Population Council, (2011). 2011 Adolescent sexual and reproductive health conference, Nairobi, May 5, 2011. Summary of key issues discussed
[4] In this report adolescents are persons aged between 10-19 years and youth as persons between 10-24 years. However, we are aware that MOYAS has a broad definition of youth covering 10-34 years.

also identified the priority actions to be undertaken to respond to the RH needs of youth. These include:

- Ensuring adolescents and youth have full access to sexual and reproductive information and services
- Establishing high quality, comprehensive and integrated youth-friendly reproductive health services
- Promoting a multi-sectoral approach to addressing youth SRH
- Strengthening partnership and referral with NGOs and FBOs, especially those in hard to reach areas

This report is a first step towards developing an AYSRH strategy by the DRH and its partners, and reviewing the ARH and Development Policy by NCAPD. Even though Kenya has had an ARH and Development Policy since 2003[5] and went further to develop an Action Plan[6] for its implementation, there has been no strategy to guide implementers. Additionally, this policy is long overdue for review given the rapidly changing environment for AYSRH in the country and worldwide.

In order to move toward better coordination of AYSRH activities, the DRH needs to understand the coverage of current projects and work with various agencies and partners to update as needed strategies, guidelines, and plans toward improving information and services to underserved young people. As a first step, the DRH is undertaking this two-part review of existing programs providing SRH services to youth. The DRH has therefore commissioned FHI 360 with financial support from United States Agency for International Development (USAID) to undertake a review to determine who is implementing AYSRH activities, their area of coverage, the approaches being used and find out from the partners what approaches work.

METHODS

The review was conducted in two parts: a desk review, and a mapping of SRH youth serving organizations together with stakeholder interviews from these organizations.

Desk Review

The desk review was undertaken to identify evidence-based interventions and approaches for addressing AYSRH, what approaches work, and what gaps exist in addressing AYSRH in Kenya. Background information was collected from various sources including government ministries and agencies, development partners and implementing organizations. Internet searches to identify evidence-based interventions were also conducted.

[5] NCPD and DRH (2003). Adolescent Reproductive Health and Development Policy
[6] NCAPD and DRH (2005). Adolescent Reproductive Health and Development Policy: Plan of Action 2005-2015

Mapping of YSOs and Interview with Stakeholders

An inventory of AYSRH organizations was developed and key contacts from the organizations interviewed on email or telephone on the activities they are undertaking on AYSRH. The list developed included government agencies, development partners (both multi-lateral and bilateral) and non-governmental organizations (NGOs). The list was compiled with assistance from the ASRH technical working group (TWG) and an inventory of youth serving organizations on RH and HIV/AIDS compiled by FHI 360 in 2006[7]. This is not an exhaustive list of AYSRH organizations, but it provides a good starting point for compiling a more comprehensive list as the project moves forward. In addition it captures the major players in AYSRH in Kenya. The interviews were conducted from July 19 to October 10, 2011 using an open-ended question guide that allowed the respondents the freedom to list all the AYSRH activities they were undertaking and provide as much detail as they deemed necessary. Most organizations completed the question guide and sent it to the interviewer on email. A few organizations were interviewed on phone. Table 1 below gives details of the organizations contacted and the response rate.

Table 1: Organizations' Response Rate

Action	Number organizations	Number of Development partners	Total
Total number on list	67	13	79
Contacted but did not respond	11	3	14
No telephone or email contact	10	1	11
Total interviewed	**45**	**9**	**54**

Out of 67 youth organizations and 13 development partners identified, 45 organizations and nine development partners were contacted and interviewed. Despite numerous reminders both on telephone and email, 11 youth organizations and three development partners did not respond to the question guide sent to them. Ten YSOs and one development partner could not be reached on telephone or on email. Some inconsistencies were noted where some development partners indicated they did not fund AYSRH activities but some implementing partners reported they are funded by these same development partners.

In addition, during the AYSRH stakeholders' meeting held in September 2011, participants were requested to complete an anonymous open-ended questionnaire on what they thought of AYSRH programming in Kenya. They were also asked to suggest ways of strengthening AYSRH programming, what they thought were evidence based interventions and identify gaps in the current program.

[7] Schueller et al. (2006). Assessment of youth reproductive health and HIV/AIDS programs in Kenya (FHI Report)

The interview notes and open-ended question guides were analyzed for activities being undertaken, area of coverage, approaches being used and source of financial support. Suggestions on perceived evidence-based interventions, key research or evaluation work, gaps, recommendations for improving the program and coordination were derived from the open-ended questionnaires administered during the stakeholders' meeting. A matrix of AYSRH organizations was also compiled.

LITERATURE REVIEW

Kenya has been inundated with projects addressing youth health issues especially after HIV/AIDS was declared a national disaster. The projects mainly address prevention, care and support for HIV/AIDS. This was necessary given the huge resources invested in HIV/AIDS and the urgency to curb the spread of the infection especially among young people. The HIV projects have concentrated on HIV prevention including sexuality and life skills education (LSE) but hardly touching on issues of unintended pregnancy and other RH issues among youth. A recent comparison of life skills education (LSE) curriculum in schools with the UNESCO guidelines found gaps in the content of the MOE curriculum used in primary and secondary schools in the country[8].

Status of Adolescent and Youth SRH

As young people pass through puberty and adolescence, health needs related to sexual and reproductive health arise. Adolescents and youth have been perceived to have few health needs and little income to access to health services[9]. As a result, they have generally been neglected by the health system though all need information on reproductive health and some need targeted services[10]. The health system should provide information on sexuality, pregnancy prevention, and prevention of HIV/AIDS and other sexually transmitted infections by providing information and skill-based approaches such as life planning that can lead to favorable reproductive health outcomes.

Adverse SRH outcomes among adolescents and youth include unintended pregnancy, early childbirth, abortion, early marriage, and sexually transmitted infections including HIV[11]. The results of risky behaviors include early sexual debut, substance abuse, sexual and gender violence, multiple sexual partners, and inadequate access to and use of contraceptives including condoms for dual protection. These negative outcomes curtail young people's ability to achieve their economic and social goals, which in turn affect the country's long-term development.

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[8]UNESCO (2009). *International Technical Guidance on Sexuality Education* UNESCO et agencies, Dec 2009

[9] Makona et al., (2008). 2008 National youth shadow report: Progress made on the 2001 UNGASS Declaration of commitment on HIV/AIDS, Kenya *New York Global Action Network, Global Youth Coalition on HIV/AIDS*

[10] Republic of Kenya (2005). National Guidelines for Youth Friendly Services - YFS, 2005

[11] Magadi, M. (2006). Poor pregnancy outcomes among adolescents in South Nyanza region of Kenya. *African Journal of Reproductive Health 10(1): 26-38*

Gender disparities in sexual relationships among young people are also significant with girls feeling they have an obligation to give in to men's sexual demands especially if the men offer them gifts[12] .) There is also a perception among various communities that boys cannot do without sex and cannot control their sexual urge[13].

Education: An analysis of KDHS trends by Chio and Mishra (2009) on primary and secondary sexual abstinence found that youth attending school initiate sex later, with never married male and female youth in school being four to five times more likely to abstain from sex than those out of school. However, there were differentials by gender: females in secondary school were more likely to abstain than their male counterparts of the same educational attainment[14].

Sexual debut, experience and condom use: Sexual initiation often marks the beginning of sexual and reproductive health challenges mentioned earlier, as well as socio-economic and cultural challenges including dropping out of school and a disruption in social and economic goals. Most young people who are sexually active have little knowledge of sexual matters[15]. The low perceived risk of infection coupled with alcohol use negatively affects consistent condom use[16] [17]. Involvement in higher risk sex, coupled with low and inconsistent condom use among this population pre-disposes them to a high risk of STIs and unintended pregnancies[18]. Most young people do not appreciate the risk of exposure to STIs through multiple sexual partnerships resulting in low condom use[19] [20] [21]. This trend is observed even among HIV positive youth[22].

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[12] Ministry of Education (2010). Draft Life Skills Education in Kenya: A Comparative Analysis and Stakeholder Perspectives, 2010

[13] Nzioka, C. (2004). Unwanted pregnancy and sexually transmitted infection among young women in rural Kenya. *Culture and Health 6(1): 31-44*

[14] Chiao, C. and V. Mishra (2009). Trends in primary and secondary abstinence among Kenyan youth. *AIDS Care 21(7): 881-892*

[15] Njoroge, KM et al. (2010). Voices unheard: youth and sexuality in the wake of HIV prevention in Kenya. *Sexual and Reproductive Healthcare 1(4): 143-148.*

[16] Yotebieng, M. et al. (2009). Correlates of condom use among sexually experienced secondary school male students in Nairobi, Kenya. *Sahara Journal 6(1): 9-16*

[17] Ikamari, L. et al., (2007). Sexual initiation and contraceptive use among female adolescents in Kenya. African. *Journal of Health Sciences 4(1-2): 1-13*

[18] Delva, WK et al., (2010). HIV prevalence thru sport: the case of the Mathare Youth and Sports Association in Kenya. *AIDS Care 22(8): 1012-1020*

[19] Kabiru, CW and P. Orpinas (2009). Correlates of condom use among high school students in Nairobi, Kenya. *Journal of School Health 79(9): 425-32*

[20] Yotebieng, MC et al. (2009). Correlates of condom use among sexually experienced secondary school male students in Nairobi, Kenya. *Sahara Journal 6(1): 9-16*

[21] Xu HN et al., (2010). Concurrent Sexual partnership among youth in urban Kenya: Prevalence and partnership effects. *Population Studies 64(3): 247-61*

[22] Obare, F and H. Birungi (2010). The limited effect of knowing they are HIV-positive on the sexual and reproductive experiences and intentions of infected adolescents in Uganda. *Population Studies 64(1): 97-104*

Table 2: Sexual Initiation by Various Characteristics (KDHS, 2008/9[23])

Characteristic	
Median age at first sexual intercourse	
Women	18.2 years
Men	17.6 years
Percent who have had sex by age 18 years	
Rural	
Men	60%
Women	50%
Urban	
Men	51%
Women	39%
Higher risk[24] last 12 months (15-24 years)	
Men	83%
Women	33%
Higher risk sex & used condoms (15-24 years)	
Men	64%
Women	40%

Table 2 is a summary of age at first sex and involvement in high risk sex among youth aged 15-24 years. The median age at first sexual intercourse is about 18 years for both men and women. By 18 years of age, 50% of girls and 60% of boys have already initiated sex in both urban and rural areas with the exception of a lower proportion (39%) among girls in urban areas. Young men (22%) are twice as likely to engage in sexual intercourse before age 15 than young women (11%). Both young men and women engage in higher risk sex with a much higher proportion being reported among men (83%) than among women (33%). A significant proportion of youth have many lifetime sexual partners as a result of a series of 'faithful' relationships to one partner at any particular time - serial monogamy.

In a study conducted in 2009 among 3,556 school-going male and female adolescents attending public secondary schools in Nairobi, 11% of girls and 50% of boys were sexually experienced with a significant proportion of students reporting multiple sexual partnerships. Forty percent of sexually experienced girls and 65% of sexually experienced boys reported having more than one sexual partner with 26% of boys having more than five partners. The degree of sexual activity was associated with religiosity, perceived parental attitude towards sex, living arrangements and school characteristics. In the same study, girls tended to have sex with partners who were on average four years older, and condom use among both boys and girls was low and inconsistent[25].

In a study conducted by Magadi and Agwanda (2009)[26], delayed initiation of sexual intercourse, age of marriage, and childbearing among adolescent girls (12-19 years) in South Nyanza were

[23] National Bureau of Statistics and Macro International (2009). Kenya Demographic and Health Survey 2008/9

[24] Higher-risk sex is defined as sex with a non-marital or non-cohabiting partner

[25] Kabiru, CW and P .Orpinas (2009). Factors associated with sexual activity among high-school students in Nairobi, Kenya. *Journal of Adolescence Health. 32(4): 1023-1039*

[26] Magadi, MA and AO. Agwanda (2009). Determinants of transition to first sexual intercourse, marriage and pregnancy among female adolescents: evidence from South Nyanza, Kenya. *Journal of Biosocial Science*

associated with high socioeconomic status of the household, high educational attainment, mother's high educational attainment, and communication with parents and girlfriends[27].

Fertility, child birth and under-five mortality: The age-specific fertility rate among young women aged 15-19 and 20-24 years is 103 and 238 per 1000 women (KDHS, 2008/9)[28] respectively. Age-specific fertility in Kenya peaks at ages 20-24 years and then starts declining from age group 25-29 onwards. The median age at first birth is 19.9 years. Pregnancies and births to adolescent girls are high risk since girls are not yet fully developed physiologically to carry a pregnancy. Young girls are more likely to develop complications of pregnancy and childbirth leading to higher rates of maternal morbidity and mortality. Limited access to youth and young mother friendly MCH/FP and SRH services[29] exacerbates the problem. Under-five mortality rate (the probability of dying between birth and the fifth birthday) is notably higher among children born to mothers below 20 years (100 deaths per 1000 live births) compared to mortality among children born to mothers 20 years and above (77 deaths per 1000 live births).

Contraceptive use and unsafe abortions: Even though contraceptive prevalence rate (CPR) has been on the rise among sexually active young women, unmet need for contraception remains high. According to the KDHS 2008-09, CPR for any modern method is 25% for sexually active women aged 15-19 years and 37% for those aged 20-24 years. Among unmarried sexually active women of the same age groups (15-19 and 20-24 years) CPR for any modern method is 23% and 59% respectively. Condoms are the most commonly used method among young people. The unmet need for family planning among currently married 15-19 and 20-24 years is 30% for both age groups, which is higher than the unmet need of 26% among all currently married women. A study conducted by Nzioka (2004)[30] in Makueni District found that contraceptive use among adolescent girls was hampered by inaccessibility to services, fear of side effects and religious beliefs. Most girls used untested traditional methods of contraception, and they did not have skills to resist sexual advances or negotiate condom use.

Sexually transmitted infections: According to the Kenya AIDS Indicator Survey 2007[31], the prevalence of HIV among young people (15-24) is 3.8%. However, age specific HIV prevalence rates among young women (ranging from 2.5% to 12%) are consistently higher compared to rates among young men (ranging from 0.4% to 2.6%) of the same age group. Young women are four times more likely to be infected with HIV than young men. Given the high level of unprotected sex among young people and relatively high levels of HIV infection, we can assume that the rates of other sexually transmitted infections are also high.

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[27] Locus of control refers to a person's perception of control or responsibility for his/her own life and actions.
[28] Kenya National Bureau of Statistics and Macro International (2009). Kenya Demographic and Health Survey 2008/9
[29] Makona et al. (2008). 2008 National youth shadow report: Progress made on the 2001 UNGASS Declaration of commitment on HIV/AIDS, Kenya *New York Global Action Network, Global Youth Coalition on HIV/AIDS*
[30] Nzioka, C. (2004). Unwanted pregnancy and sexually transmitted infection among young women in rural Kenya. *Culture and Health 6(1): 31-44*
[31] National AIDS and STD Control Council, MOH (2009). Kenya AIDS Indicator Survey 2007

Service Provision: The recently conducted Kenya Service Provision Assessment explored the general provision of services for child health, family planning, maternal and newborn care, and HIV/AIDS but did not specifically examine the provision of services to young people in spite of the increased interest in providing information and services to this age group[32 33 34].

Factors associated with risky sexual behavior among young people include substance abuse, previous sexual experience, internal migration/displacement, low perceived risk of infection with STIs, inadequate knowledge of STIs, living arrangements, household socioeconomic status, school arrangements and inadequate communication with parents on sexual matters[35 36 37].

In summary, the literature review echoed global findings that many young people are sexually active and are at risk of adverse reproductive health outcomes that subsequently affect achievement of life goals and optimum contribution to national development. Many youth initiate sexual intercourse early, have multiple partners and often do not use protection during sex. In general, young people are unlikely to seek health services, and when they do they are likely to get inadequate services.

MAPPING OF YOUTH SERVING ORGANIZATIONS AND STAKEHOLDER INTERVIEW FINDINGS

The Policy Environment

The policy environment for the provision of AYSRH information and services in Kenya is generally favorable. A number of policies and guidelines have been developed that support provision of SRH information and services to youth. These include but are not limited to the National Reproductive Health Strategy (2009 – 2015), Adolescent Reproductive Health and Development Policy (2003), the Plan of Action (2005 – 2015), and Guidelines for Provision of Youth Friendly Services (2005). There are other supporting policies and guidelines within the Ministry of Health and other sectors that are not listed.

The organizations interviewed felt that in spite of the availability of the policies and guidelines, dissemination and utilization of these documents needs to be improved. A significant number of organizations did not know of the existence of some of these policies and guidelines and consequently did not use them in their SRH programming. Some organizations knew of the

[32] NCAPD, MOMS, MOPHS, Kenya National Bureau of Statistics, and ICF Macro (2011). Kenya Service provision Assessment 2010
[33] Nyambedha, EO. (2007). Vulnerability to HIV infection among Luo female adolescent orphan in western Kenya. *African Journal of AIDS Research 6(3): 287-295*
[34] SIECUS, (2006). SIECUS PEPFAR country profiles: focusing in on prevention and youth, Kenya. New York
[35] Mberu, BU and MJ White (2011). Internal migration and health: Premarital sexual initiation in Nigeria. *Social Science and Medicine 72(8):1284-93*
[36] Page RM and CP Hal (2009). Psychosocial distress and alcohol use as factors in adolescent sexual behavior among sub-Saharan African adolescents. *Journal of School Health 79(8): 369-79*
[37] Khasakala AA and AJ Mturi (2008). Factors associated with risky sexual behavior among out-of-school youth in Kenya. *Journal of Biosocial Science 50(5): 641-653*

existence of the policies and/or guidelines but did not use them or ignored what the policies and guidelines recommended. There is also inadequate monitoring of the implementation of the policies and guidelines by MOH and key line ministries.

Program Coverage

Figure 1: Mapping of AYSRH Activities

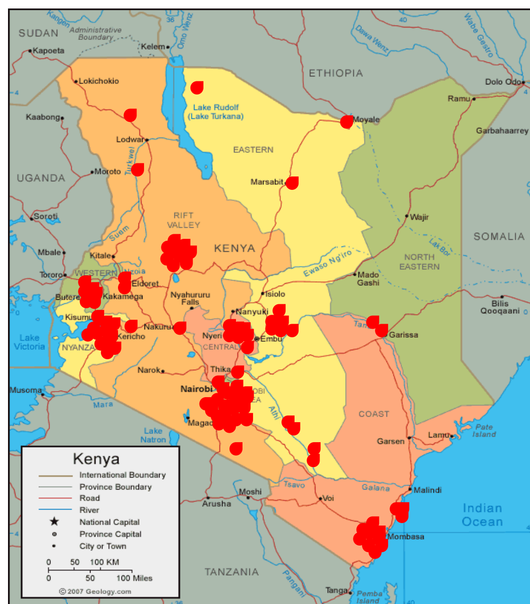

Figure 1 shows the distribution of AYSRH activities in Kenya as reported by interviewed partners. We endeavored to plot the given geographic area of coverage as closely as possible to what was provided by the implementing partners. From the map it is clear that most activities are concentrated in the highly populated regions of the country (the south-western belt). A few activities are being implemented in the less populated northern regions. It was not easy to tell from the data collected whether organizations were implementing activities in urban, peri-urban or rural areas. However, projects like APHIA Plus undertake activities both in the urban and rural areas, and their operations cover the whole country. Almost all organizations have some activities in Nairobi province. In Coast province the activities are concentrated in Mombasa and its environs as was the case with other provincial headquarters such as Embu, Kakamega, and Kisumu. The northern Rift Valley region also seems to have some concentration of activities targeting youth in the arid and semi-arid regions of the province. For a more detailed distribution of AYSRH showing what activities are being undertaken and which organizations are supporting or implementing these activities see Appendix 1.

Target Population: YSOs interviewed have from one to 30 years of experience providing SRH information and services to youth (an average of 12 years). Almost all organizations interviewed are targeting in- and out-of- school male and female youth ages 10-24 years in urban, peri-urban and rural areas. Only eight out of 45 organizations have limited their target to urban and peri-urban youth. Four organizations including one development partner target youth above the age of 24 years specifically to address the needs of young mothers and/or equip young adults with skills to face life after college. Seventeen youth organizations and two development partners target special youth populations such as young people in sex work, men having sex with men, transport industry, informal sector, urban informal settlements (slums), orphans and vulnerable children (OVC), injecting drug users, uniformed personnel, HIV positive, married adolescents, domestic workers and youth with disabilities.

Line Ministries: The Ministry of Youth and Sports (MOYAS) is in the process of establishing more than 200 youth empowerment centers (YEC) with assistance from development partners. To date, 47 centers have been established and 32 are about to be completed. The YECs will be managed by youth and provide comprehensive services on youth empowerment and participation; health; employment; ICT; education and training; environment; crime and drugs; and leisure, recreation and community service. When the youth centers are fully operational, they will provide forums or structures for provision of information, services and empowerment of youth for all issues affecting them including SRH. As is the experience with other youth centers (e.g. FHOK youth centers), utilization by girls is a challenge. Most youth centers attract more boys than girls. According to reports during the stakeholder meeting, integration of SRH information and services into the youth center activities is yet to take place in many of these centers. However, in a few of them the integration is very minimal with only a few sites having linkages with health service delivery points. MOYAS and MOPHS-DRH are currently conducting RH sensitization trainings for staff at Youth Empowerment Centers to empower them to provide RH information to the youth and to refer as necessary.

The Ministry of Education has incorporated life skills education (LSE) in various subjects for both primary and secondary schools. However, assessments have found that this fragmented mode of teaching LSE reduced its effectiveness in changing young people's behavior. At a Life Skills Stakeholders' Forum in 2006, the MOE decided that LSE should be taught as a stand-alone subject. Consequently KIE with support from USAID developed the relevant course content in 2008. The new LSE stand-alone syllabus incorporating sexuality education was introduced in primary and secondary schools in 2008 and teachers were trained on it using a cascade approach. However, not all schools have trained LSE teachers thus curtailing a countrywide implementation of the syllabus[38]. The MOE is also in the process of implementing Primary Schools Action for Better Health (PSABH) that will be discussed in detail in the evidenced-based interventions section of this report below.

Program Approaches

During an assessment conducted in 2006 by FHI[39], priority program needs were identified as follows:

- Prioritize contextual factors affecting Kenya youth
- Expand the provision of youth-friendly services (YFS)
- Change emphasis from knowledge to behavior change/maintenance
- Emphasize substance abuse within youth programs
- Operationalize youth reproductive health and HIV/AIDS policies
- Address the needs of orphan and vulnerable adolescents

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[38] Ministry of Education (2010). Draft Life Skills Education in Kenya: A Comparative Analysis and Stakeholder Perspectives, 2010

[39] Schueller et al. (2006). Assessment of youth reproductive health and HIV/AIDS programs in Kenya (FHI Report)

- Strengthen support systems for HIV positive youth
- Reach out to young married women

Most of these priority program areas have received some level of attention since 2006 and with greater emphasis on HIV and AIDS programming. Partly this has been beneficial to SRH generally but lacking in concrete focus to address SRH issues comprehensively.

The urgency of addressing AYSRH has been driven by the HIV and AIDS pandemic. Consequently most organizations addressing some component of AYSRH are focused on prevention of and mitigating the impact of HIV and AIDS among young people. It is not until the last year or two that organizations have come to recognize the importance of addressing SRH as a whole and not just HIV and AIDS in their programs. This is as a result of concerted efforts that leaders in the SRH field internationally and locally have made to address SRH holistically instead of disease specific “silo” programs.

Most YSOs interviewed indicated they provide integrated information on SRH to youth and refer them for clinic based services in cases where they do not provide services. It was not possible to determine the content, level of integration and quality of SRH information provided by the organizations since materials used to address youth SRH issues were not collected. During the stakeholders meeting held in September 2011, it was agreed that organizations provide copies of the materials and tools they are using in their youth programs to the DRH. This compilation of information should enable partial evaluation of the content and quality of SRH information and services provided to young people during the next phase of the project.

Involvement of the community and youth in conceptualizing, planning, implementing and evaluating interventions increases ownership and enhances sustainability as experienced by some organizations interviewed. At the same time, youth engagement enhances their self-esteem and provides skills and experience in managing projects (capacity building). Most organizations felt that youth and the community were not adequately involved in programs targeting them.

Another feature observed is that most AYSRH serving organizations implement intervention approaches that cut across intervention settings. For example, some curricula on life skills education are designed for both in- and out-of-school interventions with an edutainment component. At the same time, the organizations tend to use existing structures to reach youth instead of setting up new ones. This is cost effective though can be time consuming as they have to work with existing stakeholders. In this report, we describe the approaches and gauge the extent of use by the categories used in the YSO matrix in appendix 1. In summary the approaches are peer education, edutainment, clinic service delivery (including outreach services), youth support structures, mass media, ICT, edusports, life skills education, mentorship, adult influencers, and advocacy for policy review or change.

Peer Education has long been regarded as an effective method to reach youth with information on health. Peer education refers to the use of trained peer educators to educate their peers on

various health issues and skills building. It is one of the most commonly used approaches to reach youth with information on SRH among interviewed organizations. Nineteen of the 45 YSOs interviewed used peer education to reach youth with information. None of the organizations used peer educators to deliver services other than information to youth. This approach is supported by three development partners interviewed.

Edutainment is the use of entertainment activities to attract youth to a venue and then pass health promotion or disease prevention messages to them. It includes use of folk media/drama, music/dance, puppetry, video clips, and fashion and beauty pageants etc. This approach provides an attractive environment to reach youth with information while entertaining them. Edutainment can be combined with provision of outreach SRH services such as provision of contraceptive methods, testing and counseling or screening for reproductive tract infections and cancers. The approach is used by 18 out of 45 YSOs and is supported by three development partners.

Edusports: Similar to edutainment, edusports uses sports to bring together young people and reach them with information and services. The primary target group is the players with the spectators and supporters as the secondary target group. Only eight out of 45 interviewed organizations used this approach to reach youth with information and services. Of these the main sport is football for both boys and girls.

Clinic Service Delivery, Outreach and Youth Friendly Services: This is the provision of SRH services and information to youth either at a health facility, youth center or during outreach services at edutainment or edusports events. The approach is used by 19 out of 45 YSOs to reach youth and is supported by five development partners. The DRH has been in the process of establishing youth friendly corners within public health facilities in collaboration with partners. However, these have faced many challenges and most of them are not operational. Currently, only 11% of facilities provide YFS throughout the country. A few organizations mentioned they provide or support provision of YFS. However at the Stakeholder Forum held in September 2011 to discuss the preliminary findings of this review, stakeholders felt that the term youth-friendly services has been overused/misused and needs to be re-evaluated and defined clearly including what its implementation entails. Organizations that cannot provide services directly have linkages with facilities within their area of coverage for referral and supervision of community-based service providers.

In a study conducted among nurse-midwives in Kenya and Zambia, findings show that this category of service providers disapprove of adolescent sexual activity and have pragmatic attitude to handling these issues. Nurse-midwives who had more education and had received continuing education on adolescent sexuality and reproduction were inclined to have more youth-friendly attitudes[40]. The study further suggests that critical thinking around cultural and

[40] Warenius L. et al. (2006). Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reproductive Health Matters 14(27): 119-128*

moral dimensions of adolescent sexuality should be emphasized in undergraduate training and continuing education to help nurse-midwives deal empathetically with adolescent sexuality.

Youth Support Structures: These are ‘safe spaces’ such as youth clubs (health or empowerment), youth centers, and income generating groups. The structures act as meeting points for youth in a ‘safe’ environment that does not raise eye brows. This approach has been found to be especially useful in reaching girls with information and services on SRH. Fourteen out of 45 organizations interviewed have assisted youth to come up with or use the existing youth clubs, youth centers and economic empowerment groups to provide ‘safe spaces’ where youth can discuss SRH issues and be trained in life skills including self-efficacy without facing parental or community opposition.

Mass Media is the use of print and electronic media such as newspapers, television, radio, leaflets, brochures, comic booklets, posters, music, and hotlines to educate youth on various health issues. Focused multi-pronged mass media campaigns with clear messages are effective at facilitating behavior change. This mode of communication is popular with young people and provides a cost effective way of reaching youth with information. A number of organizations have improved on the approach to make it more interactive by either forming discussion groups after sessions or providing call-in options to the target group. Among the interviewed organizations, 17 were using mass media to reach youth with information.

Information Communication and Technology (ICT) – Social Networks, Mobile Communication: This is a relatively new approach of engaging youth that is being adopted by YSOs (10 out of 45). Only two development partners were supporting the approach. ICT has become quite popular with youth especially in urban and peri-urban areas. This is a captive audience looking for and ready for information. Organizations are starting to use internet based social networks (Facebook, Twitter) and mobile telephones (SMS) to provide information on SRH. Specifically, mobile telephones have become so popular in Kenya with almost every young person in urban and rural areas having access to a hand set.

Unlike the previously mentioned approaches, these emerging channels of communication have not been rigorously evaluated for effectiveness. A number of operations research projects are on-going to evaluate the effectiveness of this approach in providing SRH information and facilitating behavior change among youth. The DRH has also set up a task force to bring together various players using the approach, share information and explore and scale-up effective strategies.

Life Skills Education is an evidence-based approach that can reach a large number of youth with information and skills they need to achieve better SRH outcomes. It is used with both in- and out-of-school youth. Among the interviewed organizations 16 are using the LSE approach.

The MOE and KIE have developed an LSE curriculum for schools to mitigate the spread of HIV. The implementation is supported by the MOE and partners. However, the implementation has been hampered by inadequate training of teachers for each school.

Various organizations have also developed their own LSE curricula and using these in their projects to train youth. Unfortunately most curricula lack a strong SRH focus and the content covered on SRH is not standardized. This is a cause for concern.

Mentorship is the use of older youth to mentor younger youth to achieve positive SRH outcomes. It is being used by only four out of 45 organizations interviewed. This could be because it is quite resource intensive and might not have wide reach as other approaches discussed previously.

Adult Behavior Influencers: These adults are trained to reach out to youth either in the community or within an institution with information and/or services. They can be parents/guardians, teachers or service providers. Some organizations interviewed (6 out of 45) are using this approach to reach youth with SRH information and services.

Advocacy for Policy Change: Six organizations were involved in advocacy for a better environment to implement youth SRH activities. Given that the policy environment is quite favorable in the country, advocacy needs to focus on ensuring pockets of opposition are won over and policies are implemented as stipulated.

Vulnerable Youth

Using some of the above mentioned approaches, 17 organizations interviewed implement interventions targeting youth most at risk of HIV/AIDS. These are youth in urban informal settlements, informal sector, sex work, domestic work, transport industry, and uniformed forces. It also includes married adolescents, adolescent mothers, MSMs, youth with disabilities, illiterate youth and youth living with HIV and AIDS.

Important Aspects for Implementation of SRH Interventions

In the interviews, stakeholders emphasized that contextualizing SRH interventions to particular situations in Kenya is of paramount importance, whether this process involves adopting an intervention from another country or testing the best way to implement an intervention developed in Kenya. Adapting an intervention to the local situation increases adoption and ownership of the interventions.

The deliberate integration of SRH into other health services such as HIV and AIDS information and services, voluntary medical male circumcision (VMMC) and into non-health related activities (environmental and socio-economic empowerment) has moved provision towards being more holistic and multi-sectoral. A meeting organized by EGPAF held in Kisumu in June 2011 among the region's partners recognized that integration of information and services for

young people is essential, even though most integrated interventions require demonstration and evaluation to establish effectiveness and efficiency. However, the meeting also noted that programmers are increasingly seeking to address the needs of youth holistically rather than in disease-specific programs. The meeting recommended implementing programs that mitigate disease-specific issues but at the same time address pre-disposing or confounding health and socio-economic factors[41].

Multi-faceted and multi-sectoral interventions show much promise in Kenya. The DRH with partners is currently in the process of rolling out these types of interventions in western Kenya under the Kenya Adolescent Reproductive Health Program (KARHP)[42] involving schools, Ministry of Education, Ministry of Health, religious leaders, and parents in providing (added) SRH information to youth (10-19 years) in and out-of school. A detailed description of the KARHP is provided under the evidenced-based intervention section below.

Gaps in AYSRH – Stakeholders' Perspectives

During the ASRH stakeholder forum held in Nairobi in September 2011 to share the preliminary findings of this review, participants identified some gaps in the implementation of AYSRH in Kenya. These could be classified as program or service delivery level gaps. Some gaps were also identified at the community level. No policy level gaps were mentioned by the participants.

Program level

Participants mentioned inadequate dissemination and implementation of existing policies as a gap preventing the successful implementation of AYSRH programs. They also felt that there was poor coverage of youth programs with some areas being over served while other areas hardly had any programs. This is with regard to both geographic and target population coverage. The current programs are over concentrated in some areas with little if any addressing needs in other areas, e.g., youth in hard to reach areas and most at risk youth. There is an opportunity for better coordination of programs for efficient use of available resources.

Participants felt that youth and communities were not actively involved in some programs, thus compromising effectiveness and sustainability of interventions. They felt there could be more involvement of the community and youth to adequately address issues specific to a community or population of young people.

[41] EGPAF (2011). Adolescent and young people's platform workshop and launch; Short Report, Kisumu, 31st June-1st July, 2011,

[42] Askew I. et al. (2003). A multi-sectoral approach to providing reproductive health information and services to young people in western Kenya: Kenya adolescent reproductive health program, Washington DC, *Frontiers in Reproductive Health Program*

The issue of inadequate trained personnel and organizations with inadequate capacity to implement AYSRH surfaced several times among participants. They felt that some organizations did not have enough capacity to run AYSRH programs, including the level of training for staff to implement programs. This is sometimes linked to inadequate human and financial resources available to these organizations. At the same time, some programs did not take into account the social and cultural factors that affect AYSRH, leading to shallow programs with little impact.

Inadequate coordination coupled with poor monitoring and evaluation system and documentation of practices seemed to result in inefficiencies in program implementation and can reduce the ability to rollout evidenced-informed interventions. There is also inadequate emphasis on the importance of evidence-informed interventions.

Some participants felt that a vertical approach to implementation is a major deterrent to effectiveness of AYSRH programs and the need to address AYSRH holistically. Multi-pronged and multi-sectoral approaches are more effective at reaching youth with information and services, yet this approach is not common due mainly to funding and program focus.

Most programs have not taken advantage of the emerging ICT platform that is so popular with youth both in the urban and rural areas. However, these interventions have to be implemented with a well thought-out evaluation plan to help ensure effectiveness. Few have been evaluated.

Service Delivery Level:

Participants felt that there were inadequate YFS, and where they were available each organization defined it differently. A redefinition of youth-friendly services was proposed to ensure all partners are using the same definition and thus supporting or implementing the agreed upon term. Accessibility and availability of these services were also identified as problems. Most facilities do not have YFS, and where they are available, stakeholders reported that service providers lacked positive attitudes and competence to handle AYSRH.

At the community level, there is inadequate information on the services available and a general lack of awareness of AYSRH issues. In some cases demand for services is created but the service delivery points are not adequately prepared to provide services, which then discourages utilization by young people. Shortage of supplies, equipment and commodities is a common occurrence. Some participants felt that referral linkages between programs and service delivery points is weak and hinders effective referrals.

A large network of peer educators appears to be under-utilized for service delivery. For example, youth can serve as community health workers for other youth to support a certain level of provision of services at the community level other than just provision of information and creating awareness. A lack of IEC materials was also cited as being a hindrance to effective service provision.

Stakeholder Recommendations

One of the most frequently mentioned recommendation by participants at the stakeholder forum was **better coordination of AYSRH activities** at the national, provincial and district levels and enhanced **dissemination of existing policies and guidelines** to inform program implementation. This would form the basis for the implementation of the program countrywide.

A **multi-sectoral approach** to implementation was also suggested to have a more holistic approach to AYSRH. Thus the involvement of other line ministries is important for effective implementation of the program. At both the program and service delivery level, an **integrated approach** was recommended by stakeholders to advance the holistic approach and efficiently utilize scarce resources.

A **redefinition of YFS** was recommended to bring all stakeholders to a common understanding of what this term really means. In addition, **training and orientation of service providers** on policies and guidelines on provision of services to youth was recommended as necessary to address negative attitudes and inadequate skills. Stakeholders also felt that SRH content delivered to youth by various organizations varies a lot and **needs standardization or a minimum SRH content** that would identify it as a SRH program.

ICT is popular with youth but there is need to rigorously **evaluate its effectiveness** at reaching youth with information and facilitating positive behavior change including health seeking behavior. Greater evaluation can help link ICT with **evidence-based interventions** that can enhance program impact.

EVIDENCE-BASED INTERVENTIONS

In 2006, WHO in conjunction with London School of Hygiene and Tropical Medicine, UNAIDS, UNFPA and UNICEF conducted a systematic review of over 80 studies that tested the effectiveness of the intervention in preventing HIV infection among young people. Even though they focused on interventions addressing HIV and AIDS the same principles apply to other health interventions targeting young people. They also came up with a classification that can be used to determine whether an intervention is ready for roll-out or not. This classification can be applied to the broader SRH interventions based on availability of evidence of effectiveness. The interventions were recommended as **Steady, Ready, Go** categories.

- **Go** (interventions that stop asking for more evidence and get on and do it)
- **Ready** (implement widely but evaluate carefully)
- **Steady** (not ready yet for prime time: more research and development required)

For further description of the categories of interventions see Appendix 3. A review of literature identifies a few evidenced-based interventions in Kenya that could be classified as **Go** or **Ready** with specific focus on AYSRH.

In 1999 the Centers for Disease Control and Prevention (CDC) published a Compendium of HIV Prevention Interventions with Evidence of Effectiveness to respond to requests to know how to program for best results in the United States. Regularly updated, CDC's *Compendium* now includes more than 60 evidence-based individual-level, group-level, and community-level HIV behavioral interventions, many of which are targeting segments of youth populations.

These evidence-based interventions have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. With input from the developers, the materials necessary to implement the interventions have been packaged into user-friendly kits to maintain fidelity with expansion.

In past years, several of the CDC evidence-based interventions have been adapted for the Kenyan context. Two have targeted youth. Indirectly a program called *Families Matter* targets parents of adolescent children to improve communication and reduce sexual risk taking. *Healthy Choices I & II* are comprehensive HIV prevention interventions for in- and out-of-school populations. Additional adaptations are currently being planned with guidance and coordination from NASCOP.

NASCOP coordinates a technical working group (TWG) on evidence-based interventions and connected subcommittees, including one for youth. This TWG, which was launched in 2010, is considered essential to finding effective models for HIV prevention that were nationally approved and scalable. Given that most of these interventions were originally developed and tested in the United States, this TWG provides input into the review and adaptation for proposed Kenyan adaptation. They are also in the process of setting up a review system to examine Kenyan developed interventions.

NASCOP will officially request partners to submit their intervention and materials from January 2012. Small review teams will use a standardized assessment tool to determine the degree to which partner activities meet most internationally recognized standards of good practice. And where available evaluation and study data connected to the intervention will be used to make a determination. Standards were reviewed using guidance from UNESCO[43], YouthNet[44], Kirby[45]

[43] UNESCO (2009). *International Technical Guidance on Sexuality Education*, UNESCO et agencies, Dec 2009
[44] FHI (YouthNet Standards in RH and HIV Prevention programming for youth,
[45] Kirby D. et al. (2007). Tools to Assess Effective Sex and STD/HIV Programs; *Healthy Teen Network and ETR Associates, Feb 2007*

and Galbraith[46], as designed for youth audiences. They include items such as a defined target audience, objectives, theoretical model, logic framework, guided sessions for accurate delivery, including skills that are practiced, and more. A grading system will be used to assess the quality of such evidence-informed interventions. Those approved will be posted on the NASCOP website so that partners have easier access to scalable models. Most of these interventions are HIV focused but apply strategies that can be adopted for AYSRH.

During the compilation of a best practices compendium in reproductive health, two evidence-based interventions for youth reproductive health were documented. Both interventions have been evaluated and found to be effective at increasing SRH knowledge and access to services for young people. Other evidence-based interventions with HIV prevention as the main focus are also discussed.

Kenya Adolescent Reproductive Health Program (KARHP)

This was a multi-pronged and multi-sectoral quasi-experimental intervention that tested effectiveness of changing sexual behavior among adolescents in schools through community, health facility and school interventions. It also involved working with MOE, MOH and Ministry of Social Services, schools, health facilities, parents and teachers. The program used peer education (community and school level), guidance and counseling in school, and introduction of youth-friendly services at health facility level. The program brought together Ministries of Health, Education and Social Services, as well as schools, parents, teachers and community members. Evaluation results showed that knowledge of SRH increased among both boys and girls especially on contraception and STIs. Additionally, sexual initiation and activity reduced among both boys and girls with an increase in the proportion reporting being virgin at age 16. Discussions of SRH issues with parents among adolescents also increased[47].

A subsequent report on the same project indicates it is quite sustainable even after the project ended. Population Council through its Frontiers Project has continued to provide technical support to government ministries in Kenya and Senegal to adopt components of the intervention in various parts of each country[48]. Currently the intervention has been scaled up in the whole of Western province and is being expanded to Nyanza, Eastern, Nairobi and Central provinces[49].

Friends of Youth (FOY)

The other evidence-based intervention with a heavy leaning on reproductive health is the Friends of Youth initiative. This was a community based quasi-experimental intervention that involved

[46] Galbraith et al. (2011). Taxonomy for strengthening the identification of core elements for evidence-based behavioral interventions for HIV/AIDS prevention, *Journal of Health Education Research, May 2011*.
[47] http://www.commitnit.com/hiv-aids-africa/node/295034
[48] Joyce, S. and I. Askew et al. (2008). Multi-sectoral youth interventions: the scale-up process in Kenya and Senegal. *Frontiers in Reproductive Health*
[49] DRH/MOPHS, (2009). Best practices in reproductive health in Kenya

training of a cadre of trusted adults in the community called friends of youth (FOY) to reach out to youth with information and refer them to designated private health facilities. The referred youth are given a subsidy coupon by the FOY which when presented at designated private facilities accord the youth services. Family Health Options Kenya (FHOK) then pays for the services rendered by the facility.

The FOY are selected by the community based on set criteria. The health facilities are oriented on youth-friendly service provision at a subsidized cost. The evaluation results showed greater community participation and ownership; improved knowledge regarding STIs; improved discussion of sexuality and RH issues between parents and children; and improved health seeking behavior among youth[50]. The project has been scaled up in Nyahururu, Thika and Nairobi slums. However, the subsidy system for cost of services at the private facility has proved unsustainable and may require rethinking.

The following interventions were specifically designed with the prevention of HIV/AIDS as their primary focus but they can be applied to SRH too.

Primary School Action for Better Health (PSABH)

This was a comprehensive HIV prevention intervention targeting youth in primary schools. It involved training of teachers, formation of health clubs, in-school question boxes, outreaches and information corners. An evaluation of this intervention using a quasi-experimental design revealed increased HIV knowledge among the pupils; increased communication between parents and teachers about sexuality and HIV; increased self-efficacy related to abstinence and condom use among pupils; and decreased exposure to HIV through delayed first intercourse, decreased sexual activity and increased condom use. This intervention was however not beneficial to younger girls. Initial evaluation results indicated that the program was most beneficial to sexually inexperienced boys and facilitated a decrease in or delayed sexual activity. Additionally, the intervention effects were sustained beyond the primary school years. Students who attended a primary school with PSABH were more likely to have high HIV knowledge levels, go for VCT and have more supportive attitudes towards sexual restraint and condom use. These effects were stronger during the first year of secondary school[51]. The intervention has been rolled-out to nearly 19,000 schools countrywide.

Families Matter!

This is an intervention that was originally developed in the USA by CDC as Parents Matter! and later adopted in Kenya as Families Matter!. It is an intervention designed to improve communications between parents and children about sexual risk reduction and parenting skills.

[50] Erulkar et al. (2004). Behavior change evaluation of a culturally consistent reproductive health program for young Kenyans. *International Family Planning Perspectives* 30(2): 58-67
[51] Maticka-Tyndale, E. (2010). Sustainability of gains made in a primary school HIV prevention programme in Kenya into the secondary school years. *Journal of Adolescents 33(4): 563-73*

The aim is to equip parents of pre-teens with protective parental skills and knowledge, skills, comfort and confidence to communicate with their children about sexual risk prevention before the onset of sexual risk behaviors. Parents of children 10-12 year-olds were recruited in Nyanza Province in western Kenya. Trained facilitators took small groups of 12-16 parents through five weekly 3-hour participatory sessions conducted at community venues. At the fifth week session children were invited to participate in a guided communication exercise. An evaluation of the program found that parents' attitude regarding sexuality education changed positively after one year of intervention. Parenting skills were changed positively and there was an increase in parent-child communication about sexuality and sexual risk reduction[52].

The program has since been expanded to the whole of Asembo community where it was first adapted and adopted to an African setting and has since been expanded to neighboring communities in Uyoma. It has also been taken up by various organizations such as FHI 360 and replicated in other African countries such as Botswana.

Promising Interventions

There are numerous promising interventions being undertaken in Kenya that have not been rigorously evaluated for effectiveness. These include Youth-to-Youth implemented by DSW; provision of 'safe spaces' for survivors of female genital mutilation by AMREF; and integration of SRH into economic empowerment and sports activities by Population Council, DSW[53], MYSA and GIZ. However these interventions have either not reached the evaluation stage or have not undergone rigorous evaluation to provide the evidence.

CONCLUSIONS

Youth form a significant proportion of the country's population. If their SRH needs are not addressed adequately the country will suffer multiple consequences on the social, economic, health and education levels. Youth implementing partners can no longer afford to ignore this need whether they are implementing health or non-health interventions. As a result **integration of activities targeting youth needs to be a priority.**

The findings from this review indicate a lack of **coordination in managing AYSRH** in the country among government ministries and agencies. With lack of proper coordination, stakeholders duplicate efforts and do not effectively use scarce resources. The re-activation of the ASRH working group will help contribute to more coordinated efforts among stakeholders. This review will inform the review of the AYSRH policy under the auspices of NCAPD and development of the strategy within the DRH's docket.

[52] Vandenhoudt H. et al., (2010). Evaluation of a US evidenced-based intervention in rural Western Kenya: from parents matter! To families matter! *AIDS Educ Prev. 22(4):328-43*
[53] DSW (2010). Y2Y Review

The **dissemination and implementation of policies and guidelines need to be monitored** to ensure all stakeholders adhere to the policies and guidelines. In the same light, **guidance is needed from the DRH with regard to the minimum SRH requirements for young people** to ensure that all stakeholders deliver to young people similar/standardized quality of services including information.

Organizations are implementing a combination of interventions to reach youth with information and services. **Some of the interventions have been implemented for years but without any rigorous evaluation to determine their effectiveness**. These need to be evaluated and scaled-up if they are effective. **Identified evidence-based interventions need to be scaled-up by various stakeholders to speed up the replication process**. Development partners and the government should **allocate funds to scale up proven interventions and support the evaluation of promising interventions.**

Exploration of emerging interventions such as using ICT to reach youth with SRH information needs to continue in order to take advantage of these technologies, which are popular with youth. DRH should continue coordinating the ICT task force it has formed to ensure information is shared and stakeholders complement -- not duplicate -- each other's efforts.

On the service delivery level, stakeholders identified negative attitudes of service providers to youth sexuality and inadequate understanding of YFS. Studies have shown that with continuing education and pre-service training service providers develop more favorable attitudes towards youth SRH. The **DRH and partners need to invest in the training and orientation of service providers on AYSRH both at the facility and community levels**. In addition, **frequent shortage of commodities and supplies hamper the delivery of SRH services** and should be addressed at the national level.

Most YSO use the peer education approach and have trained large numbers of **peer educators** to provide information to their peers. This is a **cadre of human resource that can be used to provide basic (level one) services to youth especially among out-of-school youth and youth in institutions of higher learning with minimal additional training.**

The **DRH and partners need to re-define YFS and ensure a common understanding of the term** by all concerned to facilitate its implementation at the facility and community levels. The definition should be articulated clearly in the upcoming strategy.

Awareness creation on SRH services available to young people is necessary both at the facility and community levels. Organizations need to incorporate this approach in their planning, including effective referral of young people to facilities. It is important to ensure that AYSRH interventions find a way of including parents and communities in their program activities since the youth do not live in vacuums. Failure to include communities in AYSRH programming will compound the current challenges and create social barriers towards the provision of SRH services including information to the youth.

APPENDIXES

Appendix 1:

AYSRH SERVING ORGANIZATIONS AND DEVELOPMENT PARTNERS

ORGANIZATION		TARGET GROUP	Age	Gender	Residence	In-School=I; Out-of-School=O; All=A	Special Population	LOCATION (PROVINCES)	Nairobi	Central	Coast	Western	North Eastern	Eastern	Nyanza	Rift Valley	APPROACHES	Peer Education	Edutainment	Clinic Service Delivery & Outreach Services - YFS	Youth Support Structures	Mass Media	ICT (e.g. social networks, mobile communication)	Edusports	Life Skills Education	Mentorship	Adult Behavioral Influencers (e.g. parents/guardians, teachers, service providers)	Advocacy for Policy change	Others	DEVELOPMENT PARTNERS	Agency/Institution
1	ADRA**																														
2	African Population & Health Research Centre (APHRC)		3	A	U	A	Urban poor		x											x											DFID, Wellcome Trust

AYSRH SERVING ORGANIZATIONS AND DEVELOPMENT PARTNERS

3	AMREF*		3	A	A	A	Illiterate youths		x	x	x		x	x	x	x		x	x	x	x	x	x	x			x				Dutch Ministry of Foreign Affairs thru AMREF Netherlands, DANIDA, DFID, SIDA, USAID, AMREF Italy, EC, Italian Cooperation, UNICEF
9	Catholic Relief Services (SAIDIA Project)																														CDC
10	Centre for the Study of Adolescence (CSA)		3	A	A	A	Youth with disabilities		x	x	x	x			x	x		x	x	x			x		x	x		x			Donor aid
11	EGPAF		3	A	A	A				x		x		x	x	x		x		x					x	x					CDC, UNICEF, USAID
12	Family Health Options Kenya (FHOK)		3	A	A	A	Sex workers, matatu crew, jua kali artisans		x	x	x			x	x	x		x	x	x	x	x					x		Integration of livelihood skills		IPPF, UNFPA, RFSU-Sweden, USAID/FHI, DFID, CDC
13	FHI 360		3	A	A	A	Female Domestic worker		x		x				x	x		x	x			x	x	x	x						PEPFAR, USAID, Gates Foundation,
14	HIV Free Generation****		3	A	U	A	HIV+ youth, married adolescents		x		x				x				x			x	x	x					Youth lifestyle brand, public-private partnership		PEPFAR, Global Business Coalition,

AYSRH SERVING ORGANIZATIONS AND DEVELOPMENT PARTNERS

15	Hope Worldwide Kenya	3	A	U	A	Urban slums, OVC	x									x			x		x					IGA, vocational training, entrepreneurial skills	
16	I Choose Life Africa (ICL)	3	A	P, U	A	Sex workers, MSM, truck drivers	x		x				x	x	x	x	x	x	x	x	x	x			x		PEPFAR /USAID, The Henry Jackson Foundation, APHIA II Rift Valley, CDC, SIDA, USAID /APHIA+ Nairobi /Coast, AIDS Care Treatment Services, UON, USIU, KU, UNFPA
17	JHPIEGO	3	A	A	A		x	x	x	x	x	x	x	x		x	x	x	x							Use of champions	USAID, Gates Foundation
18	Kericho Youth Centre	3	A	A	A									x	x	x	x	x	x			x					PEPFAR, AMREF
19	Life Ministry, The	1	A	A	A		x					x	x	x								x				Holiday camps	CRS, World Relief
20	Life skills Promoters	1	A	U, P	A		x	x		x		x	x		x							x				Dialogue forums	Not listed
21	LVCT	3	A	A	A	MSM, sex workers											x	x	x	x						Sanitary pads	HIVOS, Trocaire, Ford Foundation, IMC, CDC
22	Mathare Youth Sports Association (MYSA)	3	A	U	A		x								x	x			x		x	x				Educative forums in schools	Strome Foundation, DSW, Pathfinder
23	Ministry of Youth & Sports Affairs	3, 4	A	A	A	Teenage mothers	x	x	x	x	x	x	x	x	x		x	x	x					x		IGA	GOK, UNFPA, UNICEF

AYSRH SERVING ORGANIZATIONS AND DEVELOPMENT PARTNERS

24	National AIDS & STD Control Program, MOH		3	A	A	A	MSM, fisher folk, truckers, sex workers, IDIs, OVCs		x										x	x		x									UNFPA, CDC, Great Lakes Consortium
25	National AIDS Control Council (NACC)		3	A	A	A			x	x	x	x	x	x	x	x						x							Exchange programs		GOK, UNFPA, World Bank-TOWA
26	National Organization of Peer Educators (NOPE)		3	A	A	A	MARP youth		x	x				x	x	x		x	x	x		x	x								NACC, Care International, PSI, KANCO, UNFPA, USAID, FHI360), Jhpiego
27	PATH		3	A	A	A	Married adolescents		x	x	x	x	x	x	x	x			x	x					x						USAID, Nike Foundation, CDC
28	Pathfinder International Kenya		3	A	A	A	MARPS, OVC, HIV+ youth, youth with disabilities, Uniformed personnel, miraa business, milk & tea vendors		x		x		x			x		x		x	x			x	x		x	x	SGBV services, youth forums, working groups, capacity building		USAID /PEPFAR, DSW
29	Plan International		1	A	A	A	Youth with disabilities		x		x		x		x			x		x	x		x		x	x	x	x	Capacity building		DFID
30	Planned Parenthood Federation of America (PPFA)		3	A	A	A			x		x							x		x	x			x							American donors and Foundation
31	Population Council		3	A	A	A	Married adolescents, HIV + youth, urban slums		x		x				x	x		x	x	x	x	x			x				Eco. Empowerment, multi-sectorial approach		USAID, Nike Foundation, Financial Aid Trust

AYSRH SERVING ORGANIZATIONS AND DEVELOPMENT PARTNERS

32	Population Services International Kenya (PSI)		3	A	A	A			x	x	x	x	x	x	x	x			x		x	x	x		x	x					DFID
	Samaritan Purse**																														
33	Scripture Union		3	A	A	A			x	x	x	x			x	x		x							x		x				World Vision, World Relief, CRS, Churches
34	Tanari Trust		3, 4	A	U	A			x	x	x				x	x									x						Parents, CDC/Child Health Fund, private organizations
35	Trust for Indigenous Culture & Health (TICAH)		3	A		A			x		x							x	x		x	x							Referral for services		HIVOS, AWDF, UHAI EASRHI
44	United States International University (USIU)		3, 4	A	U, P	I	University students		x									x	x	x		x	x		x						USAID/FHI/ICL, USIU
45	World Vision*		3	A	A	A												x	x	x	x							x			USAID, DFID, Australian Aid, Children in Christ, Citizen Voice & Action (CVA), Child Health Now (CHN)

DEVELOPMENT PARTNERS

ORGANIZATION		TARGET GROUP	Age	Gender	Residence	In-School=I; Out-of-School=O; All=A	Special Population	LOCATION (PROVINCES)	Nairobi	Central	Coast	Western	North Eastern	Eastern	Nyanza	Rift Valley	APPROACHES	Peer Education	Edutainment	Clinic Service Delivery & Outreach Services - YFS	Youth Support Structures	Mass Media	ICT (e.g. social networks, mobile communication)	Edusports	Life Skills Education	Mentorship	Adult Behavioral Influencers (e.g. parents/guardians, teachers, service providers)	Advocacy for Policy change	Others	DEVELOPMENT PARTNERS	Agency/Institution
1	Canadian International Development Agency (CIDA)**																														
2	Department for International Development (DfID) Kenya & Somalia		3	A	U	A			x	x	x	x	x	x	x	x			x	x			x								UK government
3	German Foundation for World Population (DSW)*		3, 4	A	A	A	Young mothers		x		x							x		x					x		x	x	GBV, IGA, linkage jobs, eco. Empowerment, environmental,		Individual donors

4	German Technical Assistance (GIZ)*		3	A	A	A	Blind youth		x	x	x	x			x	x		x	x	x				x	x			x	Building capacity of DHMTs, computer based Braille for the blind		German government
5	Japanese International Cooperation Agency (JICA)**																														
6	Swedish International Development Agency (SIDA)***																														
7	United Nations Population Fund (UNFPA)*		3	A	U, R	O			x		x				x	x		x		x	x				x						
9	United States Agency for International Development (USAID)		3	A	A	A			x	x	x	x	x	x	x	x			x	x	x	x							Integrated approach to service delivery		US Government

Key

* These organization are both donors and implementers

** These organizations are currently not supporting or implementing AYSRH activities

*** Though this organizations indicated they do not support any youth SRH activities, other organization have mentioned them as their donors

Age: 10-19=1; 20-24=2; 10-24=3; 25+ = 4

Gender: Male=M; Female= F; All=A

Residence: Rural=R; Peri-Urban=P; Urban=U; All=A

Special Population: MSMs, Sex workers, Youth with Disabilities, Married Adolescents, Single Adolescent mothers

Appendix 2: List of Stakeholders who did not respond to Question Guide and those without Contacts

	Organization	Name	Phone Contact	Email
1	Catholic Secretariat Episcopal Conference	Dr. Margaret Njenga	4443133/4443917	health@catholicchurch.or.ke
2	Center for Disease Control	Zebedee Mwandi	0728-608750	zmwadi@ke.cdc.gov
3	Commission for Higher Education	Mrs. Elizabeth Wafula	7205000/2021150/54/56	ewafula@che.or.ke
4	Daystar University, Nairobi Campus	Reverend Mary Kinoti	2723003/4	
5	Fellowship for Christian Unions	Isaac Njoroge/Magdaline Nzuki	0724-253530	injoroge@focuskenya.org
6	Girl Child Network	Mercy Musomi	0722-921376	gcn@girlchildnetwork.org
7	Internews Network	Benjamin Kiplagat (Technical Manager/Trainer)	2228599/2229657	kip@internews.org
8	Kenyatta University	Dr. Ruth Wanjau	0722-423183	ruthwanjaug@gmail.com
9	Reach Out Center	Taib Abdulrahman	0722-415475 / 0722-796287	reachot977@yahoo.co.uk
10	NCAPD	Peter Nyakwara	0721-531220	pnyakwara@ncapd-ke.org
11	UNICEF, Garissa Office	Zeinab Ahmed	0722-528354	zeahmed@unicef.org
12	University of Nairobi (UON) Health Services	Dr. Doreen Asimba/ Dr Stephen Ochiel	0733-757754	stephen.ochiel@gmail.com
13	Walter Reed/ DOD	Norah Talam		ntalam@wrp-kch.org
14	WHO	Joyce Lavussa	0722-785941	lavussaj@ke.afro.who.int

Organizations with Non-functional Contacts or no contacts

	Organization	Name	Phone Contact	Email
1	AMPATH/Moi University Eldoret			
2	CfBT Education Trust	Salim Mohammed	0722-851326	smohammed@cfbtafrica.com
3	Christian Health Association of Kenya (CHAK)	Dr. Samuel Mwenda	4441920/4441854/4445160	
4	Crisis Pregnancy Ministries of Kenya	Mrs. Ojiambo, Kenya Youth for Christ	4445997/0722-789300	
5	KfW	Contact (out of order)	3872122	
6	Ministry of Education	Jane Mwereru, GENDER - RH	318581	
7	Save the Children (Canada)		606087/86/601551	
8	Save the Children (Sweden)		386588/90/93	
9	Save the Children (UK)		2717793	
10	Students Campaign Against Drugs (SCAD)	Adrian Kamau	3862070	
11	Youth for Christ International		44448675/44440825/444451715	

Appendix 3: WHO Classification of Interventions by availability of Evidence

The types of interventions classified as **Go** or **Ready** categories are shown in Table 2 below according to the setting of implementation i.e. schools, health services, mass media, community-based and interventions targeting most at risk young people e.g. those in sex work or transport industry.

Categories of Interventions with evidence for roll-out by setting of implementation

Setting	Type of intervention	Recommendation
Schools	Curriculum-based interventions with characteristics that have been found to effective in developed countries and are led by adults	Go
Health services	Interventions with service providers that include making changes either to the structure or functioning of the facilities themselves and are linked to interventions in the community to promote the health services to young people	Go
	Interventions with service providers in health facilities and in the community that involve other sectors	Ready
Mass media	Interventions with messages delivered through radio and other media (e.g. print media), except television	Go
	Interventions with messages delivered through radio and television and other media (e.g. print media)	Go
Geographically defined communities	Interventions targeting youths using existing youth-service organizations	Ready
Young people most at risk	Facility based programs that also have outreach and provide information and services	Ready