From pilot to program: Scaling up the Kenya Adolescent Reproductive Health Project

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ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
DEO	District Education Officer
AEO	Area Education Officer
TAC	Teacher Advisory Centre
G&C	Guidance and Counseling
MOH	Ministry of Health
MGSCSS	Ministry of Gender, Sports, Culture and Social Services
MOE	Ministry of Education
MOYA	Ministry of State for Youth Affairs
KARHP	Kenya Adolescent Reproductive Health Project
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune disease Syndrome
USAID	United States Agency for International Development
PATH	Program for Appropriate Technology in Health
STI	Sexually Transmitted Infections
DHMT	District Health Management Team
PHMT	Provincial Health Management Team
BOG	Board of Governors
SMC	School Management Committees
APHIA	AIDS, Population and Health Integrated Assistance Program

LOCATION OF PROJECT ACTIVITIES

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EXECUTIVE SUMMARY

In 1999, the Population Council's Frontiers in Reproductive Health Program (FRONTIERS) and the Program for Appropriate Technology in Heath (PATH) collaborated with three Government of Kenya ministries – the Ministry of Education (MOE), the Ministry of Health (MOH), and the Ministry of Gender, Sports, Culture and Social Services (MGSCSS) to design and implement a multisectoral project with the following goals:

- To improve knowledge about reproductive health and encourage a responsible and healthy attitude towards sexuality among adolescents;
- To delay the onset of sexual activity among younger adolescents;
- To decrease risky behaviors among sexually active adolescents.

Three interventions were piloted in Vihiga and Busia districts in the Western Province over a period of 30 months. The intervention implemented by MGSCSS addressed the sensitivity of adolescent sexual and reproductive health (ASRH) within the community, by improving support and promoting dialogue around this topic among parents and adolescents. The MOE educated in-school adolescents about ASRH issues through a life-skills curriculum presented through extracurricular sessions and peer educators. The MOH addressed the information and service needs, primarily of sexually active adolescents, by increasing access to adolescent friendly services and through peer educators.

Key findings from the pilot project demonstrated that the three ministries could successfully implement the interventions with minimal support from FRONTIERS and PATH. Parent to child communication increased significantly and there was increased awareness about contraceptive methods, especially condoms, pills and injectables. Condom use for dual prevention of STIs and pregnancy became better known among adolescents. The level of awareness of specific STIs among all adolescents also increased significantly. The interventions reinforced disapproval of premarital sex and childbearing, and a particular disapproval for teen pregnancies. Some changes were also noted in behavioral indicators, including delayed onset of sexual activity, reduced number of sexual partners, reduced incidences of sexual violence, reduced levels of unplanned pregnancies as well as fewer school dropouts.

The positive results of the pilot phase prompted a 20-month phase of adaptation and expansion of KARHP throughout the two pilot districts to enable the ministries to gain experience of implementing the services at the district level. Pilot materials and tools were revised and inter-sectoral committees set up at district and provincial level. The approach was then further scaled up throughout the remaining six districts of Western Province from June 2005 to May 2006.

This province-wide scaling-up experience led to a further 13-month phase of replication, during which the model was introduced in two districts each of Eastern and Nyanza provinces in June 2006 to May 2007. This was followed by province-wide expansion by the USAID-funded APHIA partners. From June 2007 to May 2008, KARHP was introduced in Nairobi and Central Provinces. Despite the challenges of working with public sector, this program proved that multisectoral approaches that build the capacity of government ministries to mainstream ASRH services can lead to wide-scale expansion and sustainability of effective pilot models.

INTRODUCTION

In 1999, the Population Council's USAID-funded Frontiers in Reproductive Health project (FRONTIERS) collaborated with PATH and three government ministries (Education (MOE), Health (MOH), and Gender, Sports, Culture and Social Services(MGSCSS)) to design and pilot-test a multisectoral model to address adolescent reproductive health and HIV prevention needs in Vihiga and Busia districts of Kenya's Western Province. At the time the project was initiated, there were no systematic sexual and reproductive health (SRH) information and services for in- or out-of-school adolescents. Providing SRH information and services to adolescents was then controversial, due to the false belief that sexuality education and contraceptive services would lead to promiscuity among adolescents. The Kenya Adolescent Reproductive Health Project (KARHP) was launched to:

- Improve knowledge about reproductive health and encourage a responsible and healthy attitude towards sexuality among adolescents;
- Delay the onset of sexual activity among younger adolescents; and
- Decrease risky behaviors among sexually active adolescents.

KARHP was designed around the existing structures and operations of the three ministries at the district level. Each ministry took a lead in implementing an intervention that addressed a particular aspect of adolescent sexual reproductive health. The three interventions developed focused on:

- Creating a supportive environment within which information and services could be delivered by working directly with the local communities (MGSCSS),
- Meeting adolescents' reproductive health information and service needs by increasing access within health facilities (MOH), and
- Educating in-school adolescents about sexual and reproductive health within a framework of information about life-skills and development (MOE).

The interventions were implemented through existing governmental structures, networks and systems. This report gives an overview of the nine years that KARHP was supported through FRONTIERS (1999 – 2008) and describes four different stages of the program:

- 30-month operations research phase
- 20-month adaptation phase
- 12-month expansion phase
- 13-month replication phase.

PHASE ONE: OPERATIONS RESEARCH

KARHP was first piloted as an Operations Research (OR) project between 1999-2003 in two districts, Vihiga and Busia, in Western Province. During this phase, three interventions were tested over an 18-month period using a quasi-experimental design to compare their relative effectiveness in terms of key outcome indicators. One intervention sought to address the socio-cultural sensitivity of adolescent SRH issues by working with communities to create a supportive environment within which the educational and service delivery activities could be implemented. A second intervention addressed adolescents' needs for SRH information and services, primarily those of sexually active adolescents, by increasing their access to existing MOH health facilities. A third intervention educated in-school adolescents on SRH and HIV issues using a life skills curriculum. FRONTIERS and PATH provided technical assistance to all three ministries to implement the interventions. A detailed description of the OR phase is available in an earlier report.[1]

The OR phase included a diagnostic and population-based baseline survey and an endline survey in the experimental and control locations. The endline survey measured changes in knowledge, attitudes and behaviors. Activities implemented during the OR phase were captured in standard reporting forms and entered into a computerized management information system (MIS) for analysis of outputs. The direct and indirect costs of these activities were also calculated. Table 1 below summarizes the three interventions.

Intervention one: Creating a supportive environment for addressing adolescent sexual reproductive health and rights

This intervention was implemented by the Ministry of Gender, Sports, Culture and Social Services (MGSCSS) through its community-based Social Development Assistants (SDAs). Out-of-school youth and their parents were reached by the SDAs in order to increase their SRH knowledge and to promote parent-child communication. The SDAs used their extensive community networks of provincial administration, women, youth and religious groups to mobilize support for the project. Through their membership of Location Social Development Committees the SDAs ensured the prioritization and implementation of adolescent SRH issues in the community. KARHP sought to build on the experience and network base of SDAs to develop a supportive environment for SRH concerns at the community level. Parents, youth, opinion leaders and religious groups were mobilized and sensitized by SDAs to support the provision of SRH information and services by the MOH.

[1] Askew, Ian, Jane Chege, Carolyne Njue, and Samson Radeny. 2004 " A multisectoral approach to providing reproductive health information and services to young people in Western Kenya: The Kenya Adolescent Reproductive Health Project," FRONTIERS FINAL REPORT Washington DC: Population Council http://www.pocouncil.org/pdfs/frontiers_finalreports/kenya_karp%20adol.pdf

Table 1 Interventions and key activities

	Implementing partners	**Target population**	**Activities**
INTERVENTION 1 **Creating a supportive environment to address adolescent sexual reproductive health and rights**	Ministry of Gender, Sports , Culture and Social Services	Divisional Social Development assistants Location Social Development Agents Local Chiefs Religious Leaders Women groups Youth groups Out-of-school youth Parents	Public meetings (Barazas) Sports Song, drama Peer education Video shows Public debates Church sermons
INTERVENTION 2 **Meeting the information and service needs of sexually active adolescents**	Ministry of Health	doctors Clinicians Nurses Public Health Technicians Young people	Setting up Youth Friendly rooms Provision of IEC materials Counseling Medical Treatment
INTERVENTION 3 **Educating in-school adolescents**	Ministry of Education	Guidance and Counseling teachers Peer educators Students Head teachers/principals Parents Teachers Association/ school management committees	Peer education Face to face counseling Debating clubs Essay competitions Sports competitions Songs, skits and drama educative video shows Question Boxes

SDAs received training on adolescent SRH issues and were supported to integrate them within their work-plans. They were also facilitated to conduct advocacy and mobilization activities within their respective communities. The SDAs recruited, trained and supervised out-of-school peer educators to reach out to their peers in the community with information about life skills. The "*Tuko Pamoja*" life skills curriculum was used to train the peer educators; trained peer educators were provided with Peer Educator manuals that focused on providing life skills, increasing SRH knowledge and rights, changing attitudes and providing skills to adopt safer sexual practices.

Local chiefs, religious leaders and women's group leaders were recruited and trained to mobilize and sensitize their respective groups. The community leaders used different forums to reach the community and the youth, including religious meetings and community *barazas* (community meetings). "Enter-educate" approaches, such as community drama and songs, video shows and sports were used. In addition, community leaders acted as counselors to young people in their congregations and allowed the peer educators to use their facilities for outreach activities.

Intervention two: Meeting the information and service needs of sexually active adolescents

This intervention was implemented through the Ministry of Health. The intervention provided SRH information and services by improving the "friendliness" of public (and some private) clinics in order to attract adolescents seeking care. Service providers including medical doctors, clinical officers and nurses from public and private health facilities in the four study locations

were recruited and trained on ASRH and youth friendliness. Participating public health facilities designated "youth-friendly" rooms for weekly peer education meetings. The rooms also served as contact points for service providers to pass information and deliver services to adolescents. Information, Education and Communication (IEC) materials were provided for distribution and for use in one-to-one counseling.

Intervention three: Educating in-school adolescents

The third intervention, implemented through the Ministry of Education (MOE), reached in-school adolescents and their teachers. To mobilize school support for KARHP, head teachers, members of school management committees and members of Parent Teacher Associations were sensitized on the program's initiatives. Guidance and Counseling (G&C) teachers were recommended to receive training in facilitation skills, adolescent SRH and HIV/AIDS using the *Tuko Pamoja* life-skills curriculum. The G&C teachers followed a 34-hour life-skills curriculum covering the following topics: adolescence; reproduction; health relationships; peer pressure; decision making; drug and substance abuse; parenthood; STI/HIV/AIDS; life skills; sexuality and behavior; gender; sexual exploitation and violence; and others. In total, seventy-four G&C teachers from 27 schools were trained in the intervention locations. These teachers were subsequently required by their schools to provide appropriate information and counseling to the adolescents.

The G&C teachers recruited and trained about 600 pupils in their schools to act as peer educators. Peer educators were facilitated to conducted outreach activities in schools through school debates, essay contests, educational videos, and one-on-one counseling. The peer educators were often the first contact for students requiring assistance and information. The G&C Teachers conducted life skills training sessions for different classes and facilitated the set-up of "KARHP clubs" as extra-curricular forums for students to meet and discuss SRH issues. In some schools, G&C teachers conducted KARHP sessions after regular school hours, while others integrated the contents of the sessions into other subjects or other extra-curricular activities. At the end of the pilot phase, each teacher had conducted an average of 12 sessions and had counseled about 26 school children.

Key highlights of the operations research phase

The three ministries successfully implemented the interventions with substantial proportions of adolescents, parents and other community members participating. The in-school and community interventions were very effective. The health facility-based activities were not widely used. The peer educator models were largely successful in reaching adolescents with information, although their sustainability was limited.

Sexual and reproductive health information provided through the life skills curriculum increased knowledge, awareness and communication about adolescent SRH rights. Endline survey findings showed increased levels of delayed onset of sexual activity, reduced number of sexual partners, reduced incidences of sexual violence, reduced levels of unplanned pregnancies and reported school drop-out among in-school youth, reduced reported STI cases and improved safer sexual practices. Parent-to-child discussion on SRH increased and communities became more receptive to information and dialogue about adolescent SRH.

Evaluation results also found increased awareness of contraceptive methods among all girls and younger boys. Large increases in knowledge of condoms, pills and injectables occurred among the youth. The community and school based interventions enhanced abstinence as a preventive behavior. Condom use for dual prevention of STIs and pregnancy became better known among adolescents. The level of awareness of specific STIs among all adolescents increased significantly. The interventions also reinforced the disapproval of premarital sex and childbearing particularly disapproval for teen pregnancies.

These outcomes were realized amidst dramatic changes that were occurring within Kenya at the time. Starting in 1999, HIV/AIDS was declared a national disaster, opening doors for Government campaigns and public discussion of the pandemic. All three partner ministries independently developed adolescent SRH and HIV/AIDS initiatives at the provincial and national levels. At the same time, the MOE launched a school-based HIV/AIDS education curriculum. In 2001, the Children's Act was passed into law. The 'Adolescent Reproductive Health and Development' Policy was developed and launched (September 2003) over the same period.

Changes in sexual behavior

- 59-72% of boys and 76-84% of girls reported never having undertaken any type of sexual activity (including kissing and touching). Among those reporting sexual experience, very few have practiced kissing or touching, with penetrative sex being the norm.
- Adolescents directly participating in the school-based activities reported significantly lower levels of experience of all types of sexual behavior than adolescents not exposed to the school-based intervention.
- Age at first sex among sexually experienced adolescents showed statistically significant delays after the interventions among young people in the intervention sites compared to no change in the control sites.
- The proportions of girls in all sites, and of boys in the intervention sites only, first having sex with someone other than a close friend decreased significantly. The proportions of girls indicating non-consensual sex decreased over time. Secondary abstinence remains very common, with one half to two thirds of sexually active girls and boys not having sex in the previous six months, but there was no change over time in any sites.
- There were decreases over time in the proportion of unmarried girls reporting ever been pregnant

PHASE TWO: ADAPTATION

The positive results of the operations research phase prompted the ministries to agree that the interventions should be adapted and rolled-out. Following this decision, and agreement from USAID to support the scaling-up of KARHP, KARHP activities were expanded to all communities throughout Vihiga and Busia. During this 20-month period (2003 to 2005) the KARHP model was reviewed, leading to the successful components being adapted by the ministries, while those that did not prove effective were dropped from the model. The aims of this second adaptation phase were to:

a. Gain district, provincial and national level commitment and building ministry-specific training capacities to scale-up the activities into the remaining locations in the two pilot districts;

b. Review and revise the materials and tools used in the pilot study;

c. Initiate inter-ministerial committees at various levels;

d. Establish the costs needed to implement the KARHP activities within each ministry;

e. Lobby for sustained ministry commitment

Gaining interest and commitment to build capacity for expansion

FRONTIERS and PATH facilitated workshops with each of the ministries to review the OR phase results and support them to identify which components could be absorbed routinely into their respective programs. The workshops were held at national, provincial and district levels and identified a generic package of interventions for each ministry and actual implementation plans for each set of activities. Practical implications of the proposed activities, expansion of the activities and all expected program challenges were explored. Based on the OR findings, each ministry identified a set of possible and cost-effective ARH interventions for adaptation. At each ministry level, the following outcomes were realized:

i. *The Ministry of Education* decided to continue implementing the complete package of interventions that had been introduced during the OR phase, i.e. peer education, the life-skills curriculum, strengthened guidance and counseling, school health clubs and inter-schools activities. These were extended to all schools in the two pilot locations. The ministry encouraged schools to integrate adolescent SRH into the existing syllabus. Guidance and counseling was recognized as a formal subject in the school timetable. Additionally, funds from the district education office budgets were approved to support the costs of the school-based KARHP activities and of the ministry supervision systems.

ii. *The Ministry of Health (MOH)* decided to sustain the clinic-based KARHP activities but also incorporated a community-based health outreach program. This outreach program involved training and supervising the Public Health Technicians and Community Health Workers affiliated with the clinics. The health facility component was managed by clinic-based nurses and doctors. District Health Management Teams (DHMTs) were mobilized and sensitized to oversee the implementation of these activities.

iii. *The Ministry of Gender, Sports, Culture and Social Services (MOGSCSS)* chose to continue implementing the complete sets of interventions tested during the OR phase. Adolescent SRH was integrated into district work-plans and in the 5-year national youth policy implementation plan. Out-of-school peer educators were linked to income-generating activities and micro-credit programs to reduce their attrition. They also received training sessions on entrepreneurial skills and empowerment that were provided alongside the life skills curriculum.

Intense advocacy was conducted with each ministry at the provincial and national levels to encourage government buy-in and ownership. The implementation experiences were also used by the ministries to review work plans, adolescent RH and HIV/AIDS prevention policies and guidelines.

Revision of materials and tools

Training materials and monitoring tools tested during the OR phase were revised based on experiences and evaluation results. Workshops held with each ministry at provincial and district levels identified sets of materials and tools needed for expansion. The revision of materials took into consideration the experiences of each ministry. Some materials that were considered too technical for location or community staff were simplified to accommodate the capabilities of the intended users. The possibility of integrating the recordkeeping and reporting tools into the monitoring and evaluation systems of the respective ministries was also considered.

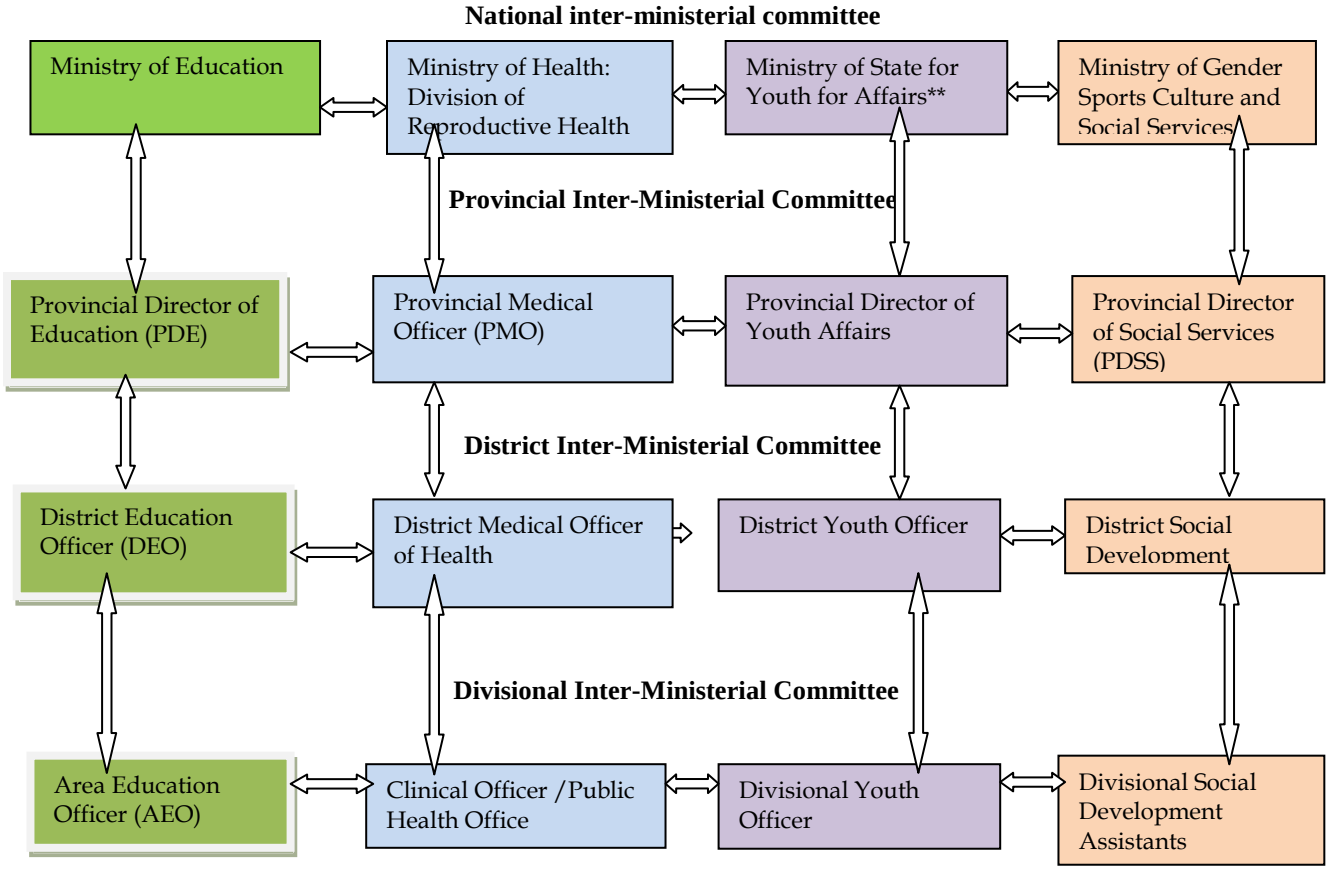
Together with the ministries, FRONTIERS and PATH developed three sets of "*How To*" manuals that provided comprehensive step-by-step instructions and tips on how to develop and implement successful SRH and HIV/AIDS prevention activities. Additionally, all three curricula and other training materials (such as job aids and other support materials) were revised to include their experiences and to become more audience-specific. The training process was reviewed to accommodate actual experiences of the ministries. A cascade training model was adopted. Master trainers at the provincial and district levels were oriented to train divisional and location ministry personnel to implement the program.

Reporting tools used during the OR phase had been criticized for being too many, too long, and too cumbersome to use routinely (they were multiple-stage, weekly, bi-monthly and monthly reporting tools). The tools were reduced to a single monthly, user-friendly reporting tool, in line with ministry expectations. District and divisional level planning committees reviewed and refined the tools to harmonize them with existing ministry protocols. A simplified single monitoring form was developed, structured around relevant data for PEPFAR and ministry reporting. The form recorded planning, training and sensitization activities as well as service delivery data (See appendix 1). The distribution and completion of the form was consistent with the organizational charts of each ministry. In the Ministry of Education, the form was to be completed by the trainer/facilitator (e.g. Religious Leader, SDA, G & C Teachers) on a monthly basis and submitted to the location heads. The MGSCSS form was to be completed by the TAC tutors and Social Development Assistants (SDAs). The MOH forms were completed by Public Health Technicians (PHTs). The forms were collected and new forms distributed at the district level by FRONTIERS field staff. A revised centralized MIS database was created that provided an integrated comprehensive data collection structure for monitoring KARHP activities.

Initiating multi-sectoral committees at various levels

During the OR phase, each ministry addressed one component of the program. Based on the pilot experience, the need to harmonize the operations of the ministries was identified. This was achieved through creating inter-ministry committees (Figure 1). The committees were based on existing government supervisory structures. At each level of government, a contact person charged with day-to-day coordination of KARHP activities was identified. The person liaised with the next level of government and other collaborating ministries. Together the liaison officers from the three ministries, facilitated by PATH or FRONTIERS, held quarterly meetings at provincial, district, divisional and location levels. These committees supervised and coordinated KARHP implementation.

Figure 1 KARHP Multi-Sectoral Committee structures



*Ministry of Youth Affairs was created in 2006 and took over most of youth activities previously handled by the MGSCSS.

Establishing costs needed to run project activities within each ministry

A common question raised by the ministries when reviewing the experience of the OR phase was the cost of running the activities. Cost analyses for all the project activities were done including: planning/preparation of project interventions; training and introduction of interventions; and routine implementation of interventions, monitoring and supervision.

The total cost of the three intervention components over the two and a half years of planning, introduction and implementation during the OR phase was approximately $154,374. The school-based intervention had the highest overall costs[2] and the single most costly activity was supervision and monitoring, which was 55% of total costs[3].

Costs of developing and implementing the interventions within the framework of the OR study were dominated by technical assistance provided from PATH. For various reasons, the costs were expected to be substantially lower for the scaling-up phases as they would be implemented primarily by government ministries. First, the structures and initial capacity had already been created and need not be carried out again, particularly in development of and planning for activities. Second, the interventions themselves, including training, life skills curricula, and IEC materials, had already been designed and so would not be repeated. Third, the expected costs would be shared with the government and were for replication only.[4]

The costs to the MOE for activities that reached the youth, parents and other community members were assessed. Cost were allocated for each activity of the project and extrapolated over a period of five years. Several assumptions were made to deduce these costs:

- A training model had already been developed and put in place.
- Planning activities already conducted through the district education office need not be replicated.
- Core training teams would train G&C teachers in new schools for at least the first two years of project expansion.
- Monitoring and supervision activities would be integrated within the existing district infrastructure and absorbed within existing district budgets at no additional cost.
- Peer educators would be trained continuously (i.e. every year) to replace those leaving at no additional cost.

It was estimated that the annual cost to the MOE of expanding the project to cover new schools within the pilot districts would require an additional Kshs 6,218 ($90) per school during the first year of expansion, which represented a 1.8% increase in the per-school budget allocation. The anticipated costs to the MOE over a five-year period for each school would be an estimated Kshs 16,416 ($238); about 50% of these costs would be incurred on training personnel and ministry trainers and 39% incurred on organizing and conducting planning meetings.

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2 *ibid*

3 No costs for implementation of the clinic based services were included because the clinical staff did not record time spent on KARHP activities.

4 *ibid*

The costs to the MGSCC were assessed for activities that reached youth, parents and other community members. Costs were allocated per location for each activity of the project and extrapolated over a period of 5 years. Several assumptions were made to work out these costs:

- Training model developed and put in place.
- Certain activities already undertaken in OR phase needed not be replicated such as national, district and divisional stakeholder meetings.
- The same core ToTs from the ministry who have already been trained would be used to train social development assistants at least for the first two years of project expansion.
- Monitoring and supervision activities would be integrated within the existing district infrastructure and therefore absorbed within the existing district budgets.
- In expanding the project to new locations, peer educators would be trained every two years.

Project expansion amounted to Kshs 517,638 ($6,900) per location annually[5]. The ministry's contribution had been in the form of labor and infrastructure. To expand the project to cover more locations within the pilot sites required the ministry to increase spending per location by about 3% over its existing budget. Over a five-year period, the additional budgetary requirements would amount to Kshs 197,590 ($2,635). The expansion to new locations within the pilot districts took advantage of the previous investments of resources in planning for the intervention, development of training materials and capacity building. To expand the project to new sites outside the pilot districts, the ministry would have to increase its recurrent budget (non–wage) per location by approximately seven times (more than its current spending per location) representing a 739 % increment in per location spending.

Lobbying for sustained ministry commitment through mainstreaming activities in work plans and budgets

FRONTIERS and PATH held consultative briefing meetings with ministry officials at all levels of government. The meetings discussed the programmatic and financial implications of the ministries absorbing the interventions and were used to lobby the ministries to buy-in to and own KARHP with a view of making the activities an integral part of each ministry's recurrent budget (non-wage).

All ministries decided to adopt the 'cascade' non-residential training approach to lower the average costs. They also recommended incorporating SRH content into existing pre- and in-service training materials for teachers, social workers and health workers. The MOE funded the development of a National Guidance and Counseling curriculum and policy, and requested FRONTIERS and PATH to provide technical assistance. Discussion with the ministries also resulted in recommendations to sensitize and brief treasury officials from the Ministry of Finance to be able to allocate funding to the ministries for adolescent SRH. Briefing papers were prepared and meetings were held with treasury officials.

[5] According to the recurrent budget estimates for 2003/004, there were about 1,129 locations in the country.

PHASE THREE: EXPANDING THE REVISED KARHP MODEL

The results of the KARHP evaluation drew enthusiasm from the ministries who recommended that the program be expanded to all eight districts of Western Province. This phase received financial support from USAID/Kenya (to replace the USAID core support used for the first two phases) through both Population and PEPFAR funding sources. FRONTIERS and PATH sustained their technical assistance to enable the three ministries to plan for and implement the expansion. Work plans were prepared and activity costs estimated. The technical capacity of ministry staff was built to implement and supervise the interventions.

During expansion, FRONTIERS and PATH used a highly participatory process, engaging local stakeholders, government officials and teams of local implementers, to reach a common understanding of the expected outcomes. A project office was opened in the provincial capital (Kakamega) and maintained by PATH and FRONTIERS. These field staff facilitated collaboration and implementation of activities by:

- Maintaining regular contact with stakeholders;
- Mobilizing the communities;
- Advocating and planning meetings with stakeholders;
- Encouraging discussions on adolescent SRH and HIV; and
- Encouraging buy in and ownership of the program.

National-level advocacy was stepped up during this period to strengthen support and create a favorable environment. The expansion model was based on three main strategies:

1. Institutionalization of capacity at district and provincial levels.
2. Strengthening of inter-sectoral collaboration.
3. Strengthening monitoring and record keeping.

Institutionalization of capacity

Day-to-day program activities during the expansion throughout Western Province included: planning, introduction of the interventions, capacity building for ministry staff and implementation. Core training and supervision teams within each ministry received training using a layered approach of skills transfer in order keep costs low and shared with the ministries.

The cascade approach for capacity building followed existing government supervisory structures, in which each level of ministry staff would train and supervise those below them. National ministry officials were inducted as “master trainers” who then trained provincial and district officials as “core trainers”. The core trainers were responsible for training the divisional and location ministry officers as illustrated in Table 2 below. This cascade-training model was strengthened at every level by the presence of a master trainer or a core trainer from the higher level; when possible, a trainer from FRONTIERS or PATH attended the training for quality assurance.

The underlying assumption was that orienting ministry staff on adolescent SRH would enable them to better plan and integrate SRH activities into their routine workplans. Throughout the expansion phase, ministry staff were facilitated to develop detailed work-plans, with clear indications of the resources required and costs implied for the activities.[6]

Table 2: Cascade training model for ministries

Ministry	Who was trained			
	Master trainers	**Core trainers**	**Division staff**	**Location/community/ school**
Ministry of Education	National officer, Department of Guidance and Counseling	Provincial education officer/deputy Provincial Quality Assurance and Supervisory officers District Education Officer/Deputy District Quality Assurance an Supervisory Officers	Area Education Officers Teacher Advisory Centre Tutors	Head teachers, Chairmen of school management committees, Board of Governors, Guidance and counseling teachers Per educators
Ministry of Health	Program Officer, ASRH, Division of Reproductive Health, Program	Provincial Medical Officer (PMO) the Provincial Public Health Officer (PPHO), Provincial Reproductive Health Coordinator District Medical Officer Of health (MOH), District Public Healthy Technician (DPHO).	District Public Health Divisional Pubic Health Officers (DPHO).	Location Public Health Technicians and Community Health Workers, clinicians, nurses
Ministry of Gender Sports, Culture and Social Services	Department of Youth affairs	Provincial Director of Social Services (PDSS), District Social Development Officers (DSDOs	Divisional Social Development Advisors (DSDAs), and all Social Development Assistants (SDAs	location social development committees (SDC), Out of school youth groups, religious leaders, chiefs

Due to the large numbers of schools included in the expansion phase districts, the MOE decided to target one-third of all primary and secondary schools in the eight districts through this project. The rationale behind this strategy was to build a minimum level of capacity in each district that would then facilitate roll out to all remaining schools in the future as funding became available from the ministry. One-day sensitization meetings were conducted for head teachers and a member of the School Management Committee or Board of Governors to facilitate and support introduction of KARHP. This was followed by a five-day residential training session for G&C teachers.

6 The development of the costing tool and its application was the responsibility of FRONTIERS, with active participation by district and PATH staff to ensure that it is appropriate for this situation. Special thanks go to Isaac Lamba, Nzoya Munguti and Rick Homan (FHI) for backstopping this exercise.

Each five-day teacher training session had 20-25 participants, facilitated by three core trainers. The course included 12 sessions (see Box 1) and was intended to enable teachers to use the KARHP curriculum within their schools. Again to keep costs low, schools and Teacher Training colleges with relatively better amenities were used as training venues. This provided adequate space for several training sessions to be conducted with different groups simultaneously.

After training, the G&C teachers were supported to recruit, train and supervise peer educators from among their pupils. Peer educators were among class pupils with good interpersonal and leadership skills. Ideally, each class was to represent a specific age set. At least five peer educators were recruited per class of 50, giving a total of 8,800 peer educators from 440 schools covered in the expansion phase in western province.

Box 1 Five-Day Training Session for Teachers

The goal of this five day Workshop was to provide knowledge and skills to enhance provision of comprehensive and integrated services to youth. It aimed at enabling participants be able to:

1. Communicate effectively and comfortably with adolescents about sexuality and reproductive health.
2. Assist youth to make informed reproductive health decisions Provide quality and youth friendly reproductive health services
3. Use the methodology of the workshop for the training of other.

Emphasis is placed on Interpersonal Communication and Counselling Skills. The module assumes that the participants are sufficiently familiar with certain topics, such as Family Planning Methods, sexually transmitted diseases including HIV/AIDS.

Session 1	Adolescent Reproductive Health
Session 2	Adolescent Sexuality and Sexual Behaviour
Session 3	Communication Skills – Providing Services to Youth
Session 4	The context of Interpersonal Communication
Session 5	The components of Effective Interpersonal Communication Skills
Session 6	Counselling Skills
Session 7	Attending Skills for Counselling
Session 8	Reflections Summary in Counselling
Session 9	Challenging Moments in Counselling
Session 10	Evaluating Counselling
Session 11	Using Visual Aids for Counselling
Session 12	Action Plans and Course Evaluation

In the MGSCSS, a team of officials comprising of staff from the national office, the Provincial Director of Social Services (PDSS) and the District Social Development Officers (DSDOs), were recruited and trained as core trainers. This team then trained Divisional Social Development Advisors (DSDAs) and all Social Development Assistants (SDAs) in each district in a three-day training session. Twelve training sessions were required to train 239 DSDAs and SDAs, with three trainers facilitating each session of 20-25 participants. The SDAs also worked closely with members of the location social development committees (SDC). SDCs comprise at least 10 members with representation from youth, community leaders, religious leaders, women group leaders and people with disabilities. These committees are then mobilized to sensitize communities on SRH and HIV prevention.

The core trainers in the MOH included: a national official from the Division of Reproductive Health, the Provincial Medical Officer (PMO), the Provincial Public Health Officer (PPHO), Provincial Reproductive Health Coordinator and the District Public Health Officers (DPHO). The trainers then trained and supervised the Divisional Pubic Health Officers (DPHO) and Public Health Technicians (PHTs) in each district who were expected to provide adolescent SRH information and services and referrals where possible. Each training session had twenty five participants facilitated by three core trainers.

Strengthening inter-sectoral collaboration

During the expansion phase, provincial, district and divisional teams were created and mandated to oversee the implementation of KARHP activities. These teams were formed by contact persons from each of the three ministries. In some instances, stakeholders from religious groups and provincial administration were co-opted members. Inter-ministry committees followed the government structure (see figure 1 above) to enhance harmony. The committees met every quarter to review progress made, discuss challenges and provide guidance for the way forward for KARHP implementation. Initially, the meetings were facilitated by FRONTIERS and PATH. Later, this role was taken over by the three ministries who chaired meetings on a rotational basis each quarter. Notable contributions of the committees to the institutionalization of KARHP included the decision to share training facilities and resources and to conduct joint supervision of activities. Whenever possible, FRONTIERS and PATH provided technical assistance in planning and budgeting for these activities.

Strengthening monitoring and record keeping

The Management Information System (MIS) modified during the adaptation phase was used to collect and report data. The MIS comprised of ministry-specific activity forms which were completed after each KARHP event. The forms gathered data on specific activities, target audience and topics, number of people reached, services received, feedback and referrals, other collaborators and observations about the activity. The forms were submitted monthly by the grassroots' implementers through ministry channels and collected by FRONTIERS and PATH field coordinators at the district level. The data were then reviewed by the field office for quality, entered into EPI-INFO and forwarded to FRONTIERS's Nairobi office for analysis. The outputs were used for donor reporting and also shared with the ministries to evaluate the program success and improve program implementation

Government input in expansion and utilization of the model

Government ministries played a key role as implementers and facilitators in expanding KARHP. They were responsible for integrating SRH activities within their routine procedures, and for coordinating and facilitating all KARHP activities within their departments. Among the key functions they played were:

i) *Recruitment and training of implementers:* Each ministry identified staff to be trained as KARHP implementers from selected divisions and locations. Most of them came from regions identified with poor sexual and reproductive health indicators such as high drug use, teen pregnancy and low SRH information levels.

ii) *Implementation and integration of SRH activities into routine ministry programs:* Trained government officers on the program were responsible for implementing KARHP activities within their area of responsibility. They ensured that these activities were well articulated in their work plans. At the lowest levels, they sensitized communities, religious leaders, parents and youth to support and adopt the program. In schools, KARHP was integrated into existing school activities – in regular class lessons, in debates, drama, essay writing, KARHP clubs, and booths set up during sports and music events. At the community level, KARHP was integrated into religious sermons, public meetings and *Barazas* addressed by government officials. At the health facilities, youth-friendly information and services were offered.

iii) Coordination, monitoring and reporting: The coordination of KARHP activities within each ministry followed government structures. The national office was responsible for overall coordination and supervision. The provincial head coordinated and supervised the province and the districts. Inter-ministry committees aided joint coordination and supervision.

iv) Advocacy and resource mobilization: In each ministry the contact person at each level spearheaded discussions to mobilize their departments to support KARHP activities. They identified opportunities for integration of SRH within departmental policies, guidelines and budgets. KARHP was discussed in key decision-making organs such as District Development Committees, and Provincial and District Education Board meetings. In Western Province, the Provincial Education Board ratified the expansion and funding of KARHP to all schools in the province. Similar approaches were taken by MGSCSS and MOH.

PHASE FOUR: REPLICATING KARHP IN OTHER PROVINCES

The successful expansion of KARHP throughout Western Province inspired USAID and the three ministries to support its scale-up nationally. The strategy used was to first introduce the model in two pilot districts per province in the first year (supported through funding and technical support from FRONTIERS and PATH), followed by expansion to the remaining districts in the second year using the capacity developed in the pilot districts and funded through the USAID-supported APHIA projects. This phase of replication built on approaches used successfully during the expansion phase including:

i. Conducting introductory and planning meetings with provincial and district heads for buy-in and support;

ii. Building ministry capacity at provincial level and in the two pilot districts;

iii. Sharing costs with ministries during training, implementation and supervision;

iv. Setting up management information systems to collect data for use by ministries and for donor reporting;

v. Initiating inter-ministerial committees and facilitating quarterly meetings; and

vi. Continued advocacy at national, provincial and district levels for acceptance, buy-in and ownership.

During this phase, two rounds of replication occurred. First, KARHP was replicated in Nyanza and Eastern provinces (June 2006 to May 2007), and secondly into Nairobi and Central provinces (June 2007 to May 2008). Each round was planned for a thirteen-month period of replication adopting similar strategies as had been applied during the introduction and expansion of KARHP in Western Province.

This phase began with consultative meetings conducted with provincial and district heads in the four provinces. The introductory meetings discussed the program, assessed the uniqueness of each province, selected pilot districts and prepared a plan for introducing the KARHP activities within each ministry. In most cases, replication began with developing annual operations plans to ensure KARHP activities were prioritized and integrated in ministry work plans.

FRONTIERS and PATH opened temporary project offices in the provinces to support the ministries. The ministries set up inter-ministry committees to coordinate and monitor KARHP implementation. As was the case in the Western Province, the initial activities and inter-ministry meetings were facilitated by FRONTIERS or PATH staff, but responsibility was transferred to the ministries who then organized the meetings on a rotational basis. During the first round of replication, FRONTIERS worked in Eastern Province while PATH facilitated activities in Nyanza Province. In the second round of replication, FRONTIERS facilitated activities in both Nairobi and Central Provinces.

The USAID-funded APHIA partners supported a range of adolescent SRH projects by working closely with government ministries. The programs targeted communities and schools to promote healthy behaviors and the uptake of health services. In many ways, APHIA provided an excellent opportunity for replicating the KARHP model in other provinces. FRONTIERS and PATH worked closely with the APHIA consortia in each province to promote adoption, adaptation and utilization of the KARHP model in Nyanza and Eastern provinces. In Nairobi and Central provinces, FRONTIERS successfully initiated discussions and briefing meetings with the APHIA partner responsible for both provinces to adopt and utilize the model.

The replication phase continued to receive support from the ministries. In April 2007, the MOE allocated Kshs 2.1 million to roll-out the program to 600 schools in Nyanza and Eastern provinces. In total, 12 districts benefited from this expansion including Nyamira, Homabay, Kuria, Suba, Siaya and Bondo in Nyanza Province and Tharaka, Meru South, Meru North, Kitui, Mwingi and Makueni in Eastern Province. A total 264 ministry staff (246 G&C teachers and 18 MEST officials) were trained in Nyanza Province and 238 staff (225 G&C teachers and 13 MEST officials) in Eastern Province. Population Council and PATH provided materials (*Tuko Pamoja* manual) and technical assistance in planning and facilitating expansion. In April 2008, the MOE approved a further Kshs 1.5 million to expand KARHP to four districts in Coast Province, while the newly-created Ministry of Youth Affairs trained 70 tutors from youth polytechnics nationally.

At the national level, FRONTIERS continued to conduct advocacy activities to ensure that the ministries include adolescent SRH activities in their annual operations plans, budgets, policies and guidelines. The development of the youth-friendly service guidelines and a national adolescent SRH service provider's training manual by the MOH were supported through this effort. Support was extended to the MOH also to review and finalize a national peer educators' trainers manual. The MGCSS has used the KARHP monitoring form to monitor and supervise its own staff at the division level. The MOE received support in developing the national Guidance and Counseling Curriculum and Policy framework.

SUMMARY OF CHALLENGES AND LESSONS LEARNED

From piloting through operations research to replication, the three ministries received substantial technical assistance from FRONTIERS and PATH in order to successfully introduce and sustain the KARHP approach over time and across the country. Working with the ministries ensured sustainability of the interventions through integration of activities within routine operational plans, protocols and policies. It has also ensured ownership and prioritization of adolescent SRH issues, including budgetary allocations from the Government. Key to the ministries' adoption of KARHP was their initial involvement in the planning and design of the model. The use of evidence from the OR phase was critical to both convince the ministries and USAID of the effectiveness of the model and to improve and adapt the original interventions within existing government structures. The ministries' priority concerns were the costs to integrate and how to implement and sustain KARHP activities within the overall government framework. The experience of piloting, adaptation, expansion and replication of KARHP has illustrated that this is feasible.

A key component has been the importance of building partnerships that support and strengthen community action for adolescent SRH. This has enhanced acceptance and the ability to negotiate with the community on how best to adapt interventions in the most culturally acceptable way. Dissemination of evidence collected in the OR study, together with advocacy at the local and national levels to communities, stakeholder and government ministries, enhanced buy-in and ownership. It also helped define levels of partner involvement. Local support and national teams strengthened implementation, coordination, monitoring and impact of the interventions.

The multi-sectoral collaboration proved efficient and effective for skills transfer. Use of cascade training from core groups of master trainers down to lower levels fitted well within government structures. They particularly enhanced program implementation and supervision.

Despite the overall success of working with public sector, several challenges were faced. These included:

i) High ministry staff turnover and attrition of out-of-school peer educators. Transfers of trained teachers without proper handing over of responsibility for KARHP interrupted implementation of the program in many schools. The MGSCSS had severe staff shortages at the location level.

ii) Substantial technical assistance to the three ministries was required when implementing the project activities, including planning and design, capacity building, budgeting, integration of SRH within routine work plans and policies, and monitoring and supervision of project activities.

iii) Availability of sufficient resources and complex budgeting and planning systems within the public sector.

iv) Countering entrenched beliefs in communities.

v) Transitions in responsibilities and initiative from a pilot project mentality to a ministry-owned program and from donor dependency to ministry support.

vi) Difficulty in estimating costs, especially in the pilot phase, due to lack of systematic data management and delays in submission of reports.

In conclusion, multi-sectoral approaches for addressing adolescent SRH and HIV/AIDS have proven effective in improving knowledge, attitudes and behaviors. The partnerships created helped to identify opportunities for leveraging of resources and funding. This worked well in the expansion and replication phases, when the government ministries funded much of the expansion, with USAID funding primarily the technical assistance provided through FRONTIERS. Government ministries were able to talk to each other and share other resources, such as training facilities and joint supervision, hence minimizing expansion cost. The success of the program benefited from the long-term commitment by FRONTIERS and PATH, as well as donor support from USAID and PEPFAR.

APPENDIX 1

KENYA ADOLESCENT REPRODUCTIVE HEALTH PROJECT (KARHP)
MINISTRY OF GENDER, CULTURE AND SOCIAL SERVICES ACTIVITY FORM

1) Type of respondent completing form*:_____ 2) Name of respondent_____
3) District: _____ 4) Division: _____
5) Location/Zone: _____ 6) Month and Year: _____

Lno	**7) Activity****	**8) Time spent (hrs)**	**9) Date Conducted**	**10) Nature of Group Involved (Admin , parents, youth, etc)**	11) No. of participants involved		12) Topics Covered***	**13) No. of other trainers /facilitators involved**	**14) Any Referrals Yes /No**
					a) Male	**b) Female**			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

** Entry No.1) is to be selected from Key Column B below.*
*** Entry No.7) is to be selected from Key Column A below*
**** Entry No12) is to be selected from Key column C below*

Key.

A) Possible Activities**
1. Group Discussions
2. Outreach Meetings
3. Individual Meetings
4. Counseling
5. Barazas
6. Video Shows
7. Recruitment of Peer Educators
8. Training of Peer Educators

Other (please specify:_____

B) Type of trainer*
1. . Religious Leader
2. .Social Development Assistant
3. .G & C Teacher
4. .In school Peer Educator
5. Out of school, Peer educator
6. Out of school youth group leader
7. TAC Tutor
8. PHT
9. Other _____

C) Possible Topics***
1. STI infections (STIs)
2. Relationships
3. Drugs & Substance Abuse
4. Communication Skills
5. Teenage Pregnancy
6. Contraceptive Use
7. Abortion
8. Sexual Violence
9. Assertive Skills
10. Other (specify)_____

Provide reasons for referral(s) and state facility(ies) referred to:

Collected and edited by _____ Date: _____ Signature: _____

KENYA ADOLESCENT REPRODUCTIVE HEALTH PROJECT (KARHP)
MONTHLY ACTIVITY FORM

Please provide any other details you wish to report (Meetings (e.g. who were involved, what topics were discussed and what were the outcomes or conclusions?)