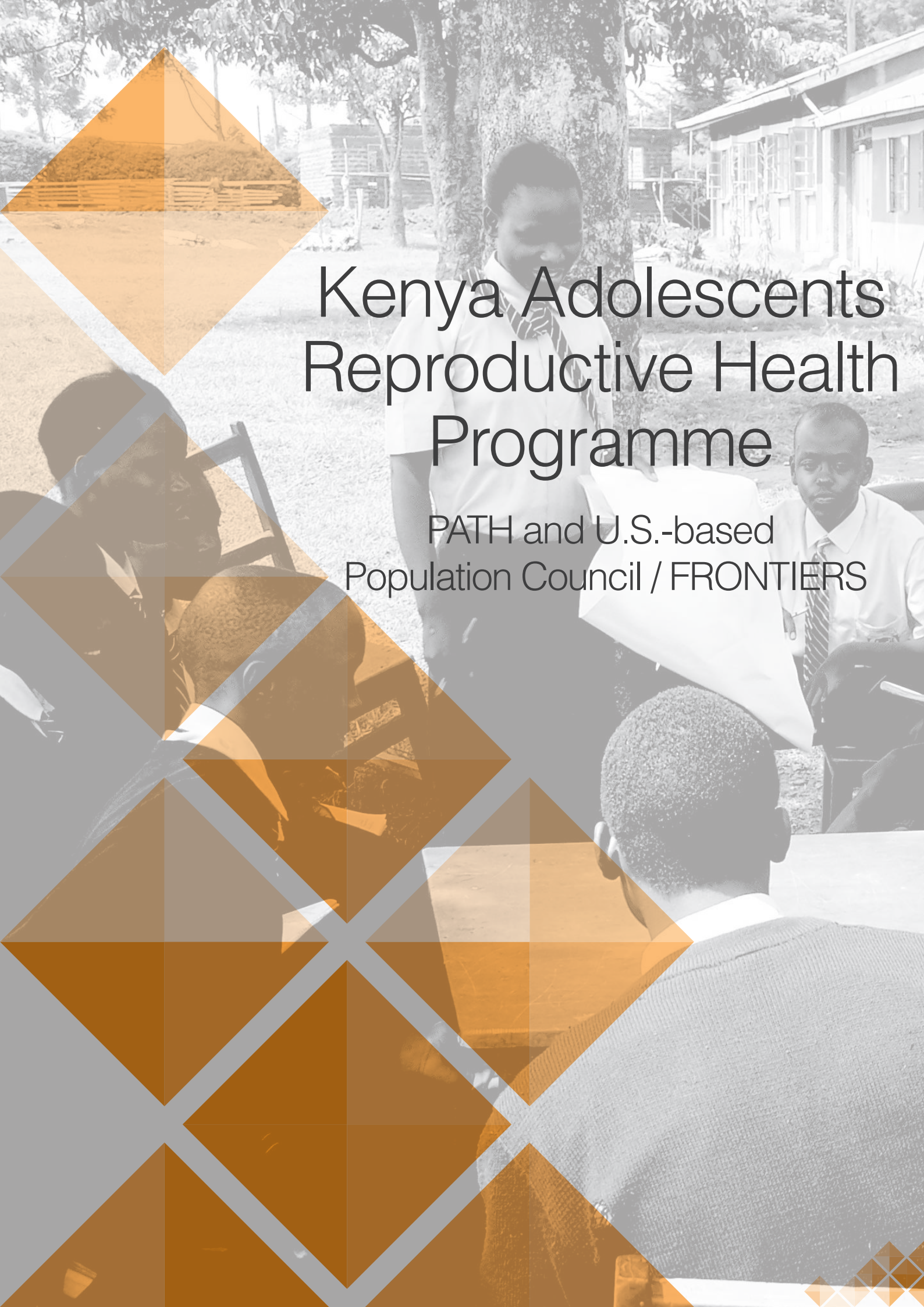

Kenya Adolescents Reproductive Health Programme

PATH and U.S.-based
Population Council / FRONTIERS

Kenya Adolescents Reproductive Health[1] Programme

Region	Global
Country	Kenya
Organization	PATH and US-based Population Council/FRONTIERS
Name	Kenya Adolescents Reproductive Health Programme (KARHP)
Category	Health
Start date	1999
End date	Ongoing
Partners	Ministries
UN involvement	Non-UN
Contact	Alfayo Wamburi alfayow@yahoo.com

1. Background and description

Adolescents and young people in Kenya face significant challenges to their health and well-being, particularly in relation to sexual and reproductive health (SRH). Studies conducted in Kenya in 1999 revealed the lack of comprehensive educational services on reproductive health for adolescents aged 10-19 years, both in and out of school. Adolescent reproductive health was perceived as a highly charged moral issue which raised concerns that sex education and reproductive health services for adolescents would lead to promiscuity. At the government level, poor coordination between ministries, the lack of systematic budgeting for youth reproductive health programmes and scattered responses at the district level, with little or no connection to national policies, were identified as key bottlenecks.[2] When HIV/AIDS was declared a national disaster in 1999, it became evident that the vulnerable and relatively highly exposed group of adolescents and young people had to be targeted with comprehensive and coordinated SRH programmes.

As a response to this need, PATH-Program for Appropriate Technology in Health and the Population Council's Frontiers in Reproductive Health Program (FRONTIERS) launched the Kenya Adolescent Reproductive Health Project (KARHP).[3] The project tested a public sector, multisectoral approach to enhance young people's knowledge and behaviour on reproductive health and HIV prevention through interventions in communities, schools and health facilities. In the pilot phase, which ran until 2003, KARHP was introduced in two districts of the Western province – Vihiga and Busia – and targeted adolescents aged 10-19 years. The design and

1 Desk Review (21 August 2014); Programme Inquiry Form (21 August 2014); Interview (16 September 2014); Internal validation (18-26 November 2014); Implementer validation (26 November-1 December 2014); Final validation (October 2015).

2 Division of Reproductive Health, Ministry of Health (2013).

3 KARHP was part of a four-country study also conducted in Bangladesh, Mexico and Senegal.

implementation of this pilot phase involved and brought together three ministries: the Ministry of Health (MoH); the Ministry of Education, Science and Technology (MoEST); and the Ministry of Gender, Sports, Culture and Social Services (MGSCSS).

As a multisectoral programme, KARHP intervened at the government level, working with the partner ministries and providing them with technical assistance on the introduction of adolescent sexual and reproductive health (ASRH) strategies and incorporation of life skills into the national curriculum. At the community level, it organized awareness and sensitization campaigns with community leaders, parents and out-of-school-youth peer educators. At the school level, it introduced the 34-part school curriculum known as Tuko Pamoja (We are One), extracurricular youth clubs, a life-skills curriculum for out-of-school youth and sensitization campaigns for parents and teachers. The establishment of spaces where youth could access youth-friendly services and information material on reproductive health was also part of the programme.

The positive results from the 30-month pilot phase guided the scaling-up of selected activities between 2003 and 2005. During the pilot, over 50 per cent of the adult population and over two thirds of adolescents in and out of school residing in the two districts were reached. The evaluation of the pilot also revealed that knowledge of SRH had increased among adolescent boys and girls and that there was a trend towards delaying sexual initiation among this age group.[4]

Between June 2005 and 2006, the intervention was scaled up to all eight districts of Western Province, followed by a replication strategy of covering two provinces each year between 2006 and 2008.[5] In 2010, the MoH identified the institutionalization of KARHP as one of the eight best practices in reproductive health in the country.[6]

Organization profile

The mission of PATH is to "improve the health of people around the world by advancing technologies, strengthening systems, and encouraging healthy behaviours".[7]

The Population Council's mission is to "improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources".[8]

4 Askew et.al. (2004).

5 2006-2007: Nyanza and Eastern; 2007-2008: Nairobi and Central; 2007-2008: Coast and Rift Valley. The implementation was done with assistance of APHIA II, a project funded by the United States Agency for International Development (USAID) aiming to improve health outcomes in Kenya.

6 Evelia H. et al. (2011). Best practice in this case was assessed on the basis of the evidence base, impact, replication, cost-effectiveness and sustainability.

7 PATH: mission, www.path.org

8 Population Council: mission, www.populationcouncil.org

2. Goal and objectives

2.1. Goal

The goal of KARHP was to delay sexual initiation, decrease and/or prevent high-risk sexual behaviours among adolescents and increase and improve young people' knowledge of reproductive health. To achieve this, it aimed to create a supportive environment that would help address the concerns about reproductive health, including HIV/ AIDS, of adolescents and youth aged 10-19 years.

2.2. Objectives

The specific objectives of the programme were 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;
- Decrease risky behaviours among sexually active adolescents.[9]

3. Target group

3.1. Age group

From the outset of the programme, the target was adolescents aged 10-19 years. For the school-based curriculum, the target groups were divided into two groups, 10-15 and 16-19 years of age.

3.2. Gender considerations

The programme targeted both males and females, in and out of school. No particular gender-based approach was recorded, although gender issues were addressed as part of the curriculum. Three sessions specifically address gender-related concepts including a definition, differentiating sex from gender roles, gender stereotyping, sexual exploitation and gender-based violence. Topics are introduced and discussed in a culturally appropriate manner. Apart from the curriculum-based approach to gender issues, the project established a referral network with other institutions dealing with prevention of gender-based violence. Teachers, social development assistants and youth peer educators were trained on how to identify cases of this type of violence and refer them to appropriate service organizations. This was actively monitored using detailed data tracking tools disaggregated by gender.

3.3. Ethnic / disability considerations

During the scale-up phase, the project engaged adolescents with disabilities in Kakamega, Turkana and Kisumu districts, where teachers trained in special education were incorporated in the programme so they could deliver the intervention to children with special needs. However, the project did not develop materials specific to their respective special needs and did not have a particular strategy for adolescents and youth with disabilities or for ethnic minorities.

3.4. Targeting the most marginalized / most at risk

During the pilot phase, the project was implemented in two districts of the Western

9 Interview with Mr. Alfayo Awamburi, Behaviour Change Communication Specialist (16 June 2014).

province – Vihiga and Busia – which had reported particularly high levels of adolescents and young people considered to be at risk through exposure to sexual activities. The selected districts also had little or no infrastructure in terms of health facilities.

3.5. Human rights programming

Activities of the programme were grounded on participatory and interactive methods which encouraged the adolescents' participation, including educational video screenings, debating clubs, group discussions, 'edutainment' and sports competitions. The curriculum addressed gender issues, decision-making and relationships, which relate to the larger human rights framework and promotion of adolescents' dignity.

The advocacy component of the project focused on influencing policies to promote the right to information, access to services and the overall well-being of the adolescents and young people.

3.6. Adolescent and youth involvement

Adolescents were involved in designing the intervention and developing the materials – a manual, peer educators' guide and advocacy brochures. Through use of focus groups to explore and define normative values and behaviour, the objectives of the intervention were designed in collaboration with the adolescents themselves. Question/suggestion boxes were placed in schools and health facilities to gather the young people's feedback. The curriculum was pretested with beneficiaries and their inputs were incorporated into the materials adapted for the scaling-up stages. Focus group discussions were conducted as part of the data collection process during the pre-test of the peer educators' guide in order to determine whether it met the adolescents' needs in terms of language, terminology, adolescent-friendliness, etc. Findings from the report and text narratives were used as source materials by the manual development team to adjust and finalize the manual.

4. Strategy and Implementation

4.1. Strategies / theoretical approaches / methodologies

KARHP was launched based on a community- and peer- based communication strategy that included peer education, counselling in schools and youth-friendly centres. PATH acted as coordinator, including of the capacity-building of implementers by the district-level officers. Each ministry was responsible for part of the core components, providing staff and ensuring monitoring and evaluation. The MoEST coordinated the school-based interventions, the MoH the facilities at the health centres and the MGSCSS the activities at the community level. The strategy adopted for reaching the target group and ensuring increased demand for services and their use was to communicate through the facilities of the community, the schools and health centres. Outreach and communication activities included drama and community theatre.

The project maximized the use of existing government structures and networks, and as such was implemented through public institutions and community resources. Government staff at the three levels (national, provincial and district levels) were involved throughout all phases of the project, from design through integration and implementation. In the community, the

young people and religious and community leaders were not only informed about the project but also were used to spread information in a cascade style.[10] The cascade training created a cadre of master trainers at the national and provincial levels. In the case of MoEST, the training of one third of staff and representatives from primary and secondary schools was able to provide reproductive and sexual health training to the remaining schools within the province. The project's key stakeholders were therefore the parents, students, out-of-school youth, school staff, public health technicians, social development assistants, community and religious leaders and district officials and ministerial representatives.

4.2. Activities

Community-based interventions, which are ongoing, include:

- Promoting parent-child communication. The school management committees are sensitized and in turn support the trained teachers to sensitize the parents on KARHP during parents' days. Social development assistants reach out to the adolescents' parents with messages on ASRH and on the need to talk to their children. The school-based components encourage the adolescents to pose questions on SRH to their parents. The schools question/suggestion boxes are used to collect information about parents' and adolescents' concerns, which in turn is used to trigger dialogue during school assemblies or parents' days;
- Training of peer educators;
- Capacity-building for project partners from the community. The project partners are the government departments, which devolve from the national level to the levels of the community, schools and health facilities which implement the intervention.
- Information and sensitization campaigns with religious leaders to ensure that the ASRH messages are reaching adolescents and the rest of the community. Social development assistants from the MGSCSS are trained to work with religious leaders and peer educators, drawn from out-of-school youth, to lead community discussions concerning ASRH.[11] The religious setting is fundamental, as it was noted during the pilot phase that over 90 per cent of young people meet in church.

School-based interventions include:

- Formal and informal peer education, guidance and counselling for adolescents in primary and secondary schools, with KARHP-trained teachers delivering guidance and counselling. Structured sessions are conducted either weekly or biweekly depending on a school's work plan. Counselling is done continuously as long as an adolescent approaches the teacher with a concern. KARHP-trained teachers work with their schools' head teachers to finalize the activity plan for each term;
- Referrals for health services;
- Implementation of the Tuko Pamoja curriculum;
- ASRH training for teachers;
- Recruitment and training of peer promoters. Selection criteria of peer educators includes adolescents capabilities to connect and influence other adolescents;
- Outreach activities by student peer educators trained in ASRH. The schools' peer educators are pupils and the

10 The Division of Reproductive Health, Ministry of Public Health and Sanitation (2009).

11 PATH.org; Improving Adolescent Reproductive Health.

community peer educators are youth who are not in school;

- Extracurricular activities and establishment of health clubs where ASRH issues are addressed.

Health facility interventions include:

- Provision of youth-friendly services. Public health officers are available to the young people and address cultural, social and religious issues that could hinder the delivery of health care services;
- Provision of information in safe spaces, the youth-friendly rooms, where adolescents access materials and peer educators are available for in-person communication;[12]
- Visits by clinic staff to schools and youth groups;
- Expanded clinic hours.

Ministerial engagement activities include:

- An interministerial coordination committee that has guided the expansion of KARHP activities;
- Training of master trainers at the national and provincial levels, with the cost of training community-level staff shared between FRONTIERS, PATH and the ministries;
- Incorporation of ASRH in the work plans of the ministries. Each ministry is responsible for one of the three levels of intervention – community, school and health facilities. The MoEST for instance, has performed cascade training for ministry staff, including a sensitization campaign with school management committees. The result was the successful incorporation of life-skills education into the school curriculum and inter-school KARHP activities.[13] The MoH has adopted the training manuals and established multisectoral collaboration with other ministries, and the MGSCSS has absorbed the established monitoring tools and decided to run community activities;
- Advocacy dialogues with senior-level staff at the three ministries to discuss all phases of the programme and its replication and scale-up;
- Monitoring of activities: monthly reports have been established and data are collected at the district level. Quarterly reports collate all data which are discussed during meetings. The KARHP activities and progress are tracked through a management information system.[14]

Tuko Pamoja

The Tuko Pamoja curriculum was developed by PATH and Population Council in collaboration with MoEST to offer adolescents relevant and appropriate information on SRH, HIV prevention and life skills. To deliver the curriculum, two teachers per school were trained as peer referees on how to guide and communicate with adolescents. Beyond the delivery of the curriculum, the peer referees had the role of forming health clubs and training club members to be peer educators and role models for the other students. Although the curriculum was designed to be used mostly with adolescents in schools, it is also suitable for out-of-school young people.

Each session has a clear learning objective, addressed through a series of participatory learning activities. The training and educational material were revised in the pilot phase through feedback sessions with teachers, students and peer educators. As a result, background information was included so that teachers

12 The Division of Reproductive Health, Ministry of Public Health and Sanitation, August 2009.

13 Ibid.

14 Ibid.

could increase their knowledge of the content before delivery and facilitate question and answer sessions with students. The facilitators complete a form monthly that is used to track progress and identify bottlenecks.

Tuko Pamoja stands for 'We are together' and is used as a reference to encourage open communication on ASRH.

As the programme developed, a series of guides and manuals were included. The Tuko Pamoja series now includes: the adolescent reproductive health and skills curriculum; a guide for talking with young people about their reproductive health; and a manual for peer educators. In addition, KARHP materials also include the ministries' trainer facilitation manuals, developed by PATH to ensure that the training workshops had all the necessary resources and content.[15]

Peer education

As part of KARHP, a group of peer educators was trained to reach out to fellow adolescents and young people, providing information and referrals to health centres. Activities initiated by the peer educators included group discussions, drama presentations, outreach meetings, individual counselling and distribution of information. Activities are conducted in the context of schools but also for out-of-school youth through public meetings, public debates and church sermons.[16] KARHP activities are aligned with the schools' weekly timetables, with two hours set aside each week for extracurricular activities. For out-of-school activities, peer educators work with social development assistants and religious leaders to use time and space within the church compounds to engage with the out-of-school youth on weekends and at any other opportune time.

4.3. Innovativeness

KARHP was the first attempt to introduce a public sector, multisectoral approach to adolescent sexual and reproductive health interventions in the Western province in Kenya.

4.4. Cost and funding

The project was funded by USAID but sought to maximize the use of government resources and staff. Comparisons between the pre- and post-intervention surveys demonstrated that the multisectoral approach allowed leveraging of resources and improved ownership of the process. Trainings were conducted at the government institutions at a negotiated cost. The time of staff from the ministries (teachers, education officers, public health officers) was computed as part of cost sharing. The trainers were from the ministries' staff and not paid as consultants. The ministry staff supervised the sessions conducted in churches, health facilities and free spaces in schools. The three ministries were also able to conduct joint field visits and share a vehicle and other resources, which drastically reduced the cost of implementation.

15 PATH Factsheet

16 American Education article.

4.5. Sustainability

The main strategy for the sustainability of KARHP was its institutionalization in the three ministries, which were part and parcel of the project design, implementation and evaluation. Existing structures and government staff were used for the delivery of activities: the MGSCSS coordinated the community activities and relied on social development assistants; the MoEST coordinated the in-school activities; and the MoH the coordinated the activities at health facilities. An important element for the sustainability of the project was the sharing of resources between ministries, the use of existing institutions for training at subsidized costs and reduced secretariat staffing. The three ministries had different strengths. While some officers had access to vehicles, others did not have such privileges. However, some who had vehicles, such as MGSCSS staff, did not have enough funds allocated for fuel. The MoH had funds for transport, but due to poor transport infrastructure, they could not reach places where public transport was not available. While the schools had dedicated teachers to implement ASRH education, their links with the health facilities were very weak. Thus, the pupils could not get effective attention when referred to the health facilities if not accompanied by the teacher. By bringing the three ministries together, MoH could fuel MGSCSS vehicles to support supervision while the teachers identified a public health technician in each facility to receive the students when referred.

4.6. Replicability

The decision to replicate KARHP in other districts was based on the successful experience of the pilot phase. Following the pilot, the model was first institutionalized and expanded into eight districts in Western Kenya. The positive experience led to the project's replication in four provinces between 2006 and 2008: Nyanza; Eastern; Central; and Nairobi. Funding for the replication phase came from the APHIA II project (see footnote 5).17

During the scale-up phase, the number of schools reached increased from 420 to 1,137 and 396 public health technicians were trained to deliver youth-friendly services. The project reached 177,945 people throughout the Western province and trained 1,951 people in the three participating ministries.[18]

In 2008, FRONTIERS provided technical support to the Ministry of Youth Affairs, which decided to roll out the Tuko Pamoja curriculum to 70 youth polytechnic schools. In addition, the MoEST has approved the curriculum as a stand-alone subject to be delivered in schools.

The model has also been replicated in Senegal (2004-2008),[19] where the focus has been on the institutionalization of ASRH activities in government structures and NGOs.

5. Evaluation of effectiveness

Results

Following the pilot phase, KARHP was evaluated in 2004 and again in 2010 in order to determine to what extent the activities had been sustained and whether the desired outcomes in knowledge, behaviour and practices had been maintained. The end-line evaluation of 2004 used a quasi-experimental design with pre- and post-curriculum testing in six locations, three in each of the two selected districts, Vihiga and Busia, to serve as experimental and control

17 The Division of Reproductive Health, Ministry of Public Health and Sanitation (August 2009).

18 The Division of Reproductive Health, Ministry of Health (April 2013).

19 Ibid.

sites. The three locations in each district were then randomly selected to be site A, B or C.[20] Community-based and health-facility interventions were introduced at 'A' sites. All three interventions – community-based, health facility and school-based – were introduced at the 'B' sites. The introduction of school-based interventions at 'B' sites was used to assess the additional effect of school-based education and sensitization of parents. The 'C' sites served as control locations.

In terms of exposure to the interventions, the study revealed that 50 per cent of parents from A and B sites and two thirds of adolescents from B sites had heard of KARHP following the pilot phase.[21] Approximately one fifth of parents from C control sites had heard of the project despite no activities being carried out in their community. The study revealed increased knowledge and awareness of ASRH issues and change in attitudes and behaviours.

When testing the type of activities, the study revealed that two thirds of the adolescents declared to have participated in activities through the school-based activities. Conversely, 80 per cent of the parents indicated community-based interventions. Participation in facility-based interventions was minimal: 5 per cent for adolescents and 14 per cent for the parents.[22]

The use of peer educators was also tested as they were an integral component of the programme. Over one quarter of adolescents confirmed they had received information through peer education.

Increased knowledge and awareness of basic sexual and reproductive health functions improved substantially among younger adolescents and older girls in site A, and in site B for younger girls. This result suggests that community-based activities are central to increasing awareness of these issues, and that school-based interventions may not necessarily provide a substantial add-on. The end-line survey also concluded that adolescents who were reached by KARHP had significantly higher awareness of specific sexually transmitted infections (STIs) compared to adolescents in the control group, and overall were much more likely to have received reproductive health information.[23]

Change in attitudes was reported in terms of reinforcement of high rates of disapproval of premarital sex and childbearing, including higher levels of disapproval for females. Conversely, the evaluation noted that premarital sex was a norm among the parents and not a modern phenomenon as it is sometimes noted. Against this norm, it is noteworthy that conservative attitudes were sustained. The approval of contraceptive and condom use was reported to have increased in only one of the tested sites, but the rate was significantly higher. However, the approval of condom use among girls showed improvement in both sites. It is noteworthy, however, that adolescents in the school-based activities reported a significantly lower rate of approval of contraceptive and condom than the rest of adolescents. The MoEST had a policy that did not allow teachers to discuss condom use with the pupils, but emphasized instead the values of abstinence among the children attending school.

Changes in sexual behaviour presented mixed results. For instance, older girls and boys reported higher incidences of penetrative sex, although boys in one of the sites reported significantly lower incidences. A significant increase among

20 Askew I. et al. (2004).

21 The sample consisted of: 140 boys and 518 girls aged 15-19 years; 190 boys and 551 girls aged 10-14 years; and 127 male and 299 female parents.

23 Askew I. et al. (2004).

older girls and boys reporting penetrative sex was observed in site A and in the control site C, and a significant reduction was observed among boys in site B. Adolescents participating in the school-based activities reported lower incidences of sexual activity than those who were not exposed to school-based interventions. Another positive result was that age at first penetrative sex among the sexually experienced showed statistically significant delays after interventions. The proportions of girls indicating non-consensual sex decreased over time in all three sites, and significantly in site A.[24] Over time, decreases in the proportion of unmarried girls reporting having been pregnant were recorded, and these were significant in site A and the control site.

An evaluation was conducted between December 2009 and March 2010, 10 years after the first pilot. It included a survey of knowledge, attitudes and practices conducted in the original KARHP pilot regions to determine whether the intended sexual and reproductive health outcomes had been sustained.[25] The study targeted in- and out-of-school adolescents aged 10-19 years. A total of 2,406 adolescents were interviewed and the results were compared to the 2003 study. In addition, school assessments were undertaken in seven provinces in 420 randomly selected primary and secondary schools. The aim was to examine the status and coverage of in-school KARHP activities. Policy documents were reviewed to analyse the level of integration of ASRH into the ministries' workplans and policies.

Key findings revealed that the Government had increasingly given priority to issues related to ASRH and HIV/AIDS with the creation of concrete policy and legislative environments as well as financial commitments. Funding had been allocated to support the roll-out of ASRH activities, with the ministries using a multisectoral approach and working with partners in the private sector, donors and NGOs. On a less positive note, weaknesses were found in monitoring and evaluation. Nonetheless, it was concluded that the Government had developed a clear priority on ASRH.

Regarding the continuity of KARHP activities in schools, the school assessment revealed that 92 per cent of the surveyed schools taught life skills supported by peer education; 96 per cent of schools had a guidance and counselling department; and 70 per cent had life-skills sessions on the school timetable. Over 20 different curricula and educational manuals from different organizations were reported to be in use.[26]

The evaluation also showed that students who had been exposed to Tuko Pamoja life-skills education showed greater improvements in knowledge and reproductive health behaviour. More specifically, it was found that knowledge of issues such as menstruation, pregnancy, contraception and sexually transmitted infectious diseases had been sustained over time and was higher among older adolescents. One of the most significant improvements was registered in the proportion of adolescents reporting safer practices at first sex. In the 2003 evaluation, 25 per cent girls and 19 per cent boys said they practiced first-time safe sex, increasing to 53 and 34 per cent respectively in the 2010 evaluation. However, poor knowledge of condom use persisted. To address this,

24 Site A had approximately twice as many peer educators than site B and had on average more activities done per group than site B. 24 Ibid.

25 This was an exploratory study involving desk review, a survey among adolescents, school and national assessments.

26 Evelia H. et al. (2010).

the programme engaged with the MoH to ensure that the adolescents seeking STI services were provided with information on condom use at the health facility level. More activities were organized for out-of-school youth, including condom demonstrations during recess in areas when sexual activity among youth is likely to be high.

Monitoring and evaluation

Routine monitoring and data collection involve monthly reports from schools, social development assistants and public health practitioners to their respective district officers. Reports are collated quarterly and discussed during district ministerial meetings, where positive results are reviewed and the challenges addressed. Data tracking tools are developed for each ministry. Tools have been revised to measure exposure to the different sessions at the individual levels, including several gender indicators and service delivery referral information, an added element to the programme. These improvements were made during the scale-up and added features to monitor the integrity and flow of data.

6. Strengths and opportunities

Institutionalization of ASRH: Government ministries were involved in the design, pilot testing and scaling up of the programme, ensuring its institutionalization beyond the initial project. Furthermore, the programme was designed to make use of existing structures, i.e., community spaces, health facilities and schools.

Use of a cascade-style approach to the institutionalization of training: At the onset, the costs of training were shared between PATH, FRONTIERS and the ministries. Master trainers prepared at the national level in turn conducted the training of trainers for the lower cadre to enable them to deliver the trainings to the adolescents and youth. To ensure quality, the master trainers supervised all the cascaded training and provided technical support to lower cohorts of trainers.

Maximization of existing structures and sharing of costs with the ministries, strengthening the sustainability of the project and reducing the overall cost of the project: The project has been adopted by many other NGOs receiving funding from various donors but the cost-sharing modality remains the same. Expenses are only incurred during the training of teachers and printing of materials. Supervision and implementation are done at zero cost.

Information, sensitization and advocacy campaigns with key stakeholders at the community, school and ministerial levels, especially religious leaders.

Development of materials: adaptation of the Tuko Pamoja curriculum and replication across the country; development of training manuals to be employed by each ministry; and development of standardized protocols for the implementation of ministry-specific interventions.

7. Challenges

Cultural barriers were one of the main challenges of the programme. There was an initial fear from the community that by delivering sex education, the programme

would promote promiscuity. To tackle this issue, the programme educated community leaders on the content, objectives and benefits while maintaining a sense of cultural responsibility.

Resource availability and competing priorities between treatment and prevention programmes within the public sector. Public sectors receive inadequate allocation of funds but are required to achieve unrealistic targets with constrained staffing. For example, health providers working at a high-volume health facility that receives a large number of sick people may not be able to spend much time with the adolescents at the expense of the ailing people in the queue.

Adequate technical assistance for ministries to continue the implementation of ASRH activities, including planning, capacity-building and monitoring activities. In Kenya, where devolution of services to the county level is the new focus, there is a need to continue building the capacities of the new officers recruited to take up the responsibilities at the county and national levels.

The institutionalization of monitoring and evaluation within the ministries has been a significant challenge. Ministries require strong support on how to incorporate and systematically perform monitoring and evaluation and retain and process data.

Gaps in coordination of activities, especially in the materials used. Different manuals and curricula are being used for life-skills education. In the 10-year evaluation, it was reported that over 20 different manuals from different organizations were in use. A compilation of life-skills education implementation in Kenya revealed that there are many organizations with different life-skills education curricula in the country.[27]

During the scale-up phase, challenges included barriers in the motivation of certain volunteers and out-of-school peer educators, and bottlenecks in data processing and transfer.

8. Next steps and the way forward

The programme did not provide any information on the next steps and way forward.

9. Lessons learned and recommendations [28]

Some of the lessons learned from this programme include:

- The potential of working with government ministries and maximizing existing resources to support ASRH;
- Multisectoral collaboration proved to be efficient not only in the implementation but also for the long-term sustainability and ownership of the process;
- Close collaboration with the community ensures the relevance of the project and enhances the maximization of local resources, and also plays a role in the ownership and sustainability of projects;
- The public sector was able to take on the intervention and spearhead the implementation of the ASRH programmes;
- Because community leaders are important 'gatekeepers' to adolescents and youth audiences, it is fundamental to gain the buy-in of community stakeholders.

27 Fhi360, December 2010 (Life Skills Education in Kenya: Comparative analysis and stakeholder perspectives)

28 Wamburi, A. August 2009.

Recommendations that emerged after the 10-year evaluation include:

- Strengthen monitoring and evaluation;
- Strengthen funding and avenues of cooperation with the private sector;
- Streamline coordination, particularly at the ministerial level;
- Advocate with the Government to increase the level of resources allocated to ASRH;
- Improve the timeliness of data generation, management, reporting and documentation.

10. Components to consider for scale-up in MENA

Strategies used for:

- Effective and coordinated communication among the varied partners and with the audience;
- Transition of responsibilities from a pilot phase involving the ministries to a programme that is fully owned by the ministries;
- Implementing a multisectoral collaboration model.

11. Resources

Tuko Pamoja: Adolescent Reproductive Health and Life Skills Curriculum

Tuko Pamoja: A Guide for Talking with Young People about their Reproductive Health

Tuko Pamoja: A Manual for Peer Educators

MoEST trainers' facilitation manual

MoH trainers' facilitation manual

MGSCSS facilitators' manual

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Websites:

- PATH - www.path.org
- Population Council

www.populationcouncil.org

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