In-School Youth Reproductive Health/ Life Skills Program - Promising Intervention

Addressing issues of adolescent reproductive health is a challenge due to the nature of the topic and the common belief that providing sex education to adolescents leads to promiscuity. Kenya has, however, put in place a ten-year strategic Adolescent Reproductive Health and Development Policy with specific goals. The In-School Youth Reproductive Health/ Life Skills Program works within the framework of this policy and builds on PATH's previously implemented Kenya Adolescent and Reproductive Health Program (KHARP). It aims to establish and support the institutionalization of RH education activities within schools. It works towards the specific objective of equipping all school children in Western province with life skills.

The In-School Youth program started in 2007 with the aim of building capacity within the Ministry of Education to implement and supervise the activities within their existing structures rather than to bring in external civil society organizations to carry out the activities. The APHIA II Western team worked closely with the Provincial Director of Education to implement the program.

A total of 2,000 schools were running an extra-curricular adolescent reproductive health/ life skills program through peer educators. A total of 1,600 teachers were trained as facilitators for the peer education activities through the initiative. District Education Office monitoring and supervisory capacity was enhanced with the donation of 21 computers to DEOs and training of 19 data clerks in monitoring and evaluation procedures.

The Ministry of Education supervisory and monitoring capacity was increased by the donation of computers to District Education Offices and training of data clerks. Oversight and supervision of the program were carried out within existing District Education Office structures.

Teachers underwent life skills training using the *Tuko Pamoja Life Skills Curriculum* and were then trained in facilitation skills to enable them to support student Peer Education Groups. Due to the nature of the topic, a peer education approach to reproductive health and life skills was adopted in the schools. On completion of their training, teachers were expected to recruit and train the students and pupils as peer educators. Trained teachers selected five students per class (average class size is 70 – 80 students) for training with the Tuko Pamoja Guide for Peer Educators. The students reach out to their peers during break time, club meetings and other extra curricular activities through discussions, individual talks and group outreaches using the *Tuko Pamoja Life Skills curriculum.*

The life skills training initiative has not been given sufficient priority within the school sector. This is partially attributable to the fact that teachers are not giving it priority within their heavy work load as they are not evaluated for the work they carry out in this area. Future interventions should look at how to incorporate the life skills and reproductive health activities into teachers' formally recognized workload. They should also focus on strengthening the linkages between schools and health facilities through a formally defined relationship between the Ministries of Health and Education. The continued success of this initiative relies on students accessing health services once they make the choice to use them.

The philosophy and design of this initiative was solid and well thought out. Its integration into pre-existing Ministry of Education structures provides a strong foundation for its sustainability. It also creates a sense of ownership for the initiative from the Ministry of Education and allows it to take place within existing structures rather than through externally imposed ones.

Orphans and Vulnerable Children

Married Adolescents - Best Practice

High numbers of adolescent girls are getting married for a variety of reasons including vulnerability as a result of being orphaned, or because they have dropped out of school due to pregnancy or lack of school fees and their parents have forced them into early marriage. These young girls are faced with a range of problems as a result of their early marriages. They are at high risk of HIV infection and are more likely to have close and unplanned deliveries. Their undeveloped reproductive systems make them more vulnerable to complications such as obstetric fistula during childbirth. Infant mortality rates are higher among young mothers.

These girls often have poor communication skills that make it difficult for them to negotiate and discuss important issues within their marriage. They are also highly likely to be experiencing emotional and physical abuse from their husbands. Strong cultural traditions give mothers-in-law a strong influence in the household. Their faith in traditional birth attendants places them as a barrier to these girls accessing skilled deliveries when they give birth.

31. KDHS 2008
32. KDHS 2008
33. KAIS 2007

The Married Adolescents Program started in 2008 and aimed at reaching 24,000 married adolescent girls in Western Province and equip them with knowledge on health issues relating to their own health and that of their families, to develop their communication skills to be able to discuss issues with their husbands and to develop skills with which to become more economically empowered within their marriages. A total of 17,269 married adolescent girls were established, reached through the program. A total of 860 mentors for the single-sex groups were trained, out of which 100 men and 100 women mentors trained for the mixed-sex support group initiative.

Married adolescent girls tend not to be involved in the youth groups that are the usual entry point for youth focused education and prevention activities. As a result of this it was decided to access them through faith-based organizations, which they are more likely to be involved with.

Activities started by bringing leaders of the Pastors Fellowship Forum and other faith-based leaders together at the provincial level to introduce to them to the concept of the initiative. These leaders helped to identify religious organizations at the district level through which to carry out the program. Further sensitization and discussion was then carried out with religious leaders at district level. The local religious leaders were responsible for identifying and recruiting mentors from their congregations who would actually run the support groups. Mentors were given training on the Married Adolescent Program, facilitation skills, technical knowledge and reporting requirements and were required to meet with the APHIA II Western Married Adolescents Coordinator on a quarterly basis for monitoring and supervision.

Following sensitization of congregations and communities, the mentors each recruited two groups of up to 25 girls selected from the religious institution or the local community. The groups met on a monthly basis to discuss their ideas on what a healthy marriage entails, life skills and relationships, reproductive health and pregnancy, sexual health, child health and planning and setting goals for the future. Each session ended with "homework" that girls were meant to carry out at home to practice their skills, apply their knowledge and strengthen their relationships with both their husbands and their mothers-in-law.

Men's influence in marital relationships and involvement in decision-making is an important factor to be considered, particularly in the case of married adolescent girls. Based on feedback from previous married adolescent programs, it was decided to pilot a version of the program that involved both married girls and their husbands in three districts. A total of 100 male and 100 female mentors were trained for this initiative. The dialogue groups were divided by gender and held their own discussions, with the men's groups using the Community Health Worker's Manual as the basis for their discussions. The facilitators would, when appropriate, bring the two groups together to discuss specific topics.

Two elements of the program that have shown impressive results are the reported improvement of communication at household level and the economic empowerment of the girls, many of whom are now able to contribute a little to the household. The strength of the initiative has been in its consultative and inclusive approach, working through faith-based organizations and including key household decision makers, husbands and mothers-in-law, in the process.

This program has made a significant impact in improving communications between married adolescent girls and their husbands as well as with other household members. We have also seen an increase in access to health services from this group as well as a reported reduction in unplanned pregnancies. The key to its success has been the involvement of the churches and community and household members in the implementation of the program. Their commitment to the process has ensured that the support groups have run and continued to provide support to the girls who would otherwise be difficult to access. When time is taken to ensure the commitment of these key community figures, this is a low-cost, effective and easily replicable intervention.

Oral Rehydration Therapy corner

A support group in Bungoma shelling the maize they harvested.

John and **Jael Machikwa** from Lukume village had a troubled marriage. John spent a lot of time away from home and gave little support to the family. When he was home, the couple used to quarrel. Their marriage has improved as a result of their involvement in the Married Adolescents Program.

"My husband used to drink so much and he couldn't listen to anything from me. He even attended disco dances in Kakamega town every Friday night and offered little assistance to the family. As a woman I had no right to question his behavior and I received regular beatings on enquiring of his whereabouts," Jael recounts.

"One day after attending the weekly married adolescents dialogue session I asked him to help me by discussing a question assigned to me by the discussion group's facilitator. At first he took no interest, but after some days I asked the same question. He tried to discuss it, but his answers were not satisfactory. He listened to me as I explained the health issue and he promised to join the dialogue session some time. From then he developed interest and further followed me to one of the meetings. He was astonished to meet some of his male village mates together with their wives seated and deeply engulfed in the dialogue sessions. The topic of discussion was on family planning."

John recalls, "The discussions were amazing. I learned a lot just listening to people sharing their experiences. Then finally the facilitator gave us highlights on family planning. I then discovered that I had been investing a lot of energy beating my wife, yet we could resolve our differences through talking as a couple. I have since changed my lifestyle. There are no more quarrels and anytime I have pending issues with my wife we sit down and have a discussion like adults."

Formal Workplace Support Program - Promising Intervention

Western Province hosts a number of large-scale employers, primarily in the tea and sugar industries, that fuel the region's economy. The employees and communities connected to these workplaces are at risk of HIV infection and vulnerable to the socio-economic impact of HIV. The majority of the workers are men who often leave their families and are prone to engaging in high-risk behaviors whilst they are away from home. Service industries that include markets, bars, transport operators and sex workers operate to meet the workers' needs. There is a high level of high-risk behavior taking place. Combined with high-risk cultural practices such as wife inheritance, these elements contribute to the transmission of HIV between home and the workplace.

Young mother with her son

The program started in 2008 and worked to establish and strengthen formal workplace programs with the specific objectives of increasing workers' knowledge of HIV/AIDS, improving their skills in negotiating safe sex, reducing high risk behaviors and reducing levels of stigma and discrimination within the workplace. Ten workplaces were supported to run HIV/AIDS workplace programs, 500 peer educators were trained and 22,165 people reached through the program.

Once a workplace agreed to establish a workplace program they signed an MoU outlining terms of engagement and responsibilities with APHIA II Western. Within the workplace, the Company HIV Steering Committee headed the program and took responsibility for developing an HIV Workplace Policy and allocating a budget for and overseeing implementation of activities. An average of five Zonal Leaders were trained as peer educators to oversee peer education activities among the workers. Beneath them an average of 25 peer educators per worksite carried out peer education activities amongst their colleagues.

"Since we started discussions with our co-workers, there has been a remarkable change in the perception of the community on matters concerning HIV/AIDS. More people are coming out to declare their HIV status and unlike before, they are not discriminated against." –
***Bernard Mutila,** Chariman of Nzoia Worksite Motivators program*

The Workplace HIV/AIDS Policy is developed in line with Kenya Federation of Employers' policy and targets both employees and the surrounding community. It provides for non-discrimination of employees and prospective employees

based on their HIV status and a zero tolerance to any form of stigmatization. It also provides for confidentiality when testing its employees. Testing is based on voluntary and informed consent and counseling and post-counseling support is offered to the staff.

Peer educators are trained in facilitation skills, reporting requirements and the use of the CHW Manual that deals with a range of health issues including HIV/AIDS. They ran regular peer discussion groups among their colleagues and offered individual support and interaction on HIV/AIDS among their peers. They also participated in workplace-based outreaches carried out in collaboration with the APHIA II Western treatment team and Ministry of Health into the surrounding community.

A review of program impact found that the peer group discussions were not an effective tool. In spite of this there were many positive outcomes from this intervention that contributed to better relations between the employers and their workers, improved health services and reduced stigma amongst workers. The establishment of CCCs in the workplace made it less time-consuming for workers to access their ART care and support as they no longer had to travel to external facilities.

This is an easily replicable intervention that relies on close partnership between the employer and the Ministry of Health and helps strengthen linkages between surrounding communities and health facilities. It is an initiative that has proved to be a resource for the health and wellbeing of workers, their families and community.

Informal Workplace Support – Promising Intervention

The high-risk behaviors that many of the informal sector workers of Western Province engage in contribute to a high HIV prevalence rate in this group. Health and program personnel tend to marginalize them in their service provision. These factors combine to create barriers for informal sector workers, particularly Commercial Sex Workers (CSWs) to access health and social services. The informal sector includes fishing communities living on the shores of Lake Victoria, many of whom are involved in the notorious "fish for sex" trade where women pay fishermen for their catch in sexual services. Boda boda, bicycle and motorbike taxi operators are also known to accept payment in sexual favors from their female clients. CSWs are widely recognized as being at increased risk of HIV and STI infection as a result of their high-risk sexual behaviors.

This intervention aimed to use peer outreach networks to increase knowledge of HIV/AIDS, improve skills for negotiating safe sex, reduce high-risk behaviors and reduce levels of stigma and discrimination against informal sector workers. Activities started in 2007 and an initial 22 peer groups were established among boda boda teams, farmers groups, beach worker groups and self-help groups. These groups were supported by 58 trained peer group educators supporting 1,715 informal sector workers with behavior change and health education messages as well as support to access medical and social services. Through its work with Survivors and Wadadia CSW support groups in Busia and Mumias, 42 peer group educators were trained and then worked with 902 CSWs.

Peer outreach is a process by which trained individuals conduct sessions with their peers with the aim of improving knowledge, skills and attitudes that reduce risk of HIV/STI transmission and acquisition. Peer outreach programs are central to prevention efforts for most-at-risk populations, including CSWs. They work to reduce high-risk behaviors and improve access to services that include HIV counseling and testing, STI screening and treatment and ART and drug treatment. The key to success of peer education initiatives lies in their community base and acceptance by their target groups.

The initiative worked with established groups that had existing management structures. This allowed the group members to manage the health education activities with monitoring and support offered by eight volunteer site coordinators. Groups were identified in target communities in major towns and the communities centered around factories, based on the assumption that these were settings most likely to have large, active boda boda and CSW populations. Fishing communities were found on the beaches from where they fished and sold their catch.

Two members from each group were selected for a week-long training in peer education skills using the Community Health Workers' Manual and reporting requirements. Groups were expected to meet twice a month and were encouraged to meet away from their places of work. Group facilitators met with site coordinators on a quarterly basis for supervision and reporting purposes. Groups were given additional support as required in the form of grants and linkages to microfinance institutions and health facilities.

Support to the CSWs was particularly effective. Many of them were young girls, many of whom were school dropouts. The CSWs already had a strong, well-established management structure that facilitated our working relationship with them. These groups were given life skills training that included assertiveness and bargaining skills that enabled them to negotiate better terms of engagement with their clients. They were also given training in resource mobilization and linked to microfinance institutions that gave them opportunities to develop alternative livelihood