

# KENYA ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY

## IMPLEMENTATION ASSESSMENT REPORT

MAY 2013



**USAID**  
FROM THE AMERICAN PEOPLE



**iDEA** INFORMING  
DECISIONMAKERS  
TO ACT





# Kenya Adolescent Reproductive Health and Development Policy

## Implementation Assessment Report

MAY 2013

# ACKNOWLEDGMENTS

The Adolescent Reproductive Health and Development (ARHD) Policy Implementation Assessment Report was prepared by the National Council for Population and Development (NCPD), Division of Reproductive Health (DRH), and the Population Reference Bureau (PRB). This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the IDEA Project (No. AID-OAA-A-10-00009). The contents are the responsibility of NCPD, DRH, and PRB and do not necessarily reflect the views of USAID or the United States government.

© 2013 Population Reference Bureau. All rights reserved.



**USAID**  
FROM THE AMERICAN PEOPLE



**iDEA**  
INFORMING  
DECISIONMAKERS  
TO ACT

**PRB**  
INFORM  
EMPOWER  
ADVANCE

# TABLE OF CONTENTS

Acronyms . . . . .	4
Foreword . . . . .	5
Executive Summary . . . . .	6
Background and Rationale. . . . .	8
Methodology . . . . .	14
Key Findings. . . . .	16
Recommendations and Lessons Learned . . . . .	33
Conclusion . . . . .	39
References . . . . .	40

# ACRONYMS

<b>ARHD</b>	Adolescent reproductive health and development
<b>ASRH</b>	Adolescent sexual and reproductive health
<b>CSO</b>	Civil society organization
<b>DRH</b>	Division of Reproductive Health
<b>FGM/C</b>	Female genital mutilation/cutting
<b>HPI</b>	United States Agency for International Development Health Policy Initiative, Task Order 1
<b>IDEA Project</b>	Population Reference Bureau's Informing Decisionmakers to Act Project
<b>M&amp;E</b>	Monitoring and evaluation
<b>MOE</b>	Ministry of Education
<b>MOH</b>	Ministry of Health
<b>MOYAS</b>	Ministry of Youth Affairs and Sports
<b>MP</b>	Member of Parliament
<b>NCPD</b>	National Council for Population and Development
<b>NGO</b>	Nongovernmental organization
<b>PIAT</b>	Health Policy Initiative's Policy Implementation Assessment Tool
<b>POA</b>	ARHD Policy Plan of Action 2005-2015
<b>PRB</b>	Population Reference Bureau
<b>STI</b>	Sexually transmitted infection
<b>TWG</b>	Technical Working Group
<b>USAID</b>	United States Agency for International Development

# FOREWORD

The implementation assessment of the Adolescent Reproductive Health and Development (ARHD) Policy was undertaken from November 2011 to September 2012. The assessment was conducted by the National Council for Population and Development (NCPD), Division of Reproductive Health (DRH), and the Population Reference Bureau's (PRB) Informing Decisionmakers to Act (IDEA) project. A range of additional government agencies and organizations were engaged in the assessment process as taskforce members.

A core research team of PRB consultants collected qualitative data for the assessment through key informant interviews and focus group discussions held throughout Kenya. Relevant government policies, strategic plans, and research documents were also reviewed. The draft assessment reports were reviewed by the assessment partners and taskforce members. The findings and draft recommendations were presented to an audience of stakeholders on 20<sup>th</sup> September 2012 at the Hilton Hotel in Nairobi, and feedback acquired from the stakeholders was used to finalize the report. The ARHD Policy Implementation Assessment Report is now ready and marks a critical milestone in ARHD Policy implementation. The report will guide future policy reviews and the design of related programs.

In 2003, the ARHD Policy was developed to respond to concerns about youth issues that were noted in the National Population Policy for Sustainable Development (2000), the National Reproductive Health Strategy (1997-2010), the Children's Act (2001), and the government's commitment to integrate youth into the national development process. To facilitate the operationalization of the ARHD Policy through a national multi-sector approach, an ARHD Plan of Action (2005-2015) was developed in 2005. Since then, there have been new developments including the formulation of other sectoral policies, implementation of Vision 2030, promulgation of a new Constitution in 2010, and more stakeholders and programs focusing on ARHD issues. In 2007, the Reproductive Health Policy was developed, and the adolescent reproductive health component is the key pillar of this policy. These developments necessitated the need to assess implementation of the ARHD Policy.

The assessment report provides valuable findings that will inform policymakers, donors, program managers, and partners about the status of ARHD Policy implementation, and provides explicit recommendations on how to strengthen implementation. The lessons learned during its implementation as assessed will also be used to revise the policy into a new National Adolescent and Youth Development Policy.



**Mr. Karugu Ngatia**  
**Deputy Director**  
**National Council for Population and Development**



**Dr. Issak Bashir**  
**Head**  
**Division of Reproductive Health**

# EXECUTIVE SUMMARY

Developed in 2003, the Adolescent Reproductive Health and Development (ARHD) Policy was the first in Kenya to focus on improving the reproductive health, well-being, and quality of life of Kenya's adolescents and youth. The ARHD Policy is a foundation for initiatives in Kenya that integrate reproductive health and development concerns for adolescents and youth into the national development process, and enhance their participation in that process. Given the increase in the number of stakeholders and programs focused on ARHD in Kenya over the last decade, and with two years before the end of the ARHD Policy timeframe, stakeholders in Kenya recognized the need to assess implementation of the policy.

Therefore, the National Council for Population and Development (NCPD), Division of Reproductive Health (DRH), and the Population Reference Bureau's (PRB) Informing Decisionmakers to Act (IDEA) project conducted an assessment of the ARHD Policy from November 2011 to September 2012. The partners organized a task force of reproductive health professionals and youth advocates from the public and private sectors to provide input for the assessment methodology and tools. The assessment sought to: explore the nature of policy implementation since the ARHD Policy was developed in 2003; assess implementation progress and achievements; identify social, political, and economic barriers for implementation; and promote policy dialogue on ways to strengthen implementation.

Using an adapted version of the Health Policy Initiative's 2010 Policy Implementation Assessment Tool (PIAT), a core research team of PRB consultants collected qualitative data from 195 participants in Nairobi, Thika, Kisumu, Wajir, and Watamu from March through June 2012. Individual interviews were conducted with 22 policymakers and 68 implementers. Fourteen focus group discussions were held with 30 service providers, 34 teachers, and 41 youth age 18 or older.

The findings of the assessment revealed that since 2003, Kenya's ARHD Policy has led to many perceived improvements in the health and well-being of adolescents and youth. The ARHD Policy has provided guidance for priority ARHD needs and target populations, and for a range of approaches to increase access to and quality of ARHD programs and services. The policy has also helped lay the groundwork for many new guidelines, policies, and strategies. All of this has contributed to more commitment to and funding for adolescent sexual and reproductive health (ASRH); strengthened partnerships between the government and nongovernmental organizations (NGOs) and civil society organizations (CSOs); improved knowledge of and attitudes toward ASRH; and improved empowerment of youth.



However, ARHD Policy implementation has been limited due to a range of factors and challenges, such as: lack of awareness about the ARHD Policy and the ARHD Policy Plan of Action (POA); lack of coordination among implementers; low stakeholder involvement, including low political will and youth involvement; limited leadership; lack of resources; poverty and unemployment among youth; and limited availability of high-quality ASRH services. Additionally, ASRH remains a contentious issue among some communities, and some cultural and religious practices are barriers for implementation. Adolescents and youth still face challenges, such as completing secondary school, finding employment, postponing marriage, and avoiding sexually transmitted infections (STIs) and unintended pregnancies.

Based on the findings, the assessment partners and stakeholders identified seven recommendations as next steps for policy action to strengthen implementation and ensure that the ARHD Policy is put into practice on a large scale:

1. Ensure an Integrated Approach to Policy Development and Implementation.
2. Strengthen Leadership and Coordination.
3. Increase Policy Awareness.
4. Strengthen Implementation Plans.
5. Improve Resource Mobilization and Management.
6. Improve Service Delivery.
7. Ensure Monitoring and Evaluation.

This assessment reinforced stakeholder commitment to the policy's goal and objectives, facilitated dialogue on ARHD needs and challenges, and identified next steps to strengthen policy implementation. The assessment partners will use the findings and the recommendations from the assessment to strengthen ARHD Policy implementation during its last two years. The lessons learned will also be used by stakeholders to revise the ARHD Policy into a new National Adolescent and Youth Development Policy to continue to improve the reproductive health and well-being of adolescents and youth, and achieve Kenya's development goals.

# BACKGROUND AND RATIONALE

## PRIOR TO 2003: LAYING THE GROUNDWORK

The 2003 Kenya Adolescent Reproductive Health and Development (ARHD) Policy was a milestone for addressing the health and development concerns of Kenya's adolescents and youth. Prior to 2003, no policy document at the national level explicitly addressed adolescent sexual and reproductive health (ASRH). Several initiatives helped lay the groundwork for the ARHD Policy, such as the:

- United Nations International Convention on the Rights of the Child, 1989
- United Nations International Conference on Population and Development, 1994
- United Nations Fourth World Conference on Women, 1995
- Kenya National Reproductive Health Strategy, 1997-2010
- United Nations World Programme for Youth, 2000
- Kenya National Population Policy for Sustainable Development, 2000
- Kenya Children's Act, 2001
- The Persons With Disabilities Act, 2003

Together, these initiatives and others highlighted the right of adolescents and youth to have high-quality health care, including reproductive health; and recognized the influence of the health and well-being of youth on national development. In response to the concerns raised about adolescents in these initiatives and other national and international declarations on ARHD, the Government of Kenya developed and launched the ARHD Policy in 2003.

## ARHD POLICY GOAL AND OBJECTIVES

The goal of the ARHD Policy is to contribute to improvement of the well-being and quality of life of Kenya's adolescents and youth.<sup>1</sup> The ARHD Policy also seeks to integrate the health and development concerns of adolescents and youth into the national development process, and to enhance their participation in that process. According to the ARHD Policy, adolescents are defined as persons ages 10 to 19, and youth are ages 10 to 24. The specific objectives of the policy are presented in Table 1.

For the rest of the report, the ARHD Policy will be referenced as "the policy."

In addition to providing a summary of ASRH challenges and indicators in Kenya in 2003, the policy identifies a set of strategic actions to address the following priority concerns: ASRH health and rights, harmful practices, drug and substance abuse, socioeconomic factors, and adolescents and youth living with disabilities. Table 2 summarizes the health, demographic, and social service targets intended to guide the achievement of policy objectives by 2015.

**Table 1: ARHD Policy Objectives**

1.	To identify and define adolescent health and development needs.
2.	To provide guidelines and strategies to address adolescent health concerns.
3.	To promote partnership among adolescents, parents, and community.
4.	To create an enabling legal and socio-cultural environment that promotes provision of information and services for adolescent and youth.
5.	To promote and protect adolescent reproductive rights.
6.	To strengthen inter-sector coordination and networking in the field of adolescent health and development.
7.	To promote participation of adolescents in reproductive health and development programmes.
8.	To identify and define monitoring and evaluation indicators for ARHD.
9.	To advocate for increased resource commitments for adolescent and youth health and development programmes.

Source: Republic of Kenya, *Adolescent Reproductive Health and Development Policy* (Nairobi, Kenya: National Council for Population and Development, Ministry of Planning and National Development and Division of Reproductive Health, Ministry of Health, 2003).

**Table 2: ARHD Policy Targets**

<b>Health Targets</b>	I. To double the contraceptive use rate among adolescents (ages 15-19 years) from 4 percent in 1998 to 8 percent in 2015; and among youth (20-24 years) from 19.9 percent to 40 percent.
	II. To increase the proportion of facilities offering basic essential obstetric care to adolescents and youth from 15 percent to 30 percent; and comprehensive essential obstetric care from 9 percent to 18 percent by the year 2015.
	III. To increase the proportion of facilities offering youth-friendly services from baseline to 85 percent by 2015.
	IV. To increase the proportion of mothers below age 25 receiving at least two doses of tetanus toxoid during pregnancy from 25 percent to 85 percent by 2015.
	V. To increase antenatal attendance by mothers below age 25 from the baseline to 85 percent by 2015.
	VI. To increase the proportion of mothers below age 25 delivering in a health facility from baseline to 60 percent by 2015.
	VII. To increase the minimum antenatal care visits by mothers below age 25 from baseline to 80 percent by 2015.
<b>Demographic Targets</b>	I. To reduce the proportion of women below age 20 with a first birth from 45 percent in 1998 to 22 percent by the year 2015.
	II. To raise the median age at first sexual intercourse from 16.7 for girls and 16.8 for boys to 18 for both by 2015.
	III. To reduce the maternal mortality ratio by 50 percent in the 15-24 age group by 2015.
<b>Social Service Targets</b>	I. To achieve universal primary education by 2003 and education for all by 2015.
	II. To achieve gender equity in education by 2015.

Source: Republic of Kenya, *Adolescent Reproductive Health and Development Policy* (Nairobi, Kenya: National Council for Population and Development, Ministry of Planning and National Development and Division of Reproductive Health, Ministry of Health, 2003).

## POLICY IMPLEMENTATION PLANS

The policy includes implementation strategies to address the priority concerns, including: advocacy, behavior change communication, provision of reproductive health services, research, capacity building, resource mobilization, networking and community participation, and monitoring and evaluation (M&E).

A multisectoral approach for implementation is recommended, and the roles of various stakeholders are outlined. The Ministry of Health (MOH) and the Ministry of Planning for National Development and Vision 2030, specifically NCPD, are designated as the lead agencies responsible for co-implementation.<sup>2</sup> The MOH is responsible for the coordination and implementation of all health activities and programs, and NCPD is mandated to coordinate population and development activities.<sup>3</sup>

Other government agencies and stakeholders called upon for policy implementation include:

- Office of the President.
- Ministry of Home Affairs and National Heritage.
- Ministry of Gender, Sports, Culture, and Social Services.<sup>4</sup>
- Ministry of Justice and Constitutional Affairs and the State Law Office.
- Ministry of Education, Science, and Technology.
- Ministry of Tourism and Information.
- Ministry of Environment, Natural Resources, and Wildlife.
- Ministry of Agriculture and Livestock Development.<sup>5</sup>
- Ministry of Labour and Human Resource Development.
- NGOs, Community-Based Organizations, and the Private Sector.
- Religious Institutions.
- Family and Community.
- Mass Media.
- Young People.
- Political Parties.
- Universities and Colleges.

## ARHD POLICY PLAN OF ACTION 2005-2015

The ARHD Policy Plan of Action 2005-2015 (POA) was developed in 2005 by NCPD and the MOH to facilitate the implementation of the policy through a national multisectoral approach.<sup>8</sup> The objectives of the POA are to:

- Spell out strategies of implementation.
- Identify priority activities and major implementers of the national ARHD program up to 2015, based on the stipulations of the policy.
- Provide an avenue and basis for resource mobilization and management of a sustainable national ARHD program.
- Outline a logical framework for implementing the policy that will also be used for monitoring and evaluation purposes.

Four strategic areas are identified in the POA: advocacy; health awareness and behavior change communication; access to and utilization of sustainable youth-friendly services; and management of implementation by national coordinating agencies.

A logical framework details all the outcomes, outputs, and lead activities with the verifiable indicators, sources of verification, and responsible parties. An M&E framework is also included in the POA

to be implemented through the ASRH Technical Working Group (TWG) under the direction of NCPD and DRH. The POA recommends regular monitoring of program performance and outcomes and includes an M&E plan and calendar.

The POA provides an estimate of the total resources required to achieve the goal and objectives outlined in the policy. The cost estimates cover the first five years (2005–2010) of implementation. These costs are based on an ideal situation and standard costing models rather than past and ongoing programmatic experiences. Realistic estimates for the second half (2010–2015) are to be determined on the basis of the experiences from the first half.<sup>6</sup>

## ARHD OVER THE LAST DECADE

Ten years since the policy was developed, Kenya has witnessed tremendous advancements and changes in the social, economic, and political environment for ARHD.<sup>7</sup> The policy has helped lay the groundwork for several policies, strategies, and guidelines that emerged over the last decade, such as the examples listed below. All of these initiatives reinforce the importance of reproductive health for adolescents and youth.

- National Guidelines for Provision of Youth-Friendly Services, 2005
- Kenya HIV & AIDS Prevention and Control Act, 2006
- Sexual Offences Act, 2006
- Ministry of Youth Affairs and Sports (MOYAS) Service Delivery Charter, 2007
- Gender Policy in Education, 2007
- National Youth Policy, 2007
- National Reproductive Health Policy: Enhancing Reproductive Health Status for All Kenyans, 2007
- Kenya Vision 2030, most notably the First Medium Term Plan, 2008-2012
- Ministry of Youth Affairs and Sports Strategic Plan, 2008-2012
- National Reproductive Health Strategy, 2009-2015
- Reproductive Health Communication Strategy, 2010-2012
- The Constitution of Kenya, 2010
- Kenya Health Sector Strategic Plan III, 2012-2017
- Population Policy for National Development, 2012-2030

Both the government and the private sector have increased efforts to address the reproductive health and development needs of adolescents and youth. The government has identified key priorities for ASRH programs and is working with a range of partners to establish high-quality care, provide comprehensive and integrated youth-friendly reproductive health services, promote a multisectoral approach to ASRH, and strengthen partnerships and referrals with NGOs and faith-based organizations, especially in hard to reach areas. Youth-friendly SRH services are being provided in youth centers that were established in the constituencies, and adolescent sexual education is being implemented under a life-skills training curriculum.<sup>8</sup>

A broad range of ARHD programs for adolescents and youth either have been or are currently being implemented throughout the nation by the government, international NGOs, and CSOs, including some faith-based organizations.<sup>9</sup> Some projects are focused explicitly on ASRH service delivery, advocacy, education, research, or peer counseling, while others have a more integrated approach with crosscutting health or development initiatives.<sup>10</sup>

Other programs are focused on broader adolescent development priorities, such as education, other health initiatives, and job preparedness. For example, some programs connect adolescents to various

career opportunities to enhance capacity for income generation. By building a strong economic base, these programs have sought to reverse poverty and ensure that adolescents have a better chance for productive and healthier lives by addressing factors associated with risky behaviors or outcomes.<sup>11</sup>

As called for in the POA, an ASRH TWG was created in 2007 under the direction of DRH and NCPD. The ASRH TWG is comprised of program implementers from various government agencies and NGOs, and meets quarterly to coordinate efforts focused on ASRH program implementation and research, and to share progress and lessons learned.

There have been some notable improvements in several ARHD indicators over the last decade. For example, from 2003 to 2009, the median age at marriage for women in most provinces increased, and teenage pregnancy and childbearing among young women declined. The median number of years of schooling has increased slightly for both men and women, and the proportion of children and young adults who have never attended school has decreased. Additionally HIV prevalence among both women and men ages 20 to 24 has decreased from 6 percent in 2003, to 5.2 in 2007, and to 4.2 in 2009.<sup>12</sup>

However, there continues to be a high need for improved ASRH. For example, more than one out of four young women is married by age 18, increasing their likelihood of having children at an early age. Nearly one-half of births to young women under age 18 are the result of unintended pregnancy. Nearly one out of three young women has an unmet need for family planning, meaning they wish to delay childbearing, but are not using any method of contraception, and are at risk for having an unintended pregnancy. Furthermore, among youth ages 15 to 19 who had sexual intercourse in the last 12 months, nearly 60 percent of young women and nearly 100 percent of young men engaged in higher-risk sex, meaning they had sexual intercourse with a partner who was neither their spouse nor lived with them. Among these youth ages 15 to 19 who had higher-risk sexual intercourse in the last 12 months, only 40 percent of the young women and 55 percent of the young men used a condom during their last higher-risk intercourse.<sup>13</sup> A longer list of ASRH indicators from the 2008-09 Kenya Demographic and Health Survey is presented Table 3.

<b>Table 3: Kenya Adolescent Sexual and Reproductive Health</b>	<b>Percent</b>
Women ages 20-24 married by age 18	26
Women ages 20-24 who had sex by age 18	48
Men ages 20-24 who had sex by age 18	58
Women under age 20 whose most recent birth was an unintended pregnancy	47
Women under age 20 whose most recent birth was not delivered by a skilled attendant	52
Women ages 20-24 who gave birth by age 18	26
Women ages 20-24 with an unmet need for family planning	30
Women ages 20-24 living with HIV	6
Men ages 20-24 living with HIV	2
Sexually active women ages 15-19 who had higher-risk sex in last 12 months	56
Sexually active men ages 15-19 who had higher-risk sex in last 12 months	98

Source: Kenya Demographic and Health Survey 2008-2009 (Calverton, MD: Kenya National Bureau of Statistics and ICF Macro, 2010).

## ASSESSMENT PURPOSE

Given the increase in the number of stakeholders and programs focused on ARHD over the last decade, and with two years before the end of the ARHD Policy timeframe, stakeholders recognize the need to assess implementation of the policy. This policy assessment sought to: explore the nature of policy implementation since 2003; look at implementation progress and achievements; identify social, political, and economic barriers to implementation; and promote policy dialogue on ways to strengthen implementation. As a result, NCPD, DRH, and PRB's IDEA project conducted an assessment of the policy from November 2011 to September 2012.

The findings of the assessment will be used to inform stakeholders about policy implementation so lessons learned can be applied to the remaining implementation of this policy and other policies in Kenya. The findings will also be used to revise the policy in the coming years.

# METHODOLOGY

As a first step, NCPD, DRH, and PRB invited a core group of reproductive health professionals and youth advocates from the public and private sectors to join a task force that met in November 2011 and January 2012 to design the assessment methodology and tools. The Health Policy Initiative's 2010 Policy Implementation Assessment Tool (PIAT) was adapted by the partners and task force members for this assessment. The PIAT gathers information about the dynamic and multifaceted process of policy implementation, and the process by which a policy is carried out to achieve its goals.<sup>15</sup>

The PIAT is comprised of interview guides that gather quantitative rankings using Likert-like scales and qualitative information based on the participants' experiences.<sup>16</sup> The interview guides address seven dimensions of policy implementation, including: (1) the goals of the policy, its formulation, and dissemination; (2) social, political, and economic context; (3) leadership for policy implementation; (4) stakeholder involvement in policy implementation; (5) implementation planning and resource mobilization; (6) operations and services; and (7) feedback on progress and results.<sup>17</sup> The interview guides were adapted by the assessment partners and task force to focus specifically on the ARHD Policy; to use language appropriate for the study participants; and to prioritize social, economic, and political factors identified as most appropriate for the Kenya context.

From March through June 2012, a core research team collected qualitative data from 195 participants. Individual interviews were conducted with 22 policymakers and 68 implementers. Fourteen focus group discussions (FGDs) were held with 30 service providers, 34 teachers, and 41 youth age 18 or older. Unless observations are noted between the groups, in this report the policymakers and implementers are collectively referred to as "key informants" and the service providers, teachers, and youth are collectively referred to as "FGD participants."

The partners and task force members selected policymakers and implementers to participate in key informant interviews if they were at least partially familiar, if not very knowledgeable, with the policy and its implementation. Service providers, teachers, and youth ages 18 or older were selected for FGDs because the partners and task force members recognize these groups as key stakeholders for policy implementation, and preferred to gather qualitative information from them through in-depth group discussions.

Interviews were conducted in Nairobi, Thika, Kisumu, Wajir, and Watamu. Based on discussions with the task force and previous research, the partners selected these locations to gather data from areas representing districts where ARHD services are widely available and ASRH indicators are best (Nairobi, Thika, and Kisumu), and where ARHD services are not widely available and ASRH indicators are worst (Wajir and Watamu).

## **Analysis of Key Informant Interviews With Policymakers and Implementers**

Once the data collection was complete, the core research team tallied and reviewed the Likert-like scaled responses. The research team reviewed the transcripts to identify themes that summarized



the open-ended responses, and counted the number of times a theme was mentioned for each response. The themes were ranked according to frequency for each question, and compared between policymakers and implementers. Although policymaker and implementer responses were coded as separate groups, the team used the same themes for each group to the extent possible.

### **Analysis of Focus Group Discussions With Service Providers, Teachers, and Youth**

The team reviewed the transcripts for each group by region to create key themes that summarized the responses, and compared the responses by group and region. Although each group and region was coded separately, the team used the same themes for each group to the extent possible.

### **Challenges and Limitations**

In most of the regions visited, policy awareness was mainly at the provincial level, and the policy was not well-known beyond this, especially in more rural areas. This made it challenging to identify assessment participants, especially for FGDs in the regions. The policy was also not well-known among implementing agencies and government agencies with high turnover of personnel. Another challenge was finding policymakers who were familiar with the policy and available to participate, resulting in a low number of policymaker participants.

The policy has contributed to an enabling environment for ASRH, and many adolescent and youth programs were initiated after the policy was developed. The core research team noted that during the interviews, it was sometimes difficult to distinguish between participant accounts of policy implementation versus program implementation. For example, some participants may have referred to program implementation when asked about barriers or successes regarding policy implementation. Therefore in this assessment, participant descriptions of policy versus program implementation may sometimes be indistinguishable.

The core research team noted that some participants did not distinguish between adolescents and youth, and the terms “adolescent,” “youth,” or “young person” were sometimes referred to interchangeably.

The findings of this assessment are the perceptions and beliefs of the key informant interviews and FGD participants. Therefore, the participants’ perceptions of ARHD in Kenya and what is included or not included in the policy may not reflect the actual content of the policy, or what other analyses have revealed about ARHD in Kenya.

### **Recommendation Development**

The core research team and assessment partners met several times after the analysis to review the key findings and develop recommendations to go forward. The assessment partners presented the key findings and draft recommendations to an audience of task force members and multisectoral stakeholders in Nairobi on September 20, 2012. The key findings and recommendations were discussed by meeting attendees, and feedback was provided for the recommendations before they were finalized for this report.

# KEY FINDINGS

The key findings are presented in sections representing the PIAT's seven key dimensions of policy implementation, in addition to an overall assessment of policy implementation. A summary of the findings is provided at the beginning of each section.

## SECTION 1

### POLICY FORMULATION, CONTENT, AND DISSEMINATION

Policy formulation, content, and dissemination lay the groundwork for successful policy implementation. The first section of the interview guides assessed the process of policy formulation, policy content, and the extent of policy dissemination to various stakeholders, implementers, and beneficiaries.

#### SUMMARY OF POLICY FORMULATION, CONTENT, AND DISSEMINATION

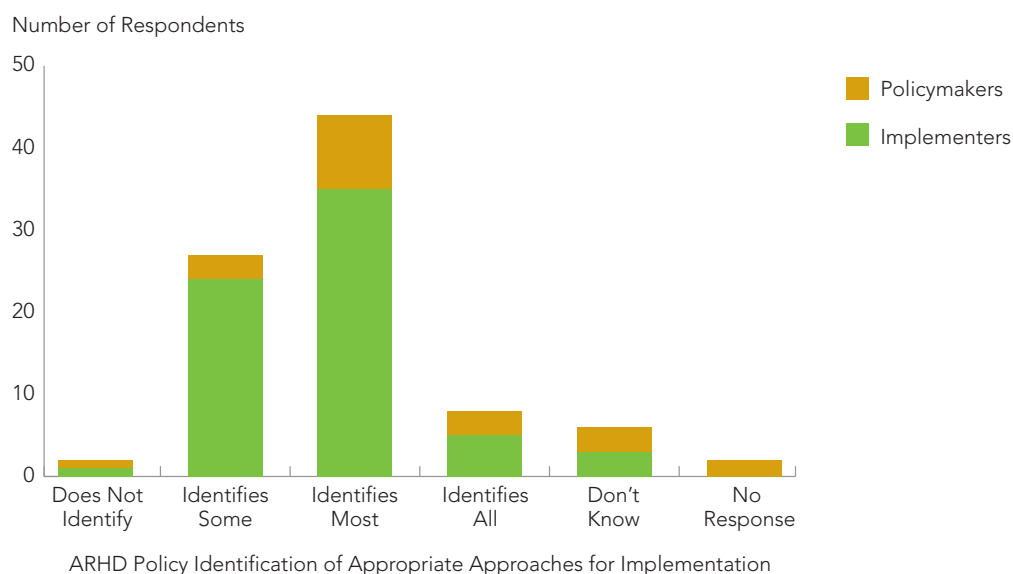
- The policy goal and objectives are achievable within the policy timeframe, but they are missing some of the key ARHD issues in Kenya.
- The identification of implementation strategies and resources are limited in the policy.
- Stakeholders were involved with policy formulation, but their level of participation during policy formulation was limited.
- Dissemination of the policy was limited, especially in areas outside of Nairobi, among implementers at the subnational level, institutions with high turnover, and policymakers.

All policy assessment participants were shown the policy goal and objectives during the interview. A majority of key informants, including policymakers and implementers, think the policy goal and all of the objectives are achievable within the timeframe established by the policy.

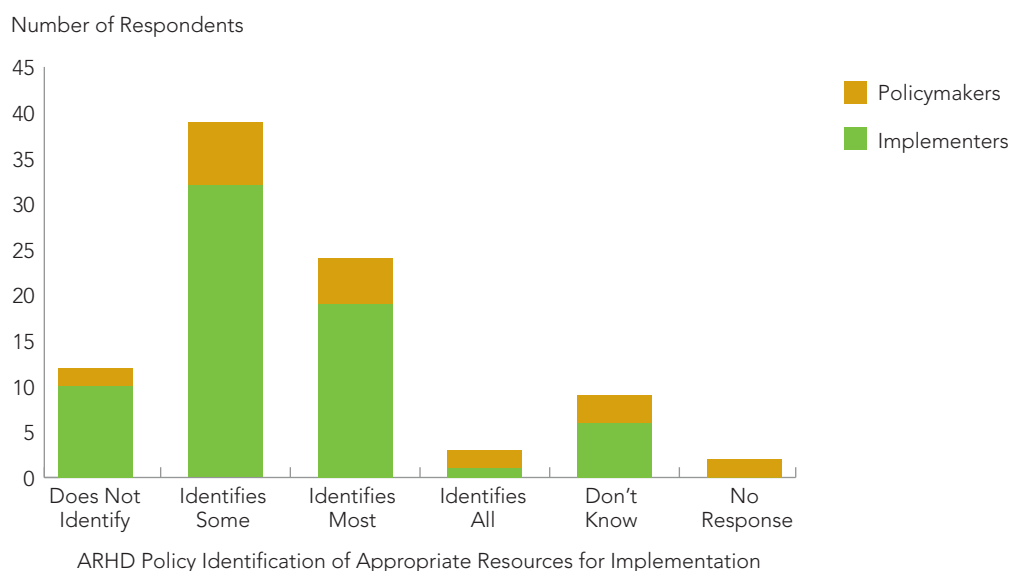
However, most policymakers and implementers (72 out of 89 key informants; 81 percent) also think the policy goal and objectives are missing some or most of the key ARHD issues in Kenya. The key issues mentioned most frequently as missing by both key informants and FGD participants include: a policy implementation framework, guidance for coordination among implementing government agencies and organizations, and resource mobilization plans. Participants also noted that the policy is missing information about religious and cultural barriers for implementation, poverty and socioeconomic challenges, barriers for youth to access ARHD information and services, and the diverse needs of vulnerable youth, including those with special needs.

The identification of appropriate implementation approaches and resources are limited in the policy. As presented in Figure 1, policymakers and implementers were most likely to report that the policy identifies most appropriate approaches for implementation, but only eight out of 89 policymakers and implementers (9 percent of key informants) think the policy identifies all appropriate approaches for implementation. In Figure 2, only three out of 89 policymakers and implementers (3 percent of key informants) think the policy identified all of the resources required for implementation.

**Figure 1: The Extent of Identification of Appropriate Approaches for ARHD Policy Implementation**



**Figure 2: The Extent of Identification of Appropriate Resources for ARHD Policy Implementation**

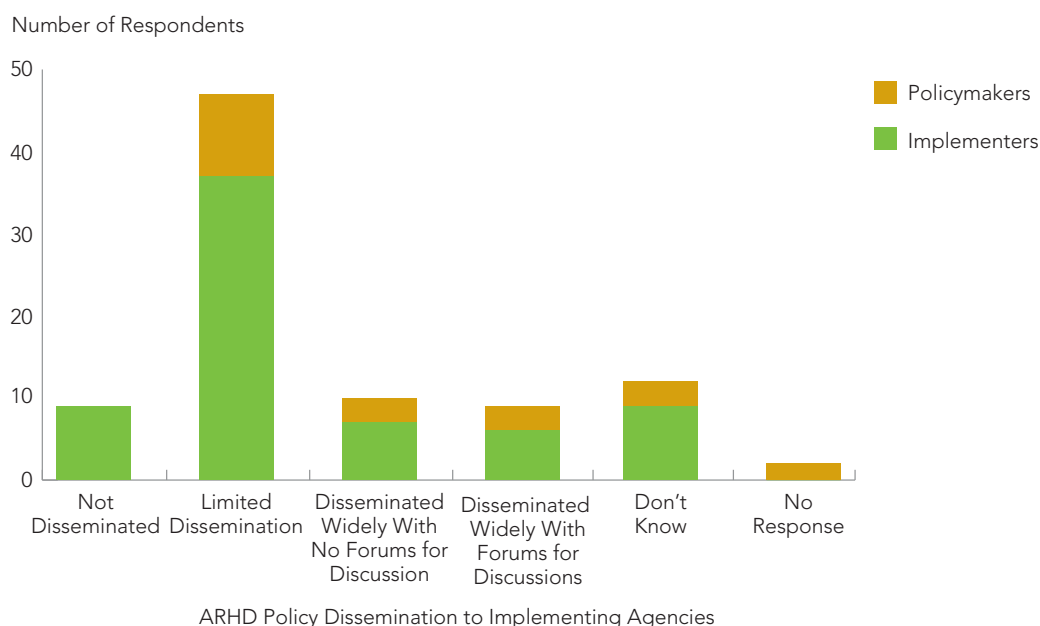


During the process of formulating the policy, nearly half of policymakers and implementers (40 out of 89 key informants; 45 percent) think there was only limited or moderate involvement of stakeholders. Eleven out of 89 policymakers and implementers (12 percent of key informants) think there was extensive involvement of various stakeholders.

Interviews with policymakers and implementers and FGDs revealed that dissemination of the policy was limited. As presented in Figure 3, policymakers and implementers were most likely to think policy dissemination was limited (47 out of 89 key informants; 53 percent). Twenty-one percent of policymakers and implementers (19 out of 89 key informants) think the policy was disseminated widely, but only 10 percent (9 out of 89 key informants) think the broad dissemination included forums for discussions about how to put the policy into practice.

The core research team also observed limited policy knowledge and lack of policy dissemination during the process of identifying assessment participants. It was especially challenging to identify participants familiar with the policy in areas outside of Nairobi, among implementers at the subnational level, among institutions with high turnover, and among policymakers.

**Figure 3: The Extent of ARHD Policy Dissemination to Implementing Agencies**



## SECTION 2

### SOCIAL, POLITICAL, AND ECONOMIC CONTEXT

Implementers and FGD participants identified the social, political, and economic factors that help facilitate policy implementation, and the factors that have a detrimental effect. Depending on the context, several factors have both positive and negative influences on policy implementation.

#### SUMMARY OF SOCIAL, POLITICAL, AND ECONOMIC CONTEXT

- International agreements facilitate implementation by establishing goals and guidelines that align with the policy, such as the MDGs.
- Global assistance and donor support help to facilitate implementation by mobilizing support and providing guidance. Global assistance or donor priorities can have a hindering effect when: there is not enough financial support; donor priorities change and projects are discontinued as a result; efforts are duplicated due to lack of coordination; there is donor dependence; and a donor's priorities are not aligned with priorities at the local level.
- Devolution and county governments may help to facilitate implementation by expanding implementation in rural areas, bringing resources and ownership to the local level, and increasing engagement at the local level. Accountability and good leadership are essential, otherwise devolution can hinder implementation.
- Changes in government have helped facilitate policy implementation over time, but only when the new leaders have been supportive of ARHD, and when changes do not happen too frequently.
- The policy environment may facilitate implementation, but only when policies and programs are aligned with similar goals, and partners work together.
- Prioritization of poverty alleviation facilitates implementation because it increases the availability of services for low-income adolescents who are most in need of ARHD information and care.
- Cultural practices and gender norms can hinder implementation because the influence they have on behavioral expectations for men and women are often not aligned with policy objectives.
- Religious practices and beliefs frequently hinder implementation because of opposition to life skills education, specifically comprehensive sex education, and access to ASRH services. However, sometimes they facilitate implementation by encouraging adolescents to abstain from sex, or fostering life skills education.

### SUMMARY OF SOCIAL, POLITICAL, AND ECONOMIC CONTEXT *(continued)*

- Migration hinders implementation when it is more difficult to reach people with services because either the providers or the clients are constantly moving. Migration facilitates implementation when the providers or the clients move to an area where it is more beneficial or easier to provide ARHD services.
- Poverty and unemployment hinder implementation because they increase the risk of school drop-out, engaging in risky behaviors, and other barriers to ASRH information and services.

## FACTORS THAT FACILITATE POLICY IMPLEMENTATION

A majority of implementers believe these factors *facilitate* policy implementation: international agreements; global assistance mechanisms and donor priorities; devolution and county governments; changes in government; policy environment; and prioritization of poverty alleviation.

The FGDs with service providers, teachers, and youth provided more detail regarding factors that facilitate policy implementation. According to the FGD participants, some of these factors may facilitate or hinder implementation depending on the context.

### International Agreements Facilitate Implementation

The FGD participants, especially teachers, generally agreed that international agreements facilitate policy implementation by establishing goals and guidelines that tend to align with the policy, such as the MDGs for universal education, poverty reduction, human rights, and others. However, the participants note that awareness of these international agreements and goals is more common at the national level, and it is lacking at the county levels.

According to the youth, international agreements put pressure on the government to be more accountable to the public regarding the commitments they sign. International agreements also help set standards for ARHD service provision.

### Global Assistance Mechanisms and Donor Priorities Facilitate Implementation in Certain Circumstances

According to the FGD participants, global assistance and donor support for ARHD help facilitate policy implementation. Global assistance is often goal-oriented, and this helps mobilize support and provide guidance for policy implementation. For example, the targets set by the MDGs help mobilize support for their achievement.

Youth had a favorable view of global assistance and donor priorities, because they believe most policy implementation is being done by NGOs with donor support, and implementation would be minimal without it. In Watamu, the youth noted that donors provide materials that would otherwise be unavailable.

Global assistance or donor priorities can have a hindering effect when there is not enough financial support, when donor priorities change and projects are discontinued as a result, when there are duplicated efforts due to lack of coordination, or when there is dependence on donors for financial support and no sustainability.

In Nairobi, teachers noted the importance of donor accountability. Financial support from donors can have a facilitating effect on policy implementation when there is reporting from the implementer to the donor. However, if there is no accountability, then the money may be misused and the donor support will discontinue. For example, in Wajir, teachers discussed the misappropriation of funds for free primary education that resulted in donor withdrawal.

Also problematic is when there is a lack of alignment between a donor's priorities and priorities at the local level. For example:

“They (donors) come with fixed mind that this thing should be done the way they want, but they really do not understand the context. Whatever they are doing can hinder whatever the program is intended for. So if our policies are not in line with what they want you'll find that it will hinder it...” *A teacher in Kisumu*

### **Devolved Structure of Government Is an Opportunity to Ensure Effective Implementation**

According to FGD participants, decentralization will facilitate policy implementation, but only if there are accountability measures. Service providers stressed the importance of accountability for the allocation and use of funds at the county level. Without accountability, decentralized resources may result in the misallocation or misuse of funds.

Teachers noted that devolution will help expand ARHD services to rural areas, and bring resources and services closer to the people at the county level. However, they also discussed the potential hindering effect of devolution in situations where there is lack of leadership at the county level, where the priorities of the new local governments are not aligned with the policy, and when changes in the structure of the new government disrupt or slow ARHD policy initiatives.

The youth discussed the benefits of devolution on policy implementation, including new youth representatives in county governments, and new youth forums through which more youth will learn about their rights and services. This youth engagement will lead to more awareness and empowerment among adolescents and youth, which will result in an increased demand for and access to information and services.

### **Changes in Government Facilitate Implementation in Certain Circumstances**

Some FGD participants think changes in government have helped facilitate policy implementation over time, but only when the new leaders have been supportive of ARHD. Service providers in Nairobi noted positive changes in government because leaders have signed international agreements that are committed to youth development.

Other FGD participants, especially teachers, noted that when leaders are not aligned with the goals of the policy, or when changes in leadership happen too frequently, then there is a detrimental effect on policy implementation. New leaders come with new priorities and policies, and this often leads to fragmented or discontinued projects:

“I think sometimes when there is change in government, offices change, and management change, so whenever there is a project like this, other people come in and undermine, so some things get lost in between because people change hands, and it slows down the implementation of such projects.” *A teacher in Nairobi*

### **Aligned Policies Facilitate Implementation More Than Policies That Stand Alone**

Opinions about the influence of the current policy environment on policy implementation varied among the FGD groups. According to FGD participants, the policy environment can facilitate policy implementation, but only when policies and programs are aligned with similar goals, and partners work together. Some participants noted there are lots of policies, and when policies are not aligned, the effect can be detrimental.

Compared to the other groups, service providers were most likely to discuss the hindering effect of the policy environment because they think there are too many policies, and the policies often contradict each other, which makes implementation a challenge. In comparison to other districts, Watamu

participants were most likely to think the policy environment hinders implementation because of conflicting policies. For example, teachers mentioned the conflicting goals of the ARHD Policy compared to other policies that do not mention or prioritize life skills education in schools. According to youth in Nairobi, ASRH is often neglected because there are too many policies focused on other issues that are prioritized over reproductive health.

### **Prioritization of Poverty Alleviation Facilitates Implementation**

The FGD participants generally agreed that prioritization of poverty alleviation has facilitated policy implementation because it increases the availability of services for low-income adolescents who are most in need of ARHD information and care. Some policy initiatives have made it easier for low-income youth to access a range of health care services, and stay in school. For example, in Watamu, the provision of meals in schools has helped increase school enrollment for low-income students. A focus on poverty alleviation also contributes to economic empowerment of youth, which helps reduce some risky behaviors associated with poverty, such as sex in exchange for money.

## **FACTORS THAT HINDER POLICY IMPLEMENTATION**

A majority of implementers believe these factors *hinder* policy implementation: cultural practices and gender norms; religious practices or beliefs; migration; and poverty and unemployment.

The FGDs with service providers, teachers, and youth provided more detail regarding factors that hinder policy implementation. According to the FGD participants, some of these factors may hinder or facilitate implementation depending on the context.

### **Cultural Practices and Gender Norms Hinder Implementation**

Most FGD participants agree that cultural practices and gender norms frequently hinder implementation because the influence they can have on behavioral expectations for men and women are often not aligned with the policy objectives. According to service providers, cultural practices and gender norms often diminish women's decisionmaking power, teach women to be submissive to men and male sexual desires, and prevent women from seeking health care without a man's permission or presence. Cultural practices sometimes interfere with legal rights when traditional practices are employed to handle situations such as rape.

In Wajir, women are often perceived to have lower social status than men, and men are sometimes hesitant to seek medical care or guidance from female service providers:

“Gender hinders the implementation of the policy, women are not allowed to speak to strangers even if they are visiting health care facilities. They are expected to disclose their health issues/problems to men, who should explain her health issue to the health care provider.” *A service provider in Wajir*

According to teachers, some cultural practices and gender norms restrict communication between girls and boys, and between girls and male teachers, especially in regard to ASRH topics. Additionally, cultural practices and gender norms can restrict empowerment of women and infringe on the rights of the girl child by promoting preferential treatment for boys. Some sociocultural and religious practices condone sexual discrimination and harmful practices against girls and young women, including female genital mutilation/cutting (FGM/C), early marriage, and forced marriage after pregnancy.

According to youth, boys and men, and girls and women, are expected to have different roles in society which can pose challenges for policy implementation. Women are expected to play a secondary, submissive role to men where sexual matters are concerned, and men are expected to be

macho and to be the seducer. These expectations can put pressure on both young men and women to engage in risky behaviors. Boys feel pressure to pursue sex and put themselves at risk:

“For boys, we are the ones who are supposed to seduce a girl....when a girl decides to do such a thing it would be abominable. In that way I think the boys have become vulnerable to diseases like HIV/AIDS because now as a boy you are supposed to be brave, and do all that is associated with being macho. Now the boy becomes vulnerable to sexually transmitted diseases....” *A youth in Watamu*

Young women may not carry condoms for fear of being considered a sex worker:

“Let’s just be real, when a man is found with condoms, we all think he is a real man and knows how to protect himself. But what if you found the same with a lady, people just think you are a prostitute and that’s it.” *A youth in Nairobi*

For young men, widow inheritance is a cultural practice that has consequences:

“[Cultural practices] hinder because in some communities when you are born you are given a husband if you are a girl, for example the Maasai, and you are not allowed to marry anyone else. When a man dies his brother or close relative can inherit his wife and you don’t know what killed the man. Cultural beliefs allow you to inherit your brother’s wife.... For example [I] am a brother to someone who has died. Culture allows me to inherit his wife without finding out what killed my brother. I will also get infected.” *A youth in Kisumu*

## The Impact of Religious Practices and Beliefs on Implementation Depends on the Context

In some circumstances, religious practices and beliefs hinder policy implementation, and in other circumstances, they have a positive influence. According to service providers and teachers, religious beliefs can have a hindering effect because they often oppose any open discussions about sex. In all districts, teachers noted that religious practices do not encourage, and sometimes even forbid, parent-child communication about ASRH. Some parents will not allow their children to participate in ASRH education or other initiatives because it is against their faith. This means life skills education, specifically comprehensive sex education, is unacceptable at home or in school, especially when it addresses issues pertaining to sex outside of marriage:

“Addressing issues of sex among the Muslims is prohibited. It is talked about in a secretive way so they cannot go around to be told such things. It’s an issue that is not talked about openly.” *A teacher in Watamu*

Policy implementation is also hindered by religious opposition to contraception. In Nairobi, service providers discussed a fear of contraceptives among Catholics, because some believe that a woman can sin by using contraceptives.

The youth also discussed religious opposition to family planning and life skills education, especially as it pertains to adolescent access to contraceptives. Some religions are opposed to anyone seeking health care outside of a faith-based health institution, which makes it difficult for adolescents to access ASRH information and services. The youth also noted that religious practices often separate boys from girls during activities, which inhibits open discussion between the sexes about ARHD.

FGD participants also discussed the positive effect of religious beliefs and practices on policy implementation. According to service providers and teachers, religious practices and beliefs can help



facilitate policy implementation by encouraging youth to abstain from sex until they are older or married. This helps adolescents and youth avoid risky sexual behaviors, and prevent STIs, including HIV. Furthermore, some religious groups do allow or encourage discussions about reproductive health.

### Migration May Hinder Implementation in Certain Circumstances

Migration was discussed in many different contexts, but was most often seen as a hindrance for policy implementation among the FGD groups. In the context of migration among nomadic people or rural/urban migration, it is harder to reach a population with information and services when they are constantly moving, and it is harder for people in transition to access care because they do not know what information and services are available. Migration was also mentioned as a challenge in the context of training health care workers or program implementers who then move to a different location and do not serve the area where they were trained.

However, some participants noted that migration can be beneficial when adolescents or youth move from an area with no ARHD services to a new location where ARHD services are available. Migration can also be beneficial when program implementers or service providers move to areas where there is a greater need for the services they provide.

### Poverty and Unemployment Hinder Implementation

According to FGD participants, poverty and unemployment hinder policy implementation. This is because poverty and unemployment increase the likelihood of engaging in risky behaviors. Low-income youth are more likely to drop out of school, or engage in unprotected sex or sex work. Poverty also makes it difficult for youth to access health care services because of cost barriers. In addition to contributing to poverty, unemployment is believed to lead to idleness, which increases the likelihood of engaging in risky behaviors, such as crime or drug use.

## SECTION 3

## LEADERSHIP FOR POLICY IMPLEMENTATION

Leadership is essential to ensure policy awareness, commitment, coordination, and accountability. This section of the interview guide asked participants about the commitment and opposition from leaders for policy implementation.

### SUMMARY OF LEADERSHIP FOR POLICY IMPLEMENTATION

- There is limited support from influential leaders or institutions for policy implementation.
- Opposition to the policy is perceived to be low.
- There is lack of clarity regarding which government agency/institution is responsible for leading policy implementation.

### Policy Support and Opposition

Implementers and policymakers were most likely to acknowledge limited support from influential leaders or institutions for policy implementation (35 out of 89 key informants; 39 percent). Only 10 out of 89 implementers and policymakers (11 percent of key informants) think there is widespread financial or goodwill support among leaders for policy implementation.

Opposition to the policy is perceived to be low, and 33 percent of key informants (29 out of 89 key informants) think there is no opposition from influential leaders or institutions to implement the policy. FGD participants think opposition to the policy is mainly the result of religious opposition to ASRH,

specifically in regard to providing life skills education in schools and adolescent access to contraceptives. There was also concern about leaders who continue to stigmatize people living with HIV, including youth living with HIV, and leaders who do not speak out against FGM/C, therefore condoning the practice and inhibiting policy implementation:

“Religion, culture, and beliefs are all mixed up on issues affecting adolescent health. It would be necessary for these issues to be identified and explained clearly to the community before implementing adolescent health programs.” *A service provider in Wajir*

### Leadership for Policy Implementation

Lack of clarity exists regarding which institution is responsible for leading policy implementation. When asked which institution is currently responsible for leading implementation of the policy, responses varied and many key informants mentioned multiple implementers. The most frequently noted institutions were the Ministry of Health (including DRH), followed by NCPD, MOYAS, the Ministry of Gender and Children Affairs, and the Ministry of Education. Key informants also referenced development partners, such as USAID and their cooperating agencies, and a few people referred to religious leaders. Overall, 45 percent of policymakers and implementers (40 out of 89 key informants) ranked leadership for policy implementation as “somewhat effective.”

## SECTION 4

### STAKEHOLDER AND YOUTH INVOLVEMENT IN POLICY IMPLEMENTATION

The policy called for wide multisectoral involvement in implementation, especially among government agencies, and included some detail on the responsibilities of various agencies and stakeholders. According to the PIAT, stakeholders are defined as “groups or individuals responsible for implementation, people who may be positively or negatively affected by the policy’s implementation (or lack of implementation), and officials and professionals accountable for achieving policy goals.” Participation of stakeholders can be influenced by many factors. This section of the interview guide assessed the participants’ perceptions of stakeholder engagement and participation in policy implementation.

#### SUMMARY OF STAKEHOLDER AND YOUTH INVOLVEMENT IN POLICY IMPLEMENTATION

- A wider range of NGO stakeholders are involved with policy implementation than multisectoral government agencies.
- Adolescent involvement with policy implementation is low.
- In comparison to youth in other districts, youth in Nairobi are more involved with policy implementation through peer education initiatives, but their level of mentorship is perceived to be low.

#### Stakeholder Involvement

Only 13 out of 89 policymakers and implementers (15 percent of key informants) think there is wide multisectoral involvement of different government agencies in policy implementation, but 43 percent of the key informants (38 out of 89 key informants) believe there is wide involvement of NGO stakeholders implementing the policy. In comparison to other districts, this recognition of wide involvement of NGO stakeholders was especially strong in Nairobi.

#### Adolescent and Youth Involvement

As presented in Figure 4, 46 percent of policymakers and implementers (41 out of 89 key informants) think the involvement of adolescents in policy implementation is limited. Most FGD participants

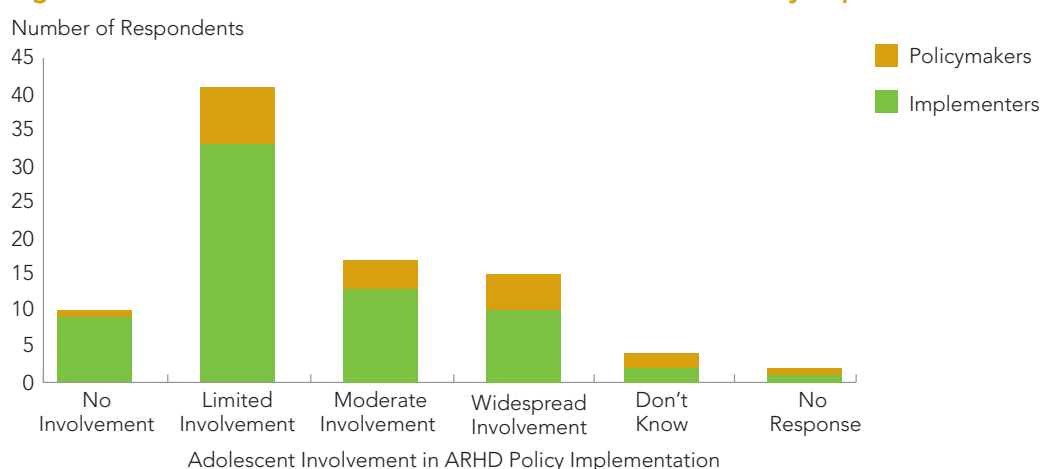
agree that adolescent involvement is limited, especially in Wajir where very few youth know the policy exists. However, some FGD participants discussed the importance of engaging adolescents:

“The extent [of adolescent involvement] is very minimal. This idea is coming up now.... Many adolescents are not aware that this policy even exists. Imagine that some of them do not even know their basic rights. I think that we need to strongly advocate for this policy and let as many adolescents as possible to know their rights.” *A teacher in Kisumu*

In comparison to other districts, youth in Nairobi are considered to be more involved with policy implementation through peer education initiatives, but their level of mentorship is perceived to be low:

“[We] find even the [youth] peer educators, they have no formal training, they just do their own research and gather information for themselves.” *A youth in Nairobi*

**Figure 4: The Extent of Adolescent Involvement in ARHD Policy Implementation**



## SECTION 5

### PLANNING FOR IMPLEMENTATION AND RESOURCE MOBILIZATION

Clear planning and sufficient resources are essential for effective policy implementation. The purpose of the ARHD Policy Plan of Action 2005-2015 (POA) is to provide a strategic and detailed plan for policy implementation. This section of the interview guide assessed the effectiveness of planning for implementation and resource mobilization, including the adequacy of capacity building for and preparedness of policy implementers, and the changes required of their organization.

#### SUMMARY OF PLANNING FOR IMPLEMENTATION AND RESOURCE MOBILIZATION

- Dissemination for the POA was not widespread, and was not ongoing. A majority of implementers are not familiar with it, especially outside of Nairobi.
- In addition the POA was criticized for being developed too long after the policy was developed, not including details for resource mobilization, and lacking widespread adoption among implementers.
- Nearly half of implementers think the policy has required moderate or substantial operational changes within their agency/organization.
- Many of the organizations are responding to these operational changes well, but approximately 25 percent of implementers are having difficulty adapting to the changes, and many implementers did not think their organization had received training for policy implementation.
- Most implementers receive funding from donors to implement the policy.
- Twenty-five percent of implementers believe their funding for policy implementation is insufficient.

### SUMMARY OF PLANNING FOR IMPLEMENTATION AND RESOURCE MOBILIZATION *(continued)*

- Almost half of the implementers have experienced problems accessing funds to implement this policy. The most frequently noted challenges for accessing funding pertained to the public sector.
- A minority of implementers have experienced problems expending funds to implement the policy.

## Implementation Planning

Dissemination for the POA was not widespread, and was not ongoing. More than half of implementers (34 out of 62 implementers; 55 percent) are not familiar with it, especially outside of Nairobi. Among the districts, Nairobi was the only area where a majority of implementers (19 out of 30 implementers; 63 percent) were familiar with the POA. There were no participants in any FGD who were familiar with the POA.

In addition to the limited dissemination, implementers criticized the POA for not being developed until two years after the policy was launched, not including details for resource mobilization, and lacking widespread adoption among implementers.

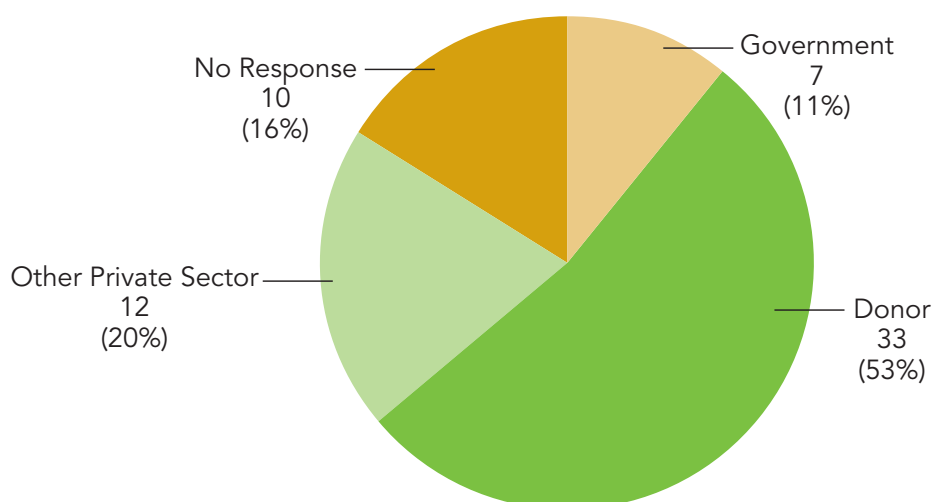
Forty-five percent of implementers (28 out of 62 implementers) think the policy has required moderate or substantial operational changes within their agency/organization. Many of the organizations (26 out of 62 implementers; 42 percent) are responding to these operational changes well or very well, but approximately 25 percent of implementers (16 out of 62 implementers) are having difficulty adapting to the changes required by the policy. Forty percent of implementers (25 out of 62 implementers) did not think their organization had received training for policy implementation.

When asked to describe areas for which training or capacity building is needed to implement the policy, service providers requested more training on policy implementation, including information about adolescent legal rights to reproductive health care, and how to: provide age-appropriate ASRH counseling and services and behavior change communication, provide services for youth living with disabilities, monitor policy implementation, and improve community outreach and engagement.

## Resource Mobilization

As presented in Figure 5, out of 62 implementers interviewed for this assessment, more than half (33 implementers; 53 percent) receive funding from donors to implement the policy, 12 implementers (19 percent of implementers) receive funding from a different private sector source, and only 7 implementers (11 percent of implementers) receive funding from government.

Figure 5: Source of Funding for ARHD Policy Implementers



One out of four implementers (16 out of 62 implementers; 26 percent) believes their funding for policy implementation is insufficient. Forty-two percent of the implementers (26 out of 62 implementers) have experienced problems in accessing funds to implement this policy.

Among implementers, the most frequently noted challenges for accessing funding to implement the policy pertained to the public sector. Implementers discussed insufficient resources for ASRH in the public sector in addition to disbursement delays and misappropriation of funds. Changes in donor funding mechanisms and donor priorities were also one of the most frequently mentioned challenges.

When asked how these funding challenges can be resolved, implementers called for more political will for ARHD, and improvements in resource mobilization, monitoring, and transparency of government funding for ARHD. Policymakers discussed the need for increased funding for ARHD through advocacy and more policy awareness, streamlined disbursement mechanisms, and ensuring supplies/commodities reach all ARHD institutions and communities. Policymakers also mentioned the need for clarity regarding the institutions in charge of policy implementation, and their responsibilities.

More than 10 percent of implementers (8 out of 62 implementers) have experienced problems expending funds to implement the policy. When asked how these problems could be resolved, implementers called for improved disbursement mechanisms, more funding, and work plans that reduce inefficiencies.

## SECTION 6

### OPERATIONS AND SERVICES

Efficient and effective service delivery is critical for policy implementation. This section of the interview guide assessed coordination among implementing agencies, and the flexibility they have to adapt the policy to respond to local needs. This section also asked participants about the positive outcomes and challenges associated with service delivery as a result of implementing the policy.

#### SUMMARY OF OPERATIONS AND SERVICES

- Very few implementers think coordination among policymakers, agencies, and organizations is effective. Implementers provided suggestions for a clear coordination framework.
- Overall, implementers feel they have flexibility to adapt policy implementation strategies and activities to respond to local needs.
- Most participants think there have been positive changes in the provision of ARHD information and services to adolescents under the policy.
- Although there have been many positive changes in service delivery as a result of implementing the policy, barriers still exist that affect access to youth-friendly ASRH services.
- The policy is not being implemented equitably to all adolescents in society, especially the hardest-to-reach and most vulnerable youth.

#### Coordination Among Policy Implementers

Only three out of 62 implementers (5 percent of implementers) think coordination among policymakers, agencies, and organizations is effective. Twenty-four percent of implementers (15 out of 62 implementers) think coordination is not effective.

According to the implementers, coordination could be improved if there was a clear framework that defined the responsibilities of implementing agencies, and required multisectoral collaboration among stakeholders. It would be ideal to have one lead agency responsible for overseeing coordination of the policy with resources available to monitor and evaluate implementation. The key informants noted that

coordination is important among stakeholders at the national and decentralized levels in both the public and private sectors. Coordination could be fostered through public and private partnerships, and joint consultative meetings or task forces that serve as platforms for sharing information.

The key informants also noted that coordination could be improved if ARHD were prioritized among more multisectoral stakeholders. This could be done through increased policy dissemination and advocacy to raise awareness and increase resources. Ideally, policy implementation would be clearly defined in the annual operating plans for implementing agencies, which would also make it easier to coordinate efforts.

Overall, implementers feel they have flexibility to adapt policy implementation strategies and activities to respond to local needs. Fourteen out of 62 implementers (23 percent of implementers) think they have “complete flexibility.”

In order to further improve the process of adapting policy implementation to respond to local needs, key informants suggested increasing policy dissemination and advocacy to engage more stakeholders at the local level, including youth, parents, religious leaders, and other community leaders. Key informants stressed the need to engage local-level stakeholders so there can be more of a “bottom-up” approach to policy implementation. Partnerships between central and local-level stakeholders are important for implementation, and help to ensure that: local needs are addressed through policy implementation, financial support is more readily available at lower levels, coordination is improved at all levels, and ARHD is mainstreamed into new and existing initiatives on the ground. Key informants also encouraged more research to have a better understanding of needs at the local level.

### Perceived Service Delivery Improvements

Most implementers (44 out of 62 implementers; 71 percent) think there have been positive changes in the provision of ARHD information and services to adolescents under the policy. The positive changes noted most frequently by implementers were: improved ASRH health outcomes; improved knowledge of and attitudes toward ASRH among providers, educators, and youth; strengthened partnerships between the government and NGOs/CSOs; improved empowerment of youth through more income-generating activities; more funding for ASRH.

According to many service providers, the number of youth-friendly service centers has increased, and so have positive attitudes about ASRH at the community level and among the youth. Service providers in Nairobi noted that youth have taken more responsibility for their health through youth support groups and peer education. In Wajir and Watamu, service providers have observed more positive attitudes about ARHD:

“[The biggest positive change is] change of attitude in the part of the service providers and adolescents. Before we would look down on the youth and even criticize them, but now there is change of attitude; there was no guideline on family planning back then, but now there are different types.” *A service provider in Watamu*

In regard to education, teachers in Kisumu have observed positive behavior change among adolescents after they were exposed to awareness campaigns and messages. In Wajir, teachers discussed improvements in hygiene among adolescents. In Watamu, teachers have noticed a reduction in early marriage, fewer pregnancies before marriage, more young women returning to school after giving birth, and increased communication about ASRH.

As a result of policy implementation, the youth have observed more knowledge and awareness about ARHD, and improved health outcomes. In Wajir and Watamu, youth have observed an increase in the number of NGOs and CBOs involved with youth initiatives in both urban and rural areas, and more emphasis on gender equality.

## Perceived Service Delivery Barriers

A majority of implementers (48 out of 62 implementers; 77 percent) think there are barriers to providing ARHD information and services. FGD participants mentioned cultural and religious barriers for providing ASRH information and services, including opposition from leaders and parents. Other barriers for providing ARHD information and services included: changing priorities among implementers; lack of resources; commodity stock-outs; lack of personnel trained in ASRH; service provider bias; not enough youth-friendly service facilities and educational materials; low youth involvement in ARHD initiatives; and poverty and unemployment among youth.

Most FGD participants think the policy is not being implemented equitably for all adolescents. The adolescents that benefit the least from policy implementation include adolescents in rural areas or slums, out-of-school adolescents, homeless adolescents, adolescent refugees, adolescents living with disabilities, and male adolescents.

## SECTION 7

### FEEDBACK ON PROGRESS AND RESULTS

M&E is important for tracking progress toward achievement of results. Feedback on implementation and results helps policymakers and implementers assess progress, and contributes to an effective and measurable outcome. This section of the interview guide asked participants about the institutions responsible for monitoring implementation, and the information stakeholders receive as part of the monitoring process.

#### SUMMARY OF FEEDBACK ON PROGRESS AND RESULTS

- Many key informants do not know which institution is responsible for monitoring policy implementation, or think no one is monitoring it.
- Almost half of the implementers' organizations are required to report on progress or accomplishments under this policy. However, a majority of implementers, including service providers, are not receiving feedback on how the policy is being implemented overall.
- To improve monitoring for policy implementation, key informants suggested establishing an M&E framework.
- Service providers requested more MOH guidance, improved tools for policy implementation and reporting at the county level, and more frequent M&E.

#### Policy Implementation M&E

Key informants were most likely not to know which institution is responsible for monitoring policy implementation, or to think no one is monitoring it. Some mentioned MOH, DRH, NCPD, other government agencies, or NGOs. Forty-four percent of the implementers' organizations (27 out of 62 implementers) are required to report on progress or accomplishments under this policy. However, a majority of implementers, including service providers, are not receiving feedback on how the policy is being implemented overall.

To improve monitoring for policy implementation, key informants suggested establishing an M&E framework that details the responsibilities of the institution(s) responsible for M&E, and includes clearly defined indicators to assess implementation and policy outcomes. Key informants noted that resources would be necessary for the M&E framework, along with capacity building for implementers so they can be equipped with the skills required for policy implementation and proper reporting.

Service providers requested more MOH guidance, improved tools for policy implementation and reporting at the county level, and more frequent M&E.

## SECTION 8

### PARTICIPANTS' OVERALL ASSESSMENT

The last section of the interview guide asked participants to provide an overall assessment of policy implementation, including overall ARHD improvements, overall barriers for implementation, and proposed next steps for policy action.

#### SUMMARY OF PARTICIPANTS' OVERALL ASSESSMENT

- Most participants think ARHD has improved in Kenya as a result of implementing the policy. Examples of ARHD improvements include increased awareness and prioritization of ARHD, improved access to ASRH information and services, improved adolescent and youth health outcomes, more empowerment of youth, and greater school completion among other examples.
- Overall implementation for the policy has been limited. Examples of barriers for policy implementation include cultural practices and religious barriers, lack of funding, low political will, low stakeholder involvement, lack of awareness about the policy and the POA, low coordination among implementers, low-quality ASRH services, and poor ASRH outcomes among other examples.
- Most participants think additional policy action would help facilitate implementation of the policy, and specific examples were provided for next steps, including enforcement of operational guidelines and strategic plans for policy implementation, improved policy dissemination, ARHD advocacy, increased multisectoral engagement, and increased funding among other examples.

#### Perceived ARHD Improvements As a Result of Policy Implementation

Most policymakers and implementers (62 out of 90 key informants; 69 percent) think ARHD has improved in Kenya as a result of implementing the policy. Only 8 out of 90 policymakers and implementers (9 percent of key informants) think there has been no positive change as a result of implementing the policy.

The positive changes noted most frequently by policymakers were increased awareness and prioritization of ARHD issues in the public sector, including more communication about contraceptives for adolescents and youth. Policymakers also noted a few successful government initiatives that happened as a result of the policy, such as the Government of Kenya's youth fund, and the "return to school" policy that has contributed to greater school completion among young women after they give birth.

As a result of implementing the policy, implementers have noticed improved access to ASRH information and services, improved ASRH outcomes, and more empowerment of youth, including increased awareness about ASRH and gender equality. Implementers also mentioned increased participation of NGOs, CSOs, and youth in ARHD, and a more supportive environment for ASRH in Kenya.

As a result of implementing the policy, FGD participants have observed improved ASRH among youth, more youth involvement in ARHD initiatives, and improved youth empowerment, especially among girls. Service providers have noticed an increase in the availability and use of youth-friendly service centers providing comprehensive ASRH care, and more health care providers with positive attitudes about ASRH. Both service providers and the youth have observed improved parent-child communication about ASRH.

Teachers have noticed greater school completion, especially among young women who return to school after giving birth. In Wajir, where teachers have focused extensively on youth hygiene as a component of health education under the policy, both teachers and youth have observed improved hygiene among adolescents.



Many youth have noticed more life skills education programs for adolescents and youth as a result of implementing the policy. In Nairobi, the youth have observed more peer-education, which they believe helps fill the gap when parents or others in the community do not talk to adolescents about SRH. In Wajir, where policy dissemination and implementation was especially low, the youth have observed more access to youth-friendly services, and more ARHD advocacy.

### Perceived Barriers for Policy Implementation

Eighty-eight percent of policymakers and implementers (79 out of 90 key informants) believe implementation for the policy has been limited. The biggest barriers for policy implementation include cultural practices and religious barriers, such as early marriage and opposition to life skills education in school. Policymakers and implementers mentioned lack of funding, poor political will, low stakeholder involvement, and lack of awareness about the policy and the POA, especially at the decentralized level. Poor coordination among implementers was also discussed, including lack of integration into other health and development programs.

Low-quality ASRH services and persistent poor ASRH outcomes were additional concerns for policy implementation:

“There is still persistent early pregnancy, high HIV infections, high sexual activities, and we seem not to be improving especially with the new media exposure to sensitive programs on TV. ASRH remains a large problem.” *A policymaker in Nairobi*

Like policymakers and implementers, most FGD participants agree that policy implementation has been limited. One of the most frequently mentioned barriers to policy implementation among all the groups was lack of awareness about the policy at the local levels, especially in Wajir where both awareness and implementation were notably lower than the other districts:

“The biggest barrier to implementing the policy is lack of awareness of the policy and the prevailing cultural practices and beliefs.” *A teacher in Wajir*

Even though ASRH guidelines do exist, not many service providers are familiar with them:

“There are [ASRH] guidelines in place but there is minimal circulation in the system, so as much as there are guidelines, health workers don’t seem to know or understand.” *A service provider in Kisumu*

Other barriers mentioned by FGD participants included cultural beliefs and religious practices, lack of resources and poor funding mechanisms, lack of coordination, poor M&E, and lack of skilled personnel.

Additionally the youth groups emphasized the limited availability of youth-friendly resources, such as age-appropriate ASRH informational materials and support finding employment. Many ARHD initiatives and resources are not presented in a youth-friendly manner, and information is not communicated effectively to them, especially for youth who cannot read.

### Participants’ Suggestions for Policy Action

Most policymakers and implementers (60 out of 90 key informants; 67 percent) think additional policy action would help facilitate implementation of the policy. Policymakers and implementers suggest the issuance and enforcement of operational guidelines and strategic plans for policy implementation that increase ownership over implementation activities, and improve M&E. They also suggest improved policy dissemination, ARHD advocacy, and increased funding. Several key

informants discussed the importance of mainstreaming ASRH by including it in broader adolescent and development policies and initiatives instead of isolating it as a separate issue.

Many FGD participants agree there is need for additional policy action to help facilitate policy implementation. They called for policy enforcement, clear standard operating procedures, more resources, and widespread dissemination, especially at the local level. Service providers requested new or improved ARHD informational and educational materials for adolescents.

In Wajir, FGD participants called for stricter laws or guidelines for policy implementation. Service providers suggested a law declaring ASRH a mandatory service, and teachers requested a law or guidelines for leaders to disseminate the ARHD policy and information to adolescents and youth.

When asked which office should be responsible for the next steps, responses varied and reinforced the notion of a multisectoral approach to policy implementation. Key informants were most likely to mention the MOH (DRH), MOYAS, MOE, Ministry of Planning (NCPD), and parliament, among others. FGD participants were most likely to mention the MOH (DRH and Division of Child and Adolescent Health) and MOE followed by MOYAS, Ministry of Gender, and Ministry of Finance, among others.

## SUMMARY OF KEY FINDINGS

The key findings of the assessment reveal that since 2003, Kenya's ARHD Policy has led to many perceived improvements in the health and well-being of adolescents and youth. The ARHD Policy has provided guidance for priority ARHD needs and target populations, and for a range of approaches to increase access to and quality of ARHD programs and services. It has also helped lay the groundwork for many new guidelines, policies, and strategies. All of this has contributed to more commitment to and funding for ASRH; strengthened partnerships between the government and NGOs/CSOs; improvements in knowledge of and attitudes toward ASRH; and improved empowerment of youth.

However, ARHD Policy implementation has been limited due to a range of factors and challenges, such as lack of awareness about the policy and the policy POA. For example, many participants were uninformed regarding the agencies responsible for implementation, the implementation strategy detailed in the POA, and the monitoring and evaluation framework. Other challenges include lack of coordination among implementers; low stakeholder involvement, including low political will and youth involvement; limited leadership; lack of resources; poverty and unemployment among youth; and limited availability of high-quality ASRH services. Additionally, ASRH remains a contentious issue among some communities, and some cultural and religious practices are barriers for implementation. Adolescents and youth still face challenges, such as completing secondary school, finding employment, postponing marriage, and avoiding STIs and unintended pregnancies.

# RECOMMENDATIONS AND LESSONS LEARNED

The following seven recommendations were developed by the core research team, assessment partners, and stakeholders after reviewing the key findings of the assessment. The recommendations provide next steps for policy action that will strengthen policy implementation and ensure this policy, and others that follow, are put into practice on a large scale.

## NEXT STEPS: ARHD POLICY IMPLEMENTATION ASSESSMENT RECOMMENDATIONS

1. Ensure an Integrated Approach to Policy Development and Implementation
  - Revise ARHD Policy Into a National Adolescent and Youth Development Policy
  - Foster Multisectoral Engagement
  - Ensure Adolescent and Youth Involvement
  - Foster Parental Involvement
2. Strengthen Leadership and Coordination
  - Strengthen Leadership
  - Improve Coordination Among Stakeholders and Implementers
3. Increase Policy Awareness
  - Scale-Up Nationwide Policy Dissemination
4. Strengthen Implementation Plans
  - Develop and Implement a Comprehensive Plan of Action
5. Improve Resource Mobilization and Management
  - Improve Resource Mobilization With Clear Leadership
  - Strengthen Financial Oversight and Accountability
6. Improve Service Delivery
  - Provide Capacity Building for Policy Implementation
  - Increase Adolescent/Youth Access to Services
7. Ensure Monitoring and Evaluation
  - Establish and Implement an M&E Framework With Clear Leadership
  - Provide Capacity Building for M&E Among Implementers

## 1 ENSURE AN INTEGRATED APPROACH TO POLICY DEVELOPMENT AND IMPLEMENTATION

**Revise ARHD Policy Into a new National Adolescent and Youth Development Policy:** When it reaches the end of its timeframe, the ARHD Policy should be revised into a National Adolescent and Youth Development Policy that encompasses both adolescents and youth, and includes reproductive health as a core pillar of development among others. The National Adolescent and Youth Development Policy, including the reproductive health component, should be clearly linked to Kenya's development goals, international agreements, and other policies based on the finding that aligned policies are stronger than policies that stand alone. Similar to the 2003 policy, the new policy should be seen as a large step in the

process of addressing ARHD rather than as the final result. It will need a goal and objectives that are achievable within the timeframe of the policy. A National Adolescent and Youth Development Policy with reproductive health as a central component that is aligned with other policies would help garner support from a broader range of stakeholders, mainstream ASRH, and make it easier to mobilize resources.

**Foster Multisectoral Engagement:** Engaging a wide range of stakeholders in policy development, implementation, and monitoring is essential. The key findings reinforce the importance of extending policy implementation beyond the health sector to support ARHD, such as engaging the education and employment sectors among others. Although the 2003 policy called for broad multisectoral engagement, the involvement of stakeholders was perceived to be limited, especially the involvement of government agencies, local-level stakeholders, and stakeholders in areas outside of Nairobi.

It is important for stakeholders, especially government agencies charged with leadership and implementation responsibilities, to provide clear, ongoing communication about their existing implementation responsibilities and activities. Also important is improving mechanisms for engaging a broader range of government agencies, private sector entities, and NGOs/CBOs. This will involve engaging leaders from multiple levels, including national and local-level government officials, donors, health sector leaders, religious and civic leaders, teachers, parents, and youth, among others.

Engaging local-level stakeholders in formulation and implementation is essential so there can be more of a “bottom-up” approach to implementation. As noted by study participants, partnerships between central and local-level stakeholders are important for implementation, and help ensure that local needs are addressed through policy implementation, financial support is more readily available at lower levels, coordination is improved at all levels, and ARHD is mainstreamed into new and existing initiatives on the ground.

Kenya’s new devolved structure of government has the potential to ensure more of a “bottom-up” approach to implementation. Decentralization with accountability and good leadership will help expand ARHD services to the counties, and increase local ownership and engagement.

**Ensure Adolescent and Youth Involvement:** Objective 7 of the policy is “to promote participation of adolescents in reproductive health and development programs.” Although there have been some improvements in youth engagement, adolescent and youth involvement in policy implementation is perceived to be low. However, the general consensus among participants is that adolescents and youth need to be engaged with ARHD policy development and implementation. As the policy is revised, the responsibilities of adolescents and youth in formulation and implementation should be clear for all implementers and youth, and mechanisms for their engagement need to be strengthened. Adolescents and youth should be informed about their policy responsibilities and benefits through policy dissemination initiatives.

Adolescent and youth SRH initiatives will need to expand beyond increasing awareness to increasing capacity building among the youth. This includes increasing the capacity of youth to take responsibility for their health, relationships, and future roles in the community. By providing a broad range of skills, information, and resources, youth can make informed and positive decisions, and advocate on their own behalf. This will increase the capacity of youth to make decisions long after their parents and other mentors are no longer in their lives.

**Foster Parental Involvement:** Parents and families are critical influences on ASRH behavior and attitudes. Parents play an important role not only in imparting knowledge about reproductive health to their children, but also in the development of self-esteem, confidence, and the ability to negotiate sexual relationships. However, few parents are equipped with accurate information about sexual

health or the realities of adolescent behavior. Therefore supporting ASRH while respecting parental concerns continues to be one of the greatest political challenges policymakers face, but it is worth investing in for the sake of future generations.

Parents should have a central role in shaping public policy to serve the best interests of adolescents and youth by: being informed voters; urging policymakers to recognize the importance of ARHD; tapping into or creating support networks that advocate for and ensure implementation of sound policies; starting discussions in their communities about ASRH with local civic and religious leaders, the media, and other community members; and working in coalitions that focus on adolescent and youth development.

## 2 STRENGTHEN LEADERSHIP AND COORDINATION

**Strengthen Leadership:** The policy and POA outlined the roles and responsibilities of various stakeholders and implementers, including the lead agencies. However there was confusion among participants regarding which agency was responsible for leading implementation. This suggests that leadership responsibilities were not clearly defined, not disseminated, and/or unrealistic for the designated agencies, and the roles of the lead agencies were not communicated to other implementers.

As a next step, there should be one lead agency responsible for ensuring the policy is put into practice. The lead agency will ensure policy awareness, commitment, coordination, and accountability. Leadership responsibilities should be realistic and appropriate for the lead agency. The responsibilities of the lead agency need to be clearly defined in its mandate and annual operating plan, and it is essential for resources to be available for implementation. The lead agency will need to have an accounting officer who is responsible for coordination, monitoring, and evaluation.

The responsibilities of this agency should be clear to all stakeholders during each stage of policy formulation, dissemination, implementation, and evaluation. Policy implementers will be accountable to the lead agency for reporting on the progress and outcomes of their implementation activities.

**Improve Coordination Among Stakeholders and Implementers:** Objective 6 of the policy is “to strengthen intersector coordination and networking in the field of adolescent health and development.” Unfortunately, lack of coordination and duplicated efforts among implementers was a concern echoed throughout the key findings. However, the general consensus continues to be that coordination is critical, especially given the emphasis on broad multisectoral engagement for policy implementation.

Coordination of a national youth policy will need leadership from a government institution with the capacity and authority to design and implement policies and programs across sectors, including health, education, and the labor force. A detailed coordination plan with clear leadership will guide collaboration and knowledge-sharing at the national and county levels among the public and private sectors. Clear leadership is important to implement the coordination plan, and organize task force meetings or other coordination mechanisms.

Existing task forces and working groups focused on ARHD should be expanded to include a broader range of stakeholders. An example of an existing working group that could be expanded or replicated for coordination purposes is the DRH and NCPD ASRH TWG. Ongoing policy implementation updates should be disseminated to a broader range of audiences through new dissemination mechanisms, including digital dissemination such as listservs.

### 3 INCREASE POLICY AWARENESS

**Scale-Up Nationwide Policy Dissemination:** The ARHD Policy and POA were not disseminated widely, and awareness and implementation were limited as a result, especially in areas outside Nairobi, and among stakeholders at the subnational level, institutions with high turnover, and policymakers.

It is essential for policy dissemination to be widespread. There should be a clear nationwide dissemination plan to ensure the policy reaches multisectoral stakeholders and implementers, including youth, and that stakeholders and beneficiaries are informed about the policy in all counties at every level. Policy dissemination should also include sensitization about the ARHD needs at the local level that the policy will address.

The dissemination plan should ensure ongoing, routine dissemination throughout the policy time-frame. Ongoing dissemination is especially important to increase awareness at institutions with high turnover of personnel, such as government agencies. As noted by assessment participants, new leaders come with new priorities and policies, which have the potential to lead to fragmented or discontinued projects. Therefore, ongoing dissemination is especially important given the 2013 national election and the new leadership that will be ushered in to office in the coming year.

A popular version of the policy should be available to provide a clear and concise summary of the policy and POA. The popular version is important for people who are unlikely to read the entire policy and POA, but will read the short version and be informed of the policy as a result.

The dissemination plan should include translation of the popular version, policy, and POA into Swahili. It should include a range of dissemination mechanisms, including information technologies and digital dissemination. The media can also have an important role in disseminating information about the new national youth policy.

### 4 STRENGTHEN IMPLEMENTATION PLANS

**Develop and Implement a Comprehensive Plan of Action:** The policy POA was criticized for being developed too long after the policy was developed, not being disseminated widely, lacking widespread adoption among stakeholders, and not including enough detail, such as resource mobilization plans.

Therefore when the policy is revised, a new POA will need to be developed with more detail, especially regarding clear leadership, coordination plans, ongoing dissemination plans, multisectoral implementation roles and responsibilities at all levels, resource mobilization mechanisms, and M&E plans.

The new POA will need to be developed and disseminated at the same time the policy is disseminated. It may be ideal to include the implementation plan in the policy instead of disseminating it as a separate document. POA implementation can be enforced through monitoring and accountability measures described in recommendation seven.

### 5 IMPROVE RESOURCE MOBILIZATION AND MANAGEMENT

Objective 9 of the policy is “to advocate for increased resource commitments for adolescent and youth health and development programs,” and there have been substantial increases in support for

ARHD initiatives since 2003. However, many implementers continue to believe funding for policy implementation is insufficient, and have experienced problems accessing funds for implementation. The most frequently noted challenges for accessing funding pertained to the public sector.

**Improve Resource Mobilization With Clear Leadership:** The revised policy and POA should include more details for resource mobilization mechanisms and leadership to ensure adequate financial support for implementation. Resource mobilization initiatives should focus on:

- Establishing national financial goals and commitments. National goals with financial objectives and commitments for ARHD are essential with monitored implementation.
- Increasing government commitment. Advocate to policymakers and government officials in relevant ministries to prioritize and mainstream ARHD activities in their performance contracts and annual operating plans.
- Engaging donors and development partners. Assessment participants recognize global assistance and donor support as facilitating factors for policy implementation. Therefore, more ARHD financial support should be sought from relevant donors. Donors and development partners should be engaged in activity prioritization to ensure their interests are aligned with the priorities at the local level.
- Leveraging public-private partnerships. Public-private partnerships should be leveraged to increase financial support for implementation, and to strengthen coordination between the sectors.
- Committing to relevant development goals. Referring to development goals aligned with the policy, such as Vision 2030 and the MDGs, will help garner support for and commitment to the policy among donors.

**Strengthen Financial Oversight and Accountability:** Financial oversight and accountability will also need to be improved. Suggestions for improvement include:

- Establishing transparency and accountability for government and donor resources, including strengthening mechanisms to monitor funds.
- Implementing effective disbursement and accounting mechanisms to avoid delays that slow activities and burn rates.
- Providing capacity building on resource mobilization and management.

## 6 IMPROVE SERVICE DELIVERY

As a result of policy implementation since 2003, there have been many perceived ARHD improvements pertaining to the eight policy objectives, and ARHD has improved in Kenya. However, there are still barriers to providing ASRH services. To address the concerns mentioned by assessment participants, the revised policy and implementation plan should:

**Provide Capacity Building for Policy Implementation:** Capacity building for policy implementation is critical, especially given that some implementers felt the policy required at least moderate operational changes at their organization and capacity building was limited. Moving forward, it will be important to:

- Train implementers on policy and POA content.
- Provide sensitization on ARHD issues, including the special needs of high-risk and hard-to-reach youth. This should include information about the ARHD rights of adolescents and youth according to the constitution, and relevant laws and policies.
- Equip service providers with skills and resources for the provision of ASRH services, including informational materials for parents and youth.

- Equip teachers with skills and resources for life skills education that includes information about ASRH, and includes educational materials for parents and adolescents/youth.

**Increase Adolescent and Youth Access to Reproductive Health Services:** Sexual and reproductive health efforts for adolescents and youth should expand beyond access to contraception or healthy timing and spacing of pregnancy to provide services and information that support life planning, attending school, healthy relationships, and increasing opportunities later in life. To address the service delivery concerns mentioned by assessment participants, the revised policy and implementation plan should:

- Increase the number and availability of youth-friendly services and resource centers that offer age-appropriate reproductive health care.
- Inform adolescents and youth about ARHD services and resources available to them. This includes increasing access to ARHD services and information through a range of informational materials and dissemination mechanisms. All ARHD information for adolescents and youth should use nontechnical terms and explanations that are easy for them to understand. This also includes targeting information and care to adolescents and youth most in need of ARHD services, such as: adolescents in rural areas or slums, out-of-school adolescents, homeless adolescents, adolescent refugees, adolescents living with disabilities, and male adolescents.
- Train adolescents and youth to be peer educators, and engage them in peer outreach. This includes providing ongoing mentorship for youth engagement and peer education, especially since this was noted as a concern among youth in Nairobi.
- Prioritize poverty alleviation because prioritization of poverty helps to increase the availability of services for low-income adolescents who tend to be most in need of ARHD information and care.
- Prioritize gender equality as a component of ARHD activities, especially empowerment of girls and young women, and male involvement in ARHD activities. As noted by assessment participants, gender norms often hinder implementation because the influence they have on behavioral expectations for men and women are frequently not aligned with the policy objectives.

## 7 ENSURE MONITORING AND EVALUATION

Objective 8 of the policy is “to identify and define monitoring and evaluation indicators for ARHD.” Some components of this objective were achieved, such as the inclusion of an M&E strategy in the POA, the development of the ASRH TWG chaired by DRH and NCPD, and more. However there was confusion among participants regarding which institution, if any, is responsible for monitoring policy implementation. This lack of awareness regarding M&E leadership suggests that dissemination and implementation for the M&E plans were not widespread. Although many implementers report on project progress or accomplishments to various donors or institutions, a majority of implementers do not receive feedback on how the policy is being implemented overall, which makes it challenging to improve implementation efforts.

**Establish and Implement an M&E Framework With Clear Leadership:** To improve monitoring for policy implementation, an M&E framework should be established and widely disseminated with clear details about leadership roles and responsibilities for implementers, measurable indicators, a realistic timeline for reporting and collecting data, and mechanisms to ensure feedback on policy implementation is provided to implementers.

**Provide Capacity Building for M&E:** M&E capacity building and financial support are important for both the lead agency and the implementers so they can be equipped with the skills and resources required for proper reporting.



# CONCLUSION

Since 2003, Kenya's ARHD Policy has led to many improvements in the health and well-being of adolescents and youth. The policy has provided guidance for priority needs and target populations, and increased and strengthened approaches to improve ARHD in Kenya. It has also helped lay the groundwork for a range of new guidelines, policies, and strategies. However, policy implementation has been limited due to a range of challenges.

The recognition of limited policy implementation among government officials, stakeholders, and implementers is the result of lessons learned from a broad range of ARHD tools and approaches used over the last decade. Lessons learned from these approaches have reinforced the notion that ARHD Policy implementation requires a supportive multisectoral political, social, and financial environment.

This assessment reinforced stakeholder commitment to the policy's goal and objectives, facilitated dialogue on ARHD needs and challenges, and identified next steps to strengthen policy implementation. Stakeholders recognize the need to update the ARHD Policy to continue the momentum of the last decade, and overcome policy implementation barriers identified in this assessment. The assessment recommendations provide next steps for policy action that will strengthen policy implementation and ensure that this policy, and others that follow, are put into practice on a large scale.

# REFERENCES

- 1 Republic of Kenya, *Adolescent Reproductive Health and Development Policy* (Nairobi, Kenya: National Council for Population and Development, Ministry of Planning and National Development, and Division of Reproductive Health, Ministry of Health, 2003).
- 2 In 2008 the Ministry of Health was established as two ministries: the Ministry of Health and the Ministry of Public Health and Sanitation.
- 3 Republic of Kenya, *Adolescent Reproductive Health and Development Policy*.
- 4 The Ministry of Gender, Sports, Culture, and Social Services was later established as two ministries: the Ministry of Gender, Culture, and Social Services and the Ministry of Youth Affairs and Sports.
- 5 The Ministry of Agriculture and Livestock Development was later established as two ministries: the Ministry of Agriculture and the Ministry of Livestock Development.
- 6 Republic of Kenya, *Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015* (Nairobi, Kenya: National Coordinating Agency for Population and Development, Ministry of Planning and National Development, and Division of Reproductive Health, Ministry of Health, 2005).
- 7 Republic of Kenya, *Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015*.
- 8 Division of Reproductive Health (DRH), Ministry of Public Health and Sanitation, *Best Practices in Reproductive Health in Kenya* (Nairobi, Kenya: DRH, Ministry of Public Health and Sanitation, 2009); National Coordinating Agency for Population and Development (NCAPD), *Protecting the Reproductive Health of Young People—An Investment in Kenya’s Future*, Policy Brief No. 11 (Nairobi, Kenya: NCAPD, 2011); and Humphres Evelia et al., *Ten Years of the Kenya Adolescent Reproductive Health Project: What Has Happened?* (Nairobi, Kenya: APHIA II OR Project in Kenya/Population Council, 2011).
- 9 FHI 360 and Division of Reproductive Health, Ministry of Public Health and Sanitation, “Adolescent and Youth Sexual and Reproductive Health (AYSRH),” presentation delivered at the AYSRH Stakeholder Forum, Nairobi, Kenya, Sept. 14, 2011.
- 10 DRH, Ministry of Public Health and Sanitation, *Best Practices in Reproductive Health in Kenya*; NCAPD, *Protecting the Reproductive Health of Young People*; and Humphres et al., *Ten Years of the Kenya Adolescent Reproductive Health Project*.
- 11 FHI 360 and Division of Reproductive Health, Ministry of Public Health and Sanitation, “Adolescent and Youth Sexual and Reproductive Health (AYSRH);” and Ian Askew et al., *A Multisectoral Approach to Providing Reproductive Health Information and Services to Young People in Western Kenya* (Washington, DC: Frontiers in Reproductive Health, Population Council, 2004).
- 12 Annabel Erulkar et al., *Tap and Reposition Youth (TRY): Providing Social Support, Savings, and Microcredit Opportunities for Young Women in Areas With High HIV-Prevalence* (New York: Population Council, 2006).
- 13 Kenya Demographic and Health Survey 2008-2009 (Calverton, MD: Kenya National Bureau of Statistics and ICF Macro, 2010).
- 14 Kenya Demographic and Health Survey 2008-2009.
- 15 Anita Bhuyan, Anne Jorgensen, and Suneeta Sharma, *Taking the Pulse of Policy: The Policy Implementation Assessment Tool* (Washington, DC: Futures Group, Health Policy Initiative, Task Order I, 2010).
- 16 A Likert scale is a method used to ascribe quantitative value to qualitative data through scaled response options in surveys and questionnaires. For example, a Likert scale response to a question may have the following one to five response options, “1: strongly disagree,” “2: disagree,” “3: undecided,” “4: agree,” and “5: strongly agree.” The scores or sums of the numbers for each scaled response are then used for analysis.
- 17 Bhuyan, Jorgensen, and Sharma, *Taking the Pulse of Policy*.



