

'Healthy Futures' Sustainable Solutions to Improve the Health Outcomes for Orphans and Vulnerable Children Affected by HIV in Mumias and Musanda Districts in Western Kenya

Proposal to consolidate the programme funded to date, building on our learning to improve impact and work towards community ownership and sustainability.

About the Author



Cheryl Hooper is a multi-skilled Senior Director with 20 years' experience & skills in fundraising, strategic planning, & capacity building for UK & international NGOs especially in sub-Saharan Africa. A skilled grant writer, with successful multi-year proposals for UKAID, USAID, Comic Relief & other strategic funders, she supports NGOs with fundraising, strategic development, mentoring, & capacity building in all functions & countries across the world.

1. Background

In 2018, a year-long innovative peer health education project was successfully piloted following funding provided by xxx. The project included a baseline study in both Musanda and Mumias locations to determine the sexual reproductive health (SRH) needs of young people and provide background information that would be used in the implementation strategy of a pilot peer health education program. The project has achieved its objectives and is showing signs of greater understanding and awareness of SRH, HIV/AIDS, the consequences of alcohol and drug abuse and increased access to youth friendly health services among young people of 12-21 years. The baseline study mainly utilized both quantitative and qualitative methodologies to collect data whereby, 100 (32% men and 68% female) respondents aged 12-21 answered questionnaires and 0 external stakeholders interviewed during focused group discussions.

The pilot is being successfully implemented and due to finish in September. Outputs have included the training of 65 youth peer educators in 27 schools which has contributed towards greater awareness, support, and accessibility of SRH information for young people living in the Mumias and Musanda districts. While it is too early to provide specific data on reduced incidences of HIV and teenage pregnancies, there has been a 17% increase in the number of young people visiting clinics for HIV testing and SRH information through data provided by our partner health clinics. This has been attributed to the health talks provided by our peer educators emphasizing the need for regular testing and early detection, and an independent evaluation which confirmed that 90% of beneficiaries believed that the approach was useful to them.

1.1 Healthy Futures Phase 2

Phase 2 of the project will continue to build on this work based on the key findings and outcomes of the baseline study and pilot peer education programme and take forward key learning from the implementation and recommendations from our beneficiaries and partners to increase impact. This project will focus on three emerging priorities- 1) life-skills training for adolescent youth; 2) gender equity; 3) community sensitization & support of young people. With funding for a further 2 years we will use this timeframe to ensure that the programme is embedded in the community and sustainable beyond the funding period.

1.2 Context, Analysis and Beneficiaries

Healthy Futures Phase 2 will continue in Mumias and Musanda districts so that we can continue to build on the work that has started and work towards sustainability.

Primary beneficiaries will be 400 adolescent boys and girls age 12-19 years already known to Nasio Trust because of their vulnerability. In addition, the interventions and impact will reach a further 20,000 indirect beneficiaries living in Musanda and surrounding villages of

Ibinda village, Muroro, Imanga, Bukaya, Buchifi in the Mumias district Kakamega County, Western Kenya.

During 2015, the county contributed to 1.8% and 2.7% total new HIV infections in Kenya among children and adults. Of this, adolescents aged 10-19 years contributed to 10% and 32% of all new HIV infections in Kakamega County. There is a growing body of evidence and our own observations and experience indicate that HIV/AIDS is most prevalent amongst young people who are uninformed and have no access to safe spaces for support with their own health matters; this is fuelled by stigma and non-disclosure of their status with statistics confirming that in 2014 (Kakamega District Health Survey) that 19% of women and 34% men in the district had never been tested for HIV. Further (Kakamega County Findings 2015) showed that youth felt that the few health facilities that do exist, were not youth friendly and discouraged them from attending clinics. These gaps are indicative that more innovative and effective strategies are needed to reach young people who show resistance to changing behaviour. This will help reduce HIV transmission and improve the health outcomes for young people and future generations. Currently, the average age of sexual debut amongst adolescent girls is 15 years which is fuelled by little awareness of the consequences of unsafe sex and HIV transmission. The pilot project not only confirmed these findings but also led the way to a better approach to reach the most vulnerable youth. Through peer education, the most marginalized young people have been able to access SRH information, guidance and support in safe secure environments and without fear of stigma or embarrassment.

The underlying strategy for phase 2 of this work is to strengthen ties with local government and other stakeholders as part of a move towards community sensitization and support for youth-led services and citizenship. We intend to continue to improve the life-skills of the trained Peer Educators from the pilot phase so that they are able to be more visible role models for younger children to emulate. This would be in line with the government's general poverty reduction policy through the effort to address the impact of HIV/AIDS through broad-based community participation. In this respect the focus of the project is on youth affected and infected by HIV/AIDS whilst also providing them with vital life skills to make them resilient. This also contributes to the government goal of reducing new HIV infection among youth. Our intention for Phase 2 is to take this strategy further by promoting active citizenship and positive young adult role models who will work alongside other stakeholders to break down barriers and strengthen local communities through a collaborative approach.

2. Aims and Objectives Phase 2: Healthy Futures

To ensure that young people in Musanda and Mumias are provided with the necessary life skills education/training and utilise them in an environment that encourages and enables them to do so for their own benefit and for the benefit of their society, with particular

emphasis on SRH and adopting attitudes and practices that protect them against HIV/AIDS and STIs.

The expected results and impacts and indicators will be as follows:

Objective 1: To increase awareness of SRH matters and avoidance of HIV amongst 400 direct beneficiaries (young people between the age 12-19 years) in Musanda and Mumias.

Expected Results

- Improved access to and utilisation of SRH, HIV and AIDS information and services by young people.
- Accurate informed sharing, education and communication between young people on SRH and HIV/AIDS and related issues.
- Improved knowledge on and attitude towards gender issues related to SRH and HIV/AIDS issues among young people especially on GBV.
- Reduced incidences of Gender Based Violence cases reported by local clinics and medical centres.

Indicators

- Increase in the number of young people attending youth friendly health clinics.
- Improved knowledge of, behaviour and attitude of young people towards SRH and HIV/AIDS issues.
- Improved uptake of safe sexual practices and respectful social behaviours by young people.
- Reduction in teenage and unwanted pregnancies.
- Increase in the number of functioning safe places for young people to interact and discuss SRH and HIV/AIDS issues.
- Greater understanding of girl beneficiaries towards SRH, transactional sex, and their own personal health and futures.
- Improved attitude of boy beneficiaries towards gender equity and equality of opportunity for girls and understanding of basic rights and need for equality.

Evidence

- Data capture of numbers of attendees at medical centres adopting youth-friendly health & information services (aggregated by gender, age, disabled/abled, presenting condition/query).
- Questionnaires provided before and after peer health education sessions.
- Focus group discussions and surveys against the original baseline.
- Monthly data capture on teenage pregnancies and HIV incidences amongst beneficiary age group.

- Number of active safe spaces providing information & advice for young people with regard to SRH matters aggregated by types of services, frequency of meetings, participation numbers, gender & age.

Objective 2: Sensitize and increase awareness of parents, community leaders, local government and other stakeholders on the importance of SRH and HIV/AIDS education among young people and the community as a whole in Musanda and Mumias.

Expected Results

- Improved knowledge, behaviour and attitude of parents, community leaders, local government and other stakeholders on the importance of SRH and HIV&AIDS education among young people.
- Improved knowledge and attitude towards basic rights and child rights by the parents/guardians.
- Improved knowledge and attitudes of parents/guardians on gender issues related to SRH and HIV/AIDS especially gender-based violence (GBV).
- Willingness of local government departments and community leaders to speak publicly and address specific issues within communities, thus endorsing the youth-led approach.
- Reduction of GBV and abuse of young children within Mumias and Musanda.

Indicators

- The number of parents/guardians attending after-school activities that engage parents through performance art, anti-AIDS messaging and gender equity.
- The attitude and practice of fathers/head of households of adolescents receiving Peer Education: towards abuse (verbal, physical, sexual) abuse of girls and women measured through surveys and focus groups as well as their understanding of the implications with regard to legal, social and psychological repercussions such as engaging in sexual activity with underage girls.
- Frequency of meetings between Nasio project staff and external stakeholders including government departments when discussing policy and strategy.
- Number of community meetings facilitated and attended by community leaders and local government representatives
- The number of youth friendly health services and clinics within Musanda and Mumias.
- Numbers of GBV and abuse of young children presenting at health clinics, police and welfare services.

Evidence

- Registration forms/attendance numbers of parent after-school activities.
- Parent questionnaires capturing knowledge of basic rights, HIV, SRH information.
- Minutes of stakeholder meetings.
- Number of youth-friendly services, attendance numbers and types of health matters presented.
- Data capture from police, welfare services and health clinics on GBV and child abuse.

Objective 3: To strengthen and improve the existing health services to provide quality youth friendly services.

Expected Results

- Health, welfare and police professionals have a comprehensive understanding of how to support young people affected by HIV, abuse, teenage pregnancy and other SRH matters.
- Health and welfare professionals will understand the importance of psycho-social support of young people.
- Simple, age-appropriate written materials available for young people.
- Visible signage and friendly messaging in health centres.
- Reduced stigma of HIV amongst young people.
- Confidential counselling and testing.

Indicators

- Participation numbers of health professionals at trainings.
- Distribution of age-appropriate SRH materials in health clinics and other community spaces.
- Number of young people seeking support at health clinics, police & welfare services and schools.

Evidence

- Questionnaires assessing behaviour and attitude change towards HIV in young people.
- Written materials for distribution.
- Questionnaires assessing professional attitudes and responses to psycho-social support interventions.
- Data capture of frequency of attendance at clinics aggregated down further by gender, age, type of service seeking, referral numbers.

We will be seeking to measure and understand the above indicators by employing mixed methodology of qualitative and quantitative data collection such as: Document reviews (relevant project documents, training records, minutes of meetings and routine M&E reports), individual and group interviews, observations, testimonials and focus group discussions.

3. Activities: Objective 1

Year 1: Month 1-6

- Hold one Internal stakeholder meeting with 65 trained peer educators who worked on the pilot phase to share learning and next stage developments, timeline and overall project aims and objectives, data capture, reporting and Monitoring and Evaluation requirements.
- Review and enhancement of Monitoring & Evaluation tools for data capture.
- Develop life-skills training and 'Train the Trainer' programme for 65 qualified peer educators.
- Delivery of life skills training to 65 Peer Educators (including child protection and safeguarding refresher course).
- On-going data collection, management and monitoring of pilot interventions.
- Hold monthly debriefing sessions with 65 peer educators delivering peer education through the pilot stage.
- Conduct 1 Youth Sport tournament with participation of over 200 young people over the school holidays.

Year 1: Month 6-12

- Continuation of weekly peer education sessions in 28 institutions (27 schools and 1 Polytechnic).
- Introduction of 4 more mobile youth friendly spaces based near schools and health centres to reach out of school youth in Mumias, Imanga, Bukaya and Musanda.
- Conduct monthly on-going Monitoring & Evaluation and data gathering.
- Delivery of monthly 'Train the Trainer' sessions whereby 30 trainers will be trained in each youth friendly corner.
- Conduct 2 Youth Sport tournaments with participation of over 200 young people over the school holidays.

3.1 Activities: Objective 2

Objective: To mobilise parents, community and external stakeholder support and raise awareness for improved access and quality of young people's SRH and HIV/AIDS health services.

Year 2: Month 1-6

- Recruit 100 new Peer Educators and conduct 2 peer training sessions each with 50 peers.
- Conduct 6 monthly mobile youth friendly services with 65 peer educators.
- Training of 40 community health providers (10 per youth friendly corner) in working and supporting adolescents with youth related issues in each youth friendly corners.
- Conduct on-going data collection and gathering of information from health clinics and schools.
- Conduct 4 meetings to introduce, check progress, update and learning information for internal stakeholders and 65 peer educators throughout the year.
- Hold 3 focus group discussions and information gathering sessions throughout the year (during school holidays) with young people on SRH, HIV/AIDS, gender equity, basic rights, and acceptance of the interventions to date.
- Hold one meeting with 15 external Stakeholders to inform and share findings from the pilot phase and plans for phase 2 by bringing together local government departments, schools, community leaders, CHV, CBOs, FBOs and health clinics.
- Develop, write and publish local community information on enriched parenting and the need to support adolescents and children.
- Hold 1 meetings with religious leaders and community leaders to begin the process of community sensitization and obtain buy-in and collaborative working.
- Hold 2 meetings with 100 local parents/guardians to share learning from pilot and inform of phase 2.
- Hold 1 meeting during school holidays with 28 school heads to plan content and type of performances by youth for parents.
- Conduct on-going data collection, management and monitoring of pilot interventions.

Year 1: Months 6-12

- Hold 6 monthly meetings with 28 teachers and school heads to review progress and behaviour changes in schools and planning for parent support and engagement.
- Hold 2 meetings during school holidays with 28 school heads to plan content and type of performances by youth for parents.
- Distribution of enriched parenting information materials such as leaflets and brochures.

- Hold monthly meetings with 15 external stakeholders including government departments.
- Distribution 4 signage's: one per youth friendly corner area with clear signposting and guidance for parents and adolescents on where and how to access information on SRH and HIV/AIDS.
- Bi-monthly meetings/forums with 100 parents/guardians as part of community sensitization.
- On-going Monitoring & Evaluation and data gathering.
- Conduct 4 Community open forums led by local leaders as part of community sensitization within the four locations of the youth friendly corners.

3.2 Activities: Objective 3

- Hold monthly meetings and engagement with 15 local government and external stakeholders.
- Training in psycho-social support for health and welfare professionals.
- Hold monthly meetings 28 with teachers and school heads to assess the progress of young people in school.
- Carry out continuous monitoring of parent engagement with schools and attendance at after school performances.
- Conduct 4 community forums led by health workers and peer educators for community sensitization within the locations of the youth friendly corners.
- Further distribution of community information materials on gender equity, enriched parenting and SRH support and information.
- On-going data collection and gathering of information.

Year 2: Months 6-12

- Conduct one sustainability planning meeting with 20 external stakeholders towards the end of the project.
- Progress update and learning meeting for internal stakeholders including peer educators.
- Conduct 3 focus group discussions and information gathering from different beneficiary groups covering SRH, HIV/AIDS, gender equity, basic rights and safeguarding knowledge and understanding; child protection and acceptance of the interventions to date.
- 1 Train the Trainers workshop for Peer Health Educators.

We will be seeking a significant increase in understanding of how to prevent HIV and other STIs in young people living in Mumias and Musanda districts being reached by the interventions. Other changes would also be an increase in the number of young people presenting at health clinics for HIV testing and counselling and other SRH information; reduction in teenage pregnancies; delayed sexual debut in young girls and incidences of transactional sex. We will also focus on trying to increase participation and understanding of government officials' particularly local leaders and other influencers on gender related issues, reproductive health and in HIV discussion and call for action to help bridge the gap in gender issues.

4. Community Sensitization & Behaviour Change

Community sensitization and changes in attitude and behaviour towards young people, and especially girls is anticipated to take longer than the proposed timeline of 2 years. The pilot stage identified a need to acknowledge the difference between cultural, development and social issues between girls and boys, youth and adults from the urban and rural areas. We learned that rural areas are more conservative which means that workers need to embrace and adapt to the differences. There is higher exploitation of girls in the rural area of Musanda. This means that we are likely to see behaviour changes in both rural and urban areas but the degree and type of change may be different. Primarily, we will be seeking changes in behaviours of parent-guardians of youth benefiting from peer education sessions and wider collaborative working and acknowledgement from stakeholders anticipated to participate in the implementation of the project. The main stakeholders within local government include sub county ministry of health, sub county youth office, government health facilities, private health centres and other non -government organizations.

5. Sustainability

As part of a longer sustainability plan, phase 2 includes a Train the Trainer component which will train existing Peer Educators who have successfully completed the foundation training and delivered peer health education sessions and left school, to then learn how to train other youth using the Nasio model, material and quality standards.

Additional peer educators' training will be included for youths who have signified an interest to become peer educators and also have proven leadership capacity to influence their peers. Continuation of the stakeholders meeting will also be done during the implementation and will have continuous discussions on how the network can be sustained after the project.

6. Management and Organisation - Kenya Implementation Partner

The project will be managed by our experienced local team based in Musanda Kenya who have successfully implemented the pilot project over the past 12 months.

The Kenyan team, headed by the Operations Director, work closely with our Guardians workers and who provide a home, nurturing and stability for children whilst also giving time to volunteer on our farms and other projects. They are community members or staff who provide a safe home with a head of the family teaching children life skills. They are committed to making sure every child belongs to a family, loved, protected and cared for to grow up skilled and achieving their full potential to contribute to society.

The local project implementation team comprises:

- A qualified Social Worker and Team Manager who led the pilot phase and knows the background of each and every supported family. She would be responsible for leading and coordinating services, training and implementation across the districts.
- A qualified PE trainer and counsellor from the local area who delivered the pilot programme and understands the area and young people's needs and challenges
- Our local Kenyan Operations Manager who will be in charge of financial management and monitoring of grant expenditure and quality assurance.
- The CEO
- Qualified researcher to assist with data collection, analysis, reporting and presentation.

6.1 Structure and Governance

The implementing team is led by our experienced CEO, who is supported by an active Board of Trustees and small UK staff team. In Kenya we work with our implementing partner which is a registered NGO xxx.

7. Finance and Budget

Our NGO has strict financial systems and monitoring processes in place and have independent audited accounts annually. Both UK and Kenyan accounts are audited independently and separately. The UK Treasurer and UK chair are responsible for transfer of funds against budget and local expenditure is further monitored by our Kenyan Finance Manager and Kenyan Board.

Kenya operations manager and UK CEO will jointly will manage staff and over-see monitoring and evaluation of the programme. They will also have responsibility for budget

expenditure and aligning budget with activities, reporting to The Egmont Trust and overall evaluation of the programme.

We will also work closely with xxx our evaluating partner learning from their experience and knowledge of community projects and programme development.

8. Monitoring and Evaluation

The log-frame that we have developed will form the basis of our M&E framework and timeline. Our Operations Manager will be responsible for monitoring activities against budget and for keeping things on track and ensuring quality control.

Data capture and reporting processes will form part of our development and measuring impact working with partners and all stakeholders. We will ensure that the all stakeholder understand the joint project objectives and through a reflect and learning facilitation process, also take responsibility for achieving the outcomes.

The UK CEO, will also undertake regular monitoring, meeting with stakeholder and PE's to see work in progress, monitor outcomes, meet beneficiaries, partners, staff, and assess progress against our log-frame.