Chapter One : Introduction

Estimates indicate that more than half the world's population is below the age of 25 – the largest youth generation in history – and nearly one-third is between the ages of 10 and 24 (UNFPA, 2003).Their numbers are still growing, particularly in sub-Saharan Africa. About 83 per cent of all adolescents currently live in developing countries with Africa holding the largest proportion.

In Kenya specifically, the high fertility and declining mortality that are typical of the region have yielded a youthful population. Over 40 per cent of Kenyans are younger than 15 years and only about 4 per cent are aged 65 years and above according to the 1999 census data. This means that over half of Kenya's population of about 31 million is aged below 24 years, with the larger proportion being adolescents. Indeed, more than one-quarter of the country's population consists of young people aged 10 to 24 years. Unfortunately, pervasive social, economic and health problems mean that circumstances for Africa's and Kenya's adolescents are often especially difficult even though these young people comprise form a formidable force that can no longer be ignored. Thus, Africa – Kenya included – must rise to the massive challenge of providing its adolescents with opportunities for a safe, healthy and economically productive future.

1.1 A Policy Imperative

Despite the overall global decline in teenage fertility rates, adolescent sexuality has nevertheless emerged as a major concern in many developing countries. In contrast to the fertility decline among older women in most countries that for the most part was achieved through fertility control, the reduction in fertility among younger women was mainly achieved through postponement of marriage. In many developing countries, the opportunity for further fertility reduction through this means remains limited, while in others early marriage continues to contribute to extremely high rates of childbearing among teenagers.

Improving young people's reproductive health is therefore key to improving the world's future economic and social well being. Indeed, adolescent fertility in Kenya continues to occupy a prime place in the design and implementation of reproductive health policies, strategies and programmes. The 2003 Kenya Demographic and Health Survey (KDHS) revealed that almost one-quarter of young women aged 15–19 years were either pregnant or already mothers and that teenage fertility is indeed on an upward trend.

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During the past decade or so, in part as a result of the HIV/AIDS pandemic, young people and their health needs have been the subject of considerable attention worldwide. The International Conference on Population and Development (ICPD, 1994) endorsed the right of adolescents and young adults to obtain the highest levels of health care. The major ICPD recommendation concerning reproductive health emphasized that all countries should make available universal access to a full range of high quality reproductive health services that are acceptable and convenient to all users. The ICPD Programme of Action was also quite explicit on reproductive health issues affecting adolescents:

> Governments, in collaboration with NGOs, are urged to establish programmes to meet the needs of adolescents and address Adolescent Sexual and Reproductive Health issues, including unwanted pregnancy, unsafe abortion, STDs and HIVAIDS. (para. 7.47)

An assessment of the first ten years of implementing the ICPD Programme of Action (ICPD+10) revealed that globally, countries have increasingly recognized the need to address the reproductive health and rights of adolescents and that 92 per cent reported some action in this regard (UNFPA, 2004). For example, some countries have done away with laws and policies restricting adolescents' access to reproductive health information and services, and more than half have established youth-friendly services. Most have also incorporated reproductive health education, as a key component of basic life skills, into school curricula and programmes for out-of-school youth. Kenya revised its laws related to children and

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formulated a specific Children's Act in 2001 to promote the rights of children and young people. The country has also put in place an Adolescent Reproductive Health and Development (ARH&D) Policy to enhance the implementation and coordination of programmes that address the reproductive health and developmental needs of young people.

As a complement to sector-specific policies and programmes, the ARH&D Policy defines the structures and key target areas for ensuring that adolescent health concerns are mainstreamed into all planning activities. The Policy further advocates a multi-sector, interdisciplinary and multidimensional approach for accomplishing this. In so doing, the Policy responds to concerns of adolescents raised in the National Population Policy for Sustainable Development (NPPSD), the National Reproductive Health Strategy (1997–2010), the Children's Act (2001), and other national and international declarations and conventions on the health and development of adolescents and young people. It is grounded in the understanding that the relationship between a nation's development and the health of its adolescents and young people is of paramount concern.

Broadly, the ARH&D Policy addresses five major sets of issues and challenges: Adolescent sexual health and reproductive rights; harmful practices; drug and substance abuse; socio-economic factors; and adolescents and young people with disabilities. These are summarized briefly in turn.

Adolescent Sexual Health and Reproductive Rights
Information and education on sexual and reproductive health is important for adolescents. They need accurate, appropriate information to help them understand their sexuality and the

reproductive process as they grow, as this would enable them to make sound choices, enjoy healthy and positive lifestyles, and avoid undesired consequences like unwanted pregnancies and sexually transmitted infections (including HIV/AIDS). It would also encourage responsible behaviour such as abstinence and delay in sexual initiation. The international community, through various United Nations conventions and resolutions made at world conferences, asserts that children and young people have special additional rights as they transit into adulthood.

One of these rights is the right to information and services required for their survival, growth and development. Thus, the ICPD Programme of Action called on national governments to promote the right of adolescents to reproductive health education, information and care that would help them to make informed choices about their reproductive lives. The main issues and challenges for Kenyan adolescents are:

- Continued limited access to reproductive health information and services, particularly for those who are also classified as "hard-to-reach".
- Risky sexual behaviour.
- Poor enforcement of existing laws (e.g., The Children's Act, 2001) and policies that guarantee the rights of adolescents, especially those who find themselves in difficult circumstances.

Harmful Practices

Adolescents have diverse experiences, given the varied economic, social and cultural environments in which they grow. Some social and cultural practices have a direct impact on the reproductive health status of adolescents, and consequently on their adult life. Some practices also violate rights that the individual is entitled to enjoy. For Kenya, the critical practices that need to be addressed are:

- Female genital cutting (FGC).
- Early and arranged/forced marriages.
- Sexual abuse, gender-based violence and exploitation.

These practices clearly violate the rights of the child as stipulated in the Children's Act, 2001.

Drug and Substance Abuse

Drug and substance abuse is widespread among young people and often begins at (or even before) adolescence. The most commonly abused substances are tobacco, alcohol (including local brews), khat (known locally as *miraa)*, marijuana, glue, heroin, and other injectable or oral drugs. Statistics from the National Agency for the Campaign against Drug Abuse (NACADA) reveal that in 2002, more than 22 per cent of primary school children in Kenya had taken alcohol.

By the time young people reach university, 68 per cent have taken alcohol, indicating that advanced education is apparently no protection from substance abuse as young people grow up. A large number of students across all age groups have also been exposed to other types of drugs, including hard drugs such as heroin and cocaine.

Socio-Economic Factors

Many adolescents in Kenya grow up in conditions of extreme poverty, which limits their access to essential social services such as basic education, health care, water and sanitation. Poverty forces adolescents from poor families to drop out of

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school before completion, preventing them from obtaining the much needed health information provided at higher levels of education.

For girls, the lack of access to education usually forces them to marry, enter childbearing early or engage in commercial sex work. With limited education, access to modern contraception is low, leading to unwanted pregnancies or ill-timed births, which bring along a myriad of reproductive health problems. According to the 2003 KDHS, almost half (46 per cent) of teenagers who had never attended school had begun childbearing, compared with only 10 per cent of those with secondary school education and above. Limited education also means limited skills for the job market and therefore limited economic opportunities.

Adolescents and Young People with Disabilities

Getting through adolescence with all its life challenges and becoming a well-adjusted member of society in adult life is difficult enough, but for young people with disabilities the barriers can be overwhelming. The major issue here is that even young people with disabilities have needs in terms of reproductive health information and services, but many are not reached by the limited existing services, which, in any case are rarely tailored to meet their needs. They are, in short, marginalized, not just in terms of access to social services and amenities, but also in the availability of reproductive health information and life skills training. Article 2 of the Children's Act (2001) prohibits any form of discrimination against children on whatever grounds, including disability. They also have a right to education, health and protection from all forms of abuse.

The implementation of the ARH&D Policy will, therefore, bring adolescent health issues into the mainstream of health and development. Its effective implementation will also contribute to the achievement of four of the eight Millennium Development Goals (MDGs): MDG 3 (promote gender equality and empower women), MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria and other diseases).

1.2 Justification for the Plan of Action

In Kenya, it is recognized that the changing economic, social and health climate makes adolescence an especially challenging time for young people in general and for young women in particular (Khan and Leonard, 2002). Yet this period provides an excellent opportunity for shaping behaviour among this group of the population through programmes that aim to develop a fundamental set of skills and competencies to deal with the challenges of health, development and sexuality (Evelia and Muganda, 2003). It is against this understanding that the Government, through the ARH&D Policy, set out to provide a framework for undertaking such programmes.

Facilitating the implementation of the Policy requires a concrete Plan of Action in order to increase commitment, partnership, collaboration and networking, as well as to mobilize resources among stakeholders. The current National Reproductive Health Strategy (1997–2010) states: "In spite of the fact that adolescents and youth constitute a significant

proportion of the population of Kenya and the fertility attributed to them has the potential to influence national trends in population growth, their reproductive health needs and rights have received relatively little attention to date…". And when some attention was given to adolescent reproductive health issues, most programmes were small-scale pilot efforts that tended to be tacked on to wider adult programmes – especially those targeting women (Evelia and Muganda, 2003). Indeed, the ad hoc way in which adolescent reproductive health activities have been implemented over the years has adversely affected their impact.

This is the gap that this Plan of Action proposes to fill by articulating the strategies and institutional framework highlighted in the ARH&D Policy. The Plan details a broad-based and coordinated approach to the promotion of adolescent health and development in the country by setting out guidelines and goals for how this will be done.

The Plan of Action, therefore, aims to promote the scaling up of adolescent reproductive health activities that have been going on in the country and to strengthen the coordinating role of key government ministries and departments by clearly spelling out their roles and responsibilities in the implementation of the ARH&D Policy.

Through this nationwide Plan of Action, the Government will also have confirmed its commitment to scaling up and/or strengthening the scope of ARH&D programmes. In the document *The State of the World Population 2004*, UNFPA maintains that "Investing in young people's health, education, and skills development and allowing girls to stay in school and marry later, are essential to meet the MDGs".

1.3 Goal and Objectives

The goal of this Plan of Action echoes the overall goal of the ARH&D Policy itself, which is *to contribute to the improvement of the quality of life and well being of Kenya's adolescents and youth by integrating their health and development concerns into the development process and enhancing their participation in that process.*
The overall goal of the POA therefore is to:

Facilitate the operationalization of the Adolescent Reproductive Health and Development Policy through a national multi-sector approach.

The objectives of the Plan of Action are four:
- To spell out strategies of implementation that will enhance the achievement of the goal and objectives of the ARH&D Policy by 2015.
- To identify priority activities and major implementers of the national ARH&D programme up to 2015 according to the stipulations of the Policy.
- To provide an avenue and basis for resource mobilization and management of a sustainable national ARH&D programme.
- To outline a logical framework for implementing the Policy that will also be used for monitoring and evaluation purposes.

The Plan of Action details a broad-based and coordinated approach to the promotion of adolescent health and development.

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1.4 How the POA Was Developed

The formulation of this Plan of Action for 2005–2015 involved several steps: developing a preliminary draft, preparing a logical framework analysis, writing narratives for the logical framework, holding consultations with NCAPD, DRH and other stakeholders, and costing and refining the draft Plan of Action. A review of relevant literature on policies, strategies, programmes and implementation plans provided significant insights into existing programmes, and helped harmonize strategic and implementation plans for addressing the reproductive health needs of adolescents.

The stakeholder analysis assisted in identifying potential implementers of the Adolescent Reproductive Health and Development Policy together with their respective roles and responsibilities. A list of key stakeholders currently involved in adolescent reproductive health programmes in the country in terms of who is doing what and where was compiled.

Subsequently, the key players were brought together in several participatory workshops that fulfilled various objectives: exchanging information, suggesting ways to improve existing programmes, recommending new programmes and strategies, raising the level of understanding of the ARH&D Policy, gaining clarity on stakeholder roles and responsibilities, and mapping out specific activities to be undertaken together with their respective timeframes. The articulation of roles and responsibilities intended not only to capitalize on the comparative advantage of each implementer, but also to avoid duplication of efforts. The workshops therefore helped build and strengthen partnerships among stakeholders in ARH&D, even as they promoted a high sense of commitment to and ownership of the Plan of Action.

Once the broad framework was in place, estimates of the costs of the lead activities were identified under each implementation strategy for the plan period. Finally, the suggestions from stakeholders and peer reviewers were used to refine the Plan of Action before its approval and adoption by the Government.

1.5 Outline of the Plan of Action

Following this introduction, the Plan of Action unfolds in three chapters. Chapter 2 outlines the *implementation strategies* for the four main areas: advocacy; health awareness and behaviour change communication; access to and utilization of sustainable youth-friendly services; and management. The *monitoring and evaluation framework*, which is the subject of Chapter 3, spells out how the implementation of the ARH&D programme will be coordinated, monitored and evaluated and the roles of the key institutions in the management of the programme. Chapter 4 then highlights aspects of the *financial resources* required through a short narrative of the estimated costs for implementing the ARH&D Policy.

A series of annexes enrich the presentation, including the logical framework analysis in Annex A, which itemizes goals, expected outcomes and outputs, and lead activities. Annex B presents the monitoring and evaluation framework, while Annex C contains the calendar for M&E activities for the first five years. Characteristics of youth-friendly services are detailed in Annex D. Finally, Annex E contains a glossary of terms used in this Plan of Action to guide those for whom adolescent reproductive health may be unfamiliar territory.

Suggestions from stakeholders and peer reviewers were used to refine the Plan of Action before its approval and adoption by the Government.

Chapter Two : Implementation Strategies

Socio-economic development in any nation – Kenya included – depends on the continuing good health of its adolescent generations as they move into productive adulthood. Kenya must invest in her young people to promote their comprehensive development and prevent the negative consequences of risky behaviours. The most effective way to invest in adolescents is to adopt a preventive and developmental focus. This Plan of Action for the next ten years thus represents a valuable opportunity for the country to outline a new conceptual framework for addressing adolescent reproductive health based on a holistic view of adolescents, their development and their health needs.

Adolescent development may be defined as a continuous process through which the adolescent satisfies needs, develops competencies, nurtures good habits and builds social networks. Health, education, employment, justice and social participation are crucial to development. The support of families, communities and institutions, and the guidance of individuals, are also critical to the development of a healthy adolescent. The five principles spelt out in the ARH&D Policy provide a conceptual guide to the development of this Plan of Action, which focuses on the following strategic areas:

advocacy; health awareness and behaviour change communication; access to and utilization of sustainable youth-friendly services; and management.

The following sections outline the expected outcomes, outputs and key activities to be undertaken under each of these strategies. The logical framework in Annex A extends this information by specifying indicators of the achievement of the various outcomes and activities, the means of verifying the achievements and a timetable for doing so, and the facilitating and constraining factors expected to affect the achievement.

2.1 Advocacy

The ARH&D Policy states: "In order to bring about change in policy and resource allocation necessary for its implementation, this Policy will provide for advocacy programmes to be undertaken". Such programmes will, of necessity, target policy makers and political, religious and opinion leaders with the aim of increasing awareness of the importance and positive impacts of addressing adolescents' and young people's health needs at individual, family, community and national levels. Advocacy for the implementation of this Policy will target mainstreaming

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adolescent reproductive health and development by packaging, repackaging and disseminating information, including policies. Advocacy will integrate issues of culture and poverty, and will incorporate community and youth participation, particularly disadvantaged young people or those in especially difficult circumstances, including orphans and vulnerable children.

The formulation and implementation of the advocacy strategy will aim not only to effect change in the policy and practices of institutions, but also to change attitudes of different groups of people.

Expected Outcome 1: Improved policy environment for effective implementation of adolescent reproductive health and development programmes.

Output 1.1: National and sub-national institutions effectively integrating youth issues into their programmes.

Lead activities:
1.1.1 Lobby for support and resources (human, financial, material and technical) for the implementation of the ARH&D Policy at all levels.
1.1.2 Lobby for the mainstreaming of youth issues into all sectors of national development.
1.1.3 Lobby for gender equality and equity.
1.1.4 Lobby for the integration of reproductive health issues into the education sector.
1.1.5 Lobby for a rights-based approach to the implementation of the AR&D Policy.

Advocacy will integrate issues of culture and poverty, and will incorporate community and youth participation.

Sub-activities:
1.1.a *Conduct situation analyses to identify advocacy needs.*
1.1.b *Develop advocacy strategies.*
1.1.c *Develop advocacy tools for identified target groups.*
1.1.d *Conduct advocacy campaigns through workshops and seminars.*
1.1.e *Conduct public expenditure tracking surveys.*
1.1.f *Monitor and evaluate activities to ascertain the impact of the actions taken.*

Output 1.2: Increased community participation and ownership of youth programmes on a sustainable basis.

Lead activities:
1.2.1 Sensitize implementers of adolescent-related programmes to involve communities in the planning and management of ARH&D programmes.
1.2.2 Sensitize programme implementers to involve young people in the planning and management of ARH&D programmes.
1.2.3 Lobby for support of community-based programmes for adolescents and young people in especially difficult circumstances.

Sub-activities:
1.2.a *Conduct situation analyses.*
1.2.b *Develop advocacy strategies and tools.*

1.2.c *Conduct advocacy campaigns through mass media, religious gatherings, open rallies, workshops and seminars.*

1.2.d *Monitor and evaluate activities to ascertain the impact of actions taken.*

Output 1.3: Relevant legislation on reproductive health and rights protecting adolescents and young people enacted and enforced.

Lead activities:

1.3.1 Lobby for enforcement of the Children's Act in total.

1.3.2 Sensitize communities on the Children's Act.

Output 1.4: Increased level of involvement and participation by young people in youth programmes on a sustainable basis.

Lead activities:

1.4.1 Train young people in leadership and advocacy.

1.4.2 Establish and/or improve youth health/development networks at all levels.

1.4.3 Lobby for representation of young people in local and national health and development programmes.

2.2 Health Awareness and Behaviour Change Communication

As they make the transition from childhood to adulthood, young people need both to acquire knowledge and to develop attitudes and skills for:

- Participating as members of the household/family and the community.
- Making rational decisions and assessing risks and
- consequences of decisions.
- Interacting and communicating effectively and appropriately with peers, sexual partners and adults.

It is equally important to promote behaviour change among young people who are already involved in risky behaviours such as premarital and/or unprotected sex, abortions, and substance abuse. Behaviour change communication (BCC) approaches need to be developed to improve knowledge, skills and attitudes. Such areas include information on the range of human development issues – sexuality, abstinence, negotiation skills, gender issues, relationships, reproductive biology, safe sex practices. Key here also are methods of protection against pregnancy and sexually transmitted infections including HIV.

Programmes should therefore not focus only on sexuality and the associated behaviours, but should also address nonsexual factors. Although these issues may not have a direct effect on reproductive health outcomes, they do have an indirect impact. Programmes that intend to improve knowledge, attitudes, skills and behaviours will be organized in

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The intent is to build capacities within youth centres to communicate positive reproductive health messages.

several settings, from institutions of learning and health facilities, to mass media, communities and the workplace.

Expected Outcome 2: Empowered young people able to develop, adopt and sustain healthy attitudes and behaviours towards reproductive health and development.

Output 2.1: Increased knowledge and awareness of risky behaviour.

Lead activity:
2.1.1   Train in life planning skills.
Sub-activities:
2.1.a   *Conduct training of trainers (TOT) and training of facilitators (TOF) in life skills.*
2.1.b   *Carry out training on life planning skills for peer educators.*
2.1.c   *Conduct training in packaging and dissemination of reproductive health information.*
2.1.d   *Conduct training on gender mainstreaming issues.*

Lead activity:
2.1.2   Develop and/or adopt, disseminate and distribute appropriate behaviour change communication materials.
Sub-activities:
2.1.e   *Create an inventory of information, education and communication materials.*
2.1.f   *Develop and disseminate appropriate IEC materials for health promotion and BCC.*

2.1.g   *Integrate ARH education into the curricula of all education and training institutions.*
2.1.h   *Standardize and disseminate training curricula.*
2.1.i   *Establish documentation/resource centres.*

Lead activity:
2.1.3   Conduct community awareness campaigns on ARH issues.
Sub-activities:
2.1.j   *Conduct situation analyses of community ARH awareness needs.*
2.1.k   *Develop relevant materials and messages.*
2.1.l   *Hold sensitization campaigns.*
2.1.m *Monitor and evaluate activities.*

Lead activity:
2.1.4   Establish and upgrade youth centres and clubs.
Sub-activity:
2.1.n   *Build capacities within the centres to communicate positive reproductive health messages; conduct life skills training; and offer safe space for young people to gather.*

Output 2.2: Reduced risky behaviours among young people.

Lead activity:
2.2.1   Integrate ARH with livelihood programmes.
Sub-activities:
2.2.a   *Establish and strengthen income-generating programmes for socio-economic empowerment of young people.*

2.2.b *Establish and strengthen partnership between micro-credit programmes and ARH programmes.*

2.2.c *Conduct training in micro-finance management.*

2.2.d *Conduct vocational training for young people.*

Lead activity:

2.2.2 Develop and support mechanisms for sustained behaviour change.

Sub-activities:

2.2.e *Develop rescue mechanisms and rehabilitation programmes for young people in distress including reconciliation and integration back into the community.*

2.2.f *Establish or improve referral systems for young people in stress.*

2.2.g *Sensitize communities on the existence of rehabilitation centres.*

2.3 Access to and Utilization of Sustainable Youth-Friendly Services

The ultimate strategy of the ARH&D Policy is to provide and promote the use of services by all young people. Such provision and promotion will be organized in a variety of settings and types such as:

- Youth-friendly health services
- Youth centres
- Social marketing and mass media
- Community outreach
- Private sector initiatives
- School-based programmes
- Workplace programmes

Youth-friendly services (se Annex D) should be accessible, acceptable and appropriate to the needs of young people. The World Health Organization (WHO) definition of youth-friendly services requires that such services should be in the right place, at the right time, at the right price and delivered in the right style to be acceptable to young people. In addition, the services should be effective, safe and able to meet the individual needs of young people – who will then return when they need to and recommend these services to friends.

The concept of establishing youth-friendly services where young people can have access to information, education and reproductive health services is therefore the way forward for tackling adolescent reproductive health concerns. Currently, Kenya does have a few youth-friendly centres where young people can access reproductive health services. These include voluntary counselling and testing (VCT), counselling on RH issues and drug abuse, and RH clinical services. Some youth centres have peer educators from the community who organize outreach programmes, while others have resource centres where young people can access RH information and internet facilities.

For young people to actually use clinic-based services, such services need to be friendly to them. For example, some form of entertainment – even entertainment with a message – for young people as they wait for services can attract them and improve their perception of the services. Service provider characteristics also strongly influence health-seeking behaviour. Providers need to be competent, non-judgemental

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and discreet. They should reassure the client on confidentiality. There is thus need to orient service providers, health workers, volunteers and community distributors in youth-friendly service provision. Reproductive health services for young people should aim at creating demand and increasing utilization of the services by addressing social, economic, and psychological barriers. This can be accomplished by addressing factors that affect accessibility and quality of care.

Expected Outcome 3: Quality and sustainable youth-friendly reproductive health and development services provided.

Output 3.1: Increased availability, accessibility and utilization of integrated quality ARH services

Service providers need to be competent, non-judgemental and discreet.

Lead activity:
3.1.1   Establish an essential service package for ARH.
Sub-activities:
3.1.a   *Define the essential service package.*
3.1.b   *Develop standards and guidelines for the essential service package.*
3.1.c   *Disseminate and publicize the essential service package.*

Lead activity:
3.1.2   Create demand for youth-friendly reproductive health services.
Sub-activities:
3.1.d   *Establish and disseminate a social marketing strategy through cultural, social and community forums.*

3.1.e   *Undertake community sensitization to profile ARH issues, thereby addressing barriers to accessing services.*

Lead activity:
3.1.3   Provide essential ARH commodities and services.
Sub-activities:
3.1.f   *Provide the following services:*
- *Counselling*
- *Family planning*
- *Post-abortion care*
- *STI management*
- *Comprehensive HIV/AIDS care*
- *Management of substance abuse*
- *Post-rape counselling and management (including anti-retroviral therapy)*
- *Pregnancy testing*
- *Nutrition care*
- *Pre- and postnatal care*
- *PMTCT*
- *Referral services to appropriate youth-friendly centres*

Lead activity:
3.1.4   Establish youth-friendly centres/clinics/outreaches/ workplaces.
Sub-activities:
3.1.g   *Develop and disseminate criteria for certifying institutions as friends of the youth.*
3.1.h   *Inspect and certify youth-friendly centres.*

Lead activity:

3.1.5 Develop programmes for young people in special circumstances (e.g., those in prisons, approved schools, the military or children's homes, those with disabilities, etc.)

Sub-activities:

3.1.i *Assess and document the extent of ARH problems within special youth groups.*

3.1.j *Design programmes to address these problems.*

Output 3.2: Enhanced human and infrastructural capacities of public, private, NGO and faith-based institutions to provide youth-friendly services.

Lead activity:

3.2.1 Train and retrain service providers in youth-friendly service provision.

Sub-activities:

3.2.a *Conduct training needs assessment among service providers on youth-friendly service provision.*

3.2.b *Review existing ARH curricula.*

3.2.c *Develop a national ARH curriculum.*

3.2.d *Incorporate ARH curriculum into pre-service training for health workers.*

3.2.e *Conduct regular refresher courses for health workers.*

3.2.f *Integrate ARH curriculum into teacher training institutions.*

Lead activity:

3.2.2 Establish and strengthen infrastructure and supplies at service delivery points.

Sub-activities:

3.2.g *Carry out a national inventory to establish the available infrastructure and supplies for youth-friendly reproductive health services.*

3.2.h *Procure and distribute the necessary supplies.*

3.2.i *Mobilize the necessary resources to scale up programmes and services for young people at all levels.*

Output 3.3: Increased availability and utilization of quality data and information for planning, monitoring and evaluating ARH programmes at all levels.

Lead activity:

3.3.1 Develop and implement an information system for youth-friendly reproductive health programmes and link it to other appropriate databases.

Sub-activities:

3.3.a *Carry out an assessment of the existing youth-friendly reproductive health information system.*

3.3.b *Design tools for data collection, analysis and reporting on youth-friendly reproductive health programmes.*

3.3.c *Train youth service providers on data management and utilization.*

The national ARH curriculum will be inncorporated into pre-service training for health workers.

Lead activity:

3.3.2   Undertake operations research on youth-friendly reproductive health issues.

Sub-activities:

3.3.d   *Identify research priorities in youth-friendly reproductive health.*

3.3.e   *Carry out selected research in youth-friendly reproductive health.*

3.3.f   *Document and disseminate best practices in youth-friendly reproductive health.*

Lead activity:

3.3.3   Monitor and evaluate the provision of youth-friendly reproductive health services.

Sub-activities:

3.3.g   *Design an M&E plan for service delivery.*

3.3.h   *Design and utilize M&E tools for service delivery.*

3.3.i   *Hold regular M&E review meetings.*

3.3.j   *Prepare and disseminate M&E reports regularly.*

2.4 Management of Programmes

The institutional framework for implementation will be as outlined in the ARH&D Policy. At all levels of programme implementation, there will be need for capacity building, scaling up and sustainability to meet national level targets and for involving young people. Among the necessary skills required to fully implement the activities are strategic assessment and planning, performance improvement, information exchange and sharing, monitoring and evaluation, operations research, and – above all – strategic leadership.

In the implementation of the ARH&D Policy, monitoring and evaluation will be conducted to measure both the process and the outcomes of the various activities undertaken. A framework for monitoring and evaluating programme planning and management will be developed to assess progress towards achieving goals and objectives. The Ministry of Health, in collaboration with NCAPD, will develop guidelines for the regular reporting of activities by implementing line ministries, districts, institutions and NGOs. NCAPD will prepare regular reports as well as arrange special impact assessments and other relevant studies from time to time as necessary.

While data are an essential component in monitoring and scaling-up of ARH activities, a number of challenges persist: lack of a multidisciplinary approach, lack of appropriate indicators for evaluations, poor documentation and dissemination of best/worst practices, and lack of an in-built process of decentralizing dissemination. As a starting point, there is need to compile an inventory of research on ARH to be used for identifying existing research gaps and priorities. Further research will require the development of appropriate, accurate and reliable methodologies for capturing adolescent perceptions and behaviours given the general shyness of young people to divulge information on sexuality. There is also need to develop appropriate strategies for the effective dissemination and utilization of research findings.

The successful roll out of this Plan of Action will require concerted efforts by all stakeholders. Efforts must be harmonized in order to avoid duplication, wastage of resources and conflicts. The key to implementation of the POA

Appropriate, accurate and reliable methodologies for capturing adolescent perceptions and behaviours will be developed, given the general shyness of young people to divulge information on sexuality.

at national level will be the support of the general national leadership and advocates for young people. In order for programmes to have impact beyond a very localized level, there will be need to leverage available resources and adapt to changing circumstances. Cooperation among the different levels of government, non-government and faith-based organizations, development partners, and private sector will be essential.

Leadership tasks differ depending on the level and needs. At the national level, it will be critical to share experiences, while at programme level, there will be need to share best practices. Community-level tasks should include the development and promotion of skills in programme management, community participation and empowerment.

In order to achieve the desired results, the following expected outcome, associated outputs and activities will be accomplished.

Expected Outcome 4: Enhanced capacity of key national coordinating agencies to manage the ARH&D programme effectively

Output 4.1: Effective coordination of all programmes achieved.

Lead Activity:
4.1.1   Develop a resource mobilization strategy.
Sub-activities:
4.1.a   *Conduct regular budget analyses of ARH allocations.*

4.1.b   *Conduct donor and NGO mapping to determine areas of operation, activities and funding levels.*
4.1.c   *Mobilize resources for key national activities and underserved areas/groups.*

Lead Activity:
4.1.2   Organize regular planning and review meetings.
Sub-activities:
4.1.d   *Hold regular planning meetings for all stakeholders at all levels.*
4.1.e   *Hold regular joint review meetings with development partners and implementers.*
4.1.f   *Prepare and disseminate reports of the regular meetings.*

Output 4.2: Networking and collaboration among stakeholders enhanced.

Lead Activity:
4.2.1   Strengthen partnerships and networks among government departments, development partners, NGOs, FBOs and communities involved in ARH&D programmes.
Sub-activities:
4.2.a   *Prepare a national inventory of youth serving organizations and experts.*
4.2.b   *Set up and regularly update a database of key players on ARH&D.*
4.2.c   *Establish networks for knowledge and information sharing.*

Community-level tasks should include the development and promotion of skills in programme management, community participation and empowerment.

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Best practices, new ideas and collaborative efforts will be documented and disseminated through multiple channels.

4.2.d *Establish linkages between institution-based health programmes and other community programmes.*

4.2.e *Regularly provide forums for coordinated dialogues among key players on policy learning, programme management and other critical issues affecting young people.*

4.2.f *Document and disseminate through multiple channels best practices, new ideas and collaborative efforts.*

4.2.g *Strengthen capacities of implementing agencies.*

Output 4.3: Increased availability of quality data and information for planning and management.

Lead activity:
4.3.1 Identify priority ARH research areas.
Sub-activities:
4.3.a *Review existing research to identify gaps.*
4.3.b *Develop research agenda.*
4.3.c *Re-package and disseminate existing research findings.*

Lead activity:
4.3.2 Conduct relevant research to inform policy, programme management and service provision.
Sub-activities:
4.3.d *Hold training workshops on proposal writing and data collection, management, analysis and utilization.*
4.3.e *Conduct intervention and policy studies.*

Lead activity:
4.3.3 Promote use of evidence-based data and information in decision making.
Sub-activities:
4.3.f *Hold training workshops on communicating research findings.*
4.3.g *Disseminate research findings to relevant audiences.*

Output 4.4: Monitoring and evaluation system for ARH&D programme developed and utilized.

Lead activity:
4.4.1 Set up a Technical Working Group for the implementation of the Policy.

Lead activity:
4.4.2 Develop M&E plans.
Sub-activities:
4.4.a *Train key players on the national M&E framework.*
4.4.b *Disseminate the national M&E framework.*
4.4.c *Develop and regularly update M&E plans.*
4.4.d *Develop performance monitoring and annual work plans.*
4.4.e *Set up database for M&E indicators.*
4.4.f *Train implementers on use of data for decision making.*
4.4.g *Prepare regular M&E reports.*
4.4.h *Disseminate and distribute M&E reports.*

Lead activity:
4.4.3 Conduct external evaluations.

Chapter Three : Monitoring & Evaluation Framework

A national system for monitoring and evaluating this Plan of Action is a critical component of the implementation of the ARH&D Policy. Such a system will enable tracking programme implementation as well as monitoring the various assumptions and risks in overall management. The M&E framework will aim at meeting the information needs of different stakeholders: policy makers, civil society organizations, research and academic institutions, external development partners, the media, and the general public.

The specific objective of the M&E system is to promote evidence-based decision making at all levels. In order to achieve this objective, the various stakeholders in the implementation of the Policy will be encouraged to:

- Ensure timely availability of data.
- Analyse the data and disseminate and promote the use of the findings by all stakeholders.
- Ensure proper storage, reliable access and easy retrieval by different users.

Further, the M&E activities will:
- Link with other national M&E systems to ensure adequate provision of more disaggregated data so as to facilitate monitoring at all levels (regional, district, facility), while still focusing on national level monitoring.
- Strive to collect and analyse qualitative information and increase participatory monitoring.
- Be guided by other research and analysis programmes to evaluate changes towards desired outcomes.

3.1 Institutional Arrangements and Implementation Mechanisms for M&E Framework

The M&E strategy will be implemented through an institutional structure consisting of a Technical Working Group (TWG) under the direction of NCAPD and DRH. The TWG will ensure that:

- A rationalized, harmonized and functional system of routine data collection at the national and regional levels is in place.
- There is capacity development at all levels for data collection, analysis and use.
- Guidelines for determining research priorities are drawn up to include outcome and impact evaluations.

The specific objective of the M&E system is to promote evidence-based decision making at all levels.

- Dissemination plans targeted to key stakeholders such as the national and regional levels, local government authorities, and civil society are developed.
- A communications strategy is developed and implemented.

The institutional capacity of the coordinating agencies will be strengthened to enable them to deliver the expected outputs and ensure sustainability of the monitoring and evaluation system. Special measures will be taken to build capacities in areas where performance is observed to be weak. These arrangements will be necessary as all information sources, including surveys, censuses and routine service data, will continue to be captured, analysed, disseminated and evaluated under this single system.

3.2 Monitoring

To be effective, monitoring requires the routine collection of data according to established indicators of performance, along with the analysis and sharing of the findings. The main purpose is to enable managers to verify progress and make evidence-based decisions about any corrections needed in implementation. The specific components of a monitoring system can be described as follows:

- *Indicators:* The list of indicators developed to meet the information needs of different stakeholders at the national level will continue to be used. However, the indicator set will be reviewed periodically to ensure that it meets the additional information requirements necessitated by new developments in ARH&D. Targets related to the Millennium

Development Goals (MDGs) will also be addressed to enable sustained reporting on these global indicators. At activity level, the indicators will be merely a checklist of the stated activities.

- *Data collection, analysis and storage:* The emphasis will be on data quality, and routine administrative data systems will be strengthened and harmonized accordingly. In addition, qualitative methodologies will be used to further explore topics of critical importance to ARH&D.

- *Data dissemination and communications:* The monitoring system will have an advocacy, sensitization and dissemination strategy that incorporates a mechanism for managing inter-sector linkages and continuous feedback from the national, provincial and district levels. The strategy is intended to improve communications for advocacy for the ARH&D, MDGs and other relevant national goals to facilitate understanding of the indicators and increase participation at all levels.

3.3 Evaluation

Evaluation will take place at three points: baseline, midline and end line. Comprehensive reviews will be informed by regular progress reports produced under national consultative processes. The evaluation strategy will pay particular attention to linkages with other monitoring and evaluation systems to ensure that systems at different levels inform each other. Operationally, the emphasis will be on generating relevant data to meet the information needs of

The emphasis will be on meeting the information needs of different stakeholders and creating awareness of the available information for its effective use in planning and decision making.

different stakeholders and creating awareness of the available information for its effective use in planning and decision making.

3.4 Monitoring Tools/Outputs and Deliverables

M&E outputs and deliverables will include a variety of reports and evaluations prepared according to established indicators. Specific outputs include:

- Quarterly reporting of progress.
- Annual progress reports.
- In-depth analytical reports using data generated by the M&E system, commissioned research and other evaluations relevant to ARH&D.

- Baseline, midline and end line evaluation reports of programmes undertaken to meet the goals of the ARH&D Policy.

The logical framework in Annex A details the chain of results (goal, expected outcomes and outputs) and lead activities to be undertaken during the plan period. The listed agencies will be responsible for the delivery of the outputs and will therefore develop further monitoring and evaluation plans and other tools including annual work plans for the actions and activities they undertake. The simplified monitoring and evaluation plan presented in Annex B shows key outputs and timelines for their evaluation.

The monitoring system will incorporate a mechanism for managing inter-sector linkages and continuous feedback from the national, provincial and district levels.

Chapter Four : Financial Resources

Costs are based on an ideal situation and standard costing models rather than past and ongoing programmatic experiences.

This chapter provides an estimation of the total resources required to achieve the goal and objectives outlined in the Adolescent Reproductive Health and Development Policy (2005–2015). The chapter specifically provides estimates of the resources needed to implement the four broad strategic areas: advocacy; health awareness and behaviour change communication; access to and utilization of sustainable youth-friendly services; and management. The cost estimates are provided for the first five years (2005–2010) of implementing the ARH&D Policy. Realistic estimates for the second half (2010–2015) will be determined by the implementation experiences of the first five years. The costs are based on an ideal situation and standard costing models rather than past and ongoing programmatic experiences.

4.1   Methodology

Various demographic and epidemiological databases were used to estimate the number of adolescents in need of the different reproductive health interventions. The data sources included Kenya's population projections and the 1993, 1998 and 2003 Demographic and Health Surveys (KDHS). The unit costs for specific key interventions were obtained from various surveys carried out in Kenya and as well as from international sources, particularly WHO.

To estimate the total resources required for the implementation of the ARH&D Policy, the Resource Needs Model was used. The model estimates resource requirements on the basis of three inputs: population in need, targets and unit costs. The formula is summarized as:

Resources (Ksh) = Population in need x coverage target x unit cost

The population in need is the number of adolescents who will require a given service or intervention (e.g., those who need counselling, antenatal care services, injectables, etc.). The coverage target is the proportion of the adolescent population in need of a given intervention that will be reached each year. For example, 80 per cent of pregnant adolescents are targeted to utilize ANC services in 2005/06. The unit cost is the amount of resources required per adolescent reached or per service provided.

4.2 Estimates of Resource Requirements

The targets used in estimating the resources required for the implementation of the ARH&D Policy by 2010 are presented in Table 4.1. The targets are based on data obtained from the sources mentioned above as well as information from previous studies on health costing. It bears repeating, however, that the estimates are drawn from standard costing models and are not based on experiential activities of the Ministry of Health or any other organization that provides services to young people.

The estimated resource requirements are summarized in Table 4.2 and illustrated in Figures 4.1 and 4.2.

Table 4.1:   Targets used in the estimation of implementation costs

Intervention	Baseline (2003)	Target in 2010
Behaviour change communication	-	80%
Antenatal care	84%	100%
Injectables	8%	14%
Pills	2.2%	1.7%
Implants	0.25%	0.35%
IUCD	3.9%	3.6%
Condoms	47%	60%
STI management	-	100%
Delivery by skilled attendant	47%	60%
Obstetric care	-	100%
Advocacy	-	100%

- Data not available

Figure 4.1:   Total resource requirement by service category
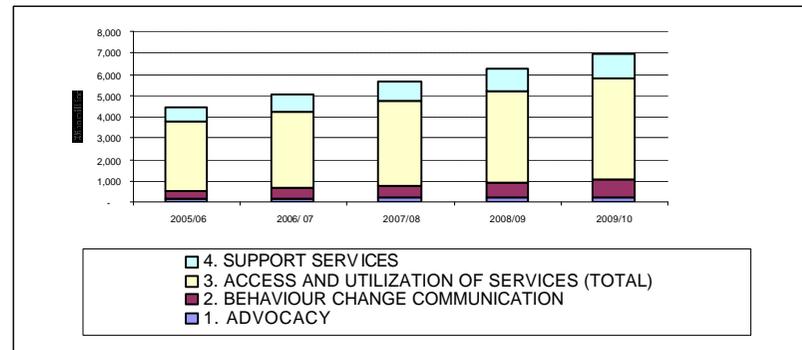
Figure 4.2:   Distribution of total resources required (2005–2010)

The costing model estimates resource requirements on the basis of three inputs: population in need, targets and unit costs.
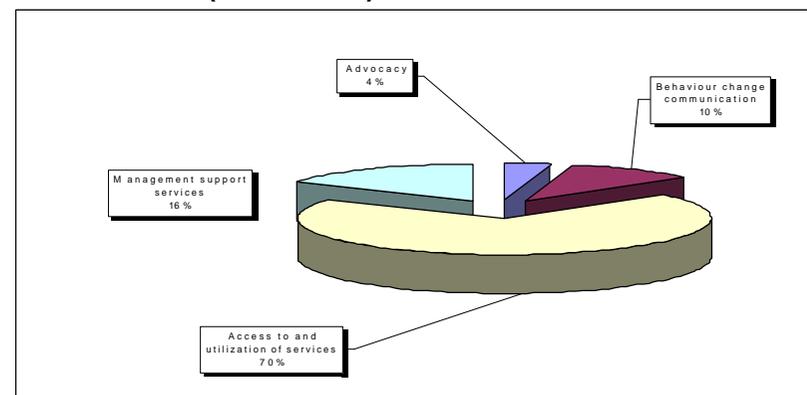
As shown in Table 4.2, the resource requirements for advocacy activities, for example, increase from Ksh165 million in FY 2005/06 to Ksh258 million in FY 2009/10. It is also shown that the total resources required for implementing activities related to BCC rise from Ksh376 million to Ksh793

million over the same period. Access to and utilization of different ARH services such as ANC, family planning and essential obstetric care among others will require Ksh3.196 billion in the first year, rising to Ksh4.778 billion by the fifth year of the plan period (2009/10). Management support services, which consist of management and coordination, monitoring and evaluation, and research, will require Ksh728 million in FY 2005/06 and Ksh1.135 billion in FY 2009/10.

Overall, the total resources for implementing the four components of the strategy rise from Ksh4.465 billion in FY 2005/06 to Ksh6.964 billion in FY 2009/10. Figure 4.1 shows the resources needed in each year of the first five years of the implementation.

The distribution of financial requirements for implementing the ARH&D Policy during the first five years (2005–2010) is illustrated in Figure 4.2. It is evident that access to and utilization of youth-friendly services will consume the largest portion (70 per cent) of the total resource requirements. This is followed by support services (16 per cent), behaviour change communication (10 per cent) and advocacy (4 per cent).

Table 4.2:   Resource requirements by type of intervention (Ksh millions)

Intervention	2005/06	2006/07	2007/08	2008/09	2009/10	2005/10
1. Advocacy	**165**	**187**	**209**	**232**	**258**	**1,050**
2. Behaviour change communication	**376**	**477**	**580**	**685**	**793**	**2,911**
3. Access to/utilization ofservices (Total)	**3,196**	**3,556**	**3,930**	**4,317**	**4,778**	**19,777**
Antenatal care	125	133	142	150	159	**710**
Injectables	205	252	301	352	404	**1,515**
Pills	67	64	61	58	55	**305**
Implant	13	14	16	17	19	**78**
IUCD	34	34	34	34	34	**171**
Condom promotion & distribution	1,403	1,602	1,808	2,023	2,246	**9,082**
STI management	249	306	367	430	551	**1,903**
Delivery	736	749	762	775	789	**3,811**
Essential obstetric care	101	102	104	106	108	**521**
Institutional capacity building	165	187	209	232	258	**1,050**
Infrastructure development	99	112	125	139	155	**630**
4. Management support services	**728**	**821**	**919**	**1,019**	**1,135**	**4,621**
Management and coordination	331	373	418	463	516	**2,101**
Monitoring and evaluation	331	373	418	463	516	**2,101**
Research	66	75	84	93	103	**420**
Total resource requirements	**4,465**	**5,041**	**5,636**	**6,253**	**6,964**	**28,359**

Access to and utilization of youth-friendly services will consume the largest portion of the total resource requirements.

Documents Reviewed

Centre for the Study of Adolescence. 2003. *The Situation of Young People in Kenya.* Nairobi, Kenya.

Commonwealth Secretariat. 1997. *Global Commitments to Young People Rights: A Guide for Young People to the Government Agreements from UN World Conferences, from Rio to Istanbul.* Commonwealth Secretariat, London.

Dagnachew, et al. 1997. *An Overview of Adolescent Reproductive Health in Kenya.*

Evelia, H. and R. Muganda. 2003. *Implementing Adolescent Reproductive Health Policies and Programmes in Kenya: Population and Sustainable Development Challenges in Kenya.* PAK Occasional Publication 4. Nairobi: Population Association of Kenya.

Family Care International. 1996. *ASRH Resource Materials: A Needs Assessment in English-Speaking Africa.*

Khan, A.B. and A. Leonard. 2002. *Expanding Livelihood Opportunities for Adolescent Girls and Young Women in Kenya.*

Kenya Alliance for the Advancement of Children (KAACR) and Action Aid Kenya. 2002. *Children Act 2001 and UNCRC*, Popular Version.* Nairobi: KAACR and Action Aid Kenya.

Ministry of Health. 2004. Draft Guidelines for the Provision of Youth-Friendly Services (YFS) in Kenya.

Mugisha et al. 2003. *Alcohol, Substance and Drug Use among Urban Slum Adolescents in Nairobi, Kenya.* Cities Volume 20 No. 4. Great Britain: Elsevier Science Ltd.

Pathfinder International. 2004. *Partnering with African Youth: Pathfinder International and the African Youth Alliance Experience.*

Republic of Kenya. 2004. *2003 Kenya Demographic and Health Survey.*

Republic of Kenya. 2003. *Adolescent Reproductive Health and Development Policy.* National Council for Population and

*UNCRC - United Nations Convention on the Rights of the Child

Development, Ministry of Planning and National Development, and Division of Reproductive Health, Ministry of Health.

Republic of Kenya. 2001. *Plan of Action to Implement the Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development 2001–2010.* National Council for Population and Development, Ministry of Planning and National Development.

Republic of Kenya. 2001. *Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development.* National Council for Population and Development, Ministry of Planning and National Development.

Republic of Kenya. 2000. *Kenya National HIV/AIDS Strategic Plan 2000–2005.* National AIDS Control Council, Office of the President.

Republic of Kenya. 1999. *National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999–2019.* Ministry of Health.

Republic of Kenya. 1996. *National Reproductive Health Strategy, 1997–2010.* Ministry of Health.

Susan et al. 2000. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs: Focus on Young Adults. Tool Series, 5* June 2000.

United Nations. 1989. *Adolescent Reproductive Behaviour: Evidence from Developing Countries.* New York.

UNFPA. 2004. *State of the World Population 2004. The Cairo Consensus at 10: Population: Reproductive Health and the Global Effort to End Poverty.* New York: UNFPA.

UNFPA. 2003. *State of the World Population 2003: Investing in Adolescents' Health and Rights.* New York: UNFPA.

Annex A : Logical Framework

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Important assumptions
GOAL: *To contribute to the improvement of the well-being and quality of life of Kenya's adolescents and youth through advocacy, creation of positive health awareness, and expansion of quality services within the context of national health and development programmes*	▪ Unplanned pregnancies among women aged 15–24 reduced ▪ HIV prevalence among those aged 15–24 reduced ▪ STI prevalence among men and women aged 15–24 reduced ▪ Ratio of girls to boys in primary, secondary and tertiary education increased ▪ Ratio of literate women to men aged 15–24 increased ▪ Unemployment rate among 15–24-year-olds reduced ▪ Proportion of young people marrying before age 18 reduced ▪ Reduced prevalence of fistulae among women aged 15–24 ▪ Per cent of women aged 15–24 who have undergone FGC reduced	▪ Demographic and health surveys, behaviour surveillance surveys, census reports ▪ MOEST reports ▪ Ministry of Labour reports ▪ MOGSCSS reports ▪ MOH reports	▪ Ministry of Planning and National Development ▪ Ministry of Education, Science and Technology ▪ Ministry of Labour ▪ Ministry of Gender, Sports, Culture and Social Services ▪ Ministry of Health	▪ Political stability ▪ Political will ▪ Availability of resources

Continued

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Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTCOME 1: *Improved policy environment for effective implementation of adolescent reproductive health and development programmes*	▪ Increased resource allocation to youth programmes ▪ Number of development and implementing agencies collaborating in planning, implementation and monitoring of ARH programmes at all levels	▪ MPND reports ▪ Printed estimates ▪ MOGSCSS reports ▪ Ministry of Health reports ▪ Hansard ▪ Attorney General's Office reports ▪ Judiciary reports ▪ Office of the President reports ▪ Content analysis of mass media reports ▪ MOEST reports	▪ Ministry of Planning and National Development ▪ MOGSCSS ▪ MOH ▪ Attorney General's Chambers ▪ Judiciary ▪ Office of the President	▪ Relevant FBOs and NGOs
OUTPUT 1.1: National and sub-national institutions effectively integrating youth issues into their programmes	▪ Number of implementing partners mainstreaming and integrating youth issues into their programmes	▪ NCAPD and DRH reports ▪ MOGSCSS reports	▪ MPND ▪ MOGSCSS ▪ MOH	
Lead activities: ▪ Lobby for support and resources (human, financial, material and technical) for the implementation of the ARH&D Policy at all levels ▪ Lobby for the mainstreaming of youth issues into all sectors of national development ▪ Lobby for gender equality and equity ▪ Lobby for the integration of RH issues into the education sector ▪ Lobby for a rights-based approach in the implementation of the ARH&D Policy	▪ Advocacy strategy in place ▪ Number of advocacy campaigns for each activity conducted ▪ Amount and type of resources allocated to ARH programmes ▪ Number and type of sectors mainstreaming youth issues into their programmes ▪ Number of males and females enrolled in the education sector	▪ NCAPD and DRH reports ▪ Departments of Young People, Children and Gender reports ▪ MOEST reports	▪ MPND ▪ MOGSCSS ▪ MOH ▪ MOEST ▪ Ministry of Home Affairs	

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTPUT 1.2: Increased community participation and ownership of youth programmes on a sustainable basis	▪ Number of organizations and implementers incorporating communities and young people into planning and management of youth programmes	▪ Same as in Output 1	▪ Same as in Output 1	
Lead activities: ▪ Sensitize implementers of adolescent-related programmes to involve communities in planning and management of ARH&D programmes ▪ Sensitize programme implementers to involve young people in planning and management of ARH&D programmes ▪ Lobby for support of community-based programmes for adolescents and young people in especially difficult circumstances	▪ Check list of activities undertaken	▪ Same as in Output 1	▪ Same as in Output 1	▪ FBOs, NGOs, private sector
OUTPUT 1.3: Relevant legislation on reproductive health and rights protecting adolescents and young people enacted and enforced	▪ Number of regulatory mechanisms that protect rights and health of young people in place ▪ Number of positive pronouncements against harmful practices by opinion leaders in public forums ▪ Laws and legislation on youth issues effectively enforced	▪ Hansard ▪ Judicial and police reports ▪ Children's Department reports ▪ Mass media content analysis reports	▪ AG Chambers ▪ Office of the President ▪ MOHA (Children's Department)	▪ Organizations dealing with victims of rights violations
Lead activities: ▪ Lobby for enforcement of the Children's Act in total ▪ Sensitize communities on the Children's Act	▪ Advocacy strategies for different target groups in place ▪ IEC strategy for targeting communities and other target groups in place ▪ Number of sensitization campaigns conducted	▪ Hansard ▪ Judicial and police reports ▪ Children's Department reports ▪ Mass media content analysis reports	▪ AG Chambers ▪ Office of the President ▪ MOHA (Children's Department)	▪ Organizations dealing with victims of rights violations

Continued

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTPUT 1.4: Increased level of involvement and participation by young people in youth programmes on a sustainable basis	▪ Expanded and active network for development of young people ▪ Number of organizations and implementers incorporating young people into planning and management of youth programmes	▪ MOGSCSS reports, ▪ NCAPD Reports	▪ NCAPD ▪ MOGSCSS ▪ MOHA ▪ Directorate of Person-nel Management ▪ MOEST	
Lead activities: ▪ Train young people in leadership and advocacy ▪ Establish youth health/development networks at all levels ▪ Lobby for representation of young people in local and national health and development programmes	▪ Number of trainings conducted ▪ Number of young people trained ▪ Number of groups reached by expanded network ▪ Number of organizations and agencies involving young people in their programmes and projects			

Continued

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTCOME 2: *Empowered young people able to develop, adopt and sustain healthy attitudes and behaviours towards reproductive health and development*	▪ Proportion of young people engaged in risky behaviour (unprotected sex, multiple sexual partners, substance abuse, etc.) reduced ▪ Number of young women experiencing obstetric complications reduced	▪ BSS, DHS, ▪ Comprehensive survey of young people	▪ MOH ▪ MOEST ▪ Office of the President ▪ MPND	▪ UNFPA, UNICEF, ILO, FBOs, NGOs, UNAIDS, WHO
OUTPUT 2.1: Increased knowledge and awareness of risky behaviour	▪ Per cent of young people who know contraceptives and where to get them ▪ Proportion of young people who can cite at least 3 misconceptions about HIV/AIDS ▪ Proportion of young people aware of at least 2 types of STIs ▪ Proportion of young people who know where to get VCT services ▪ Proportion of young people who know how HIV is transmitted	▪ BSS, DHS ▪ Comprehensive survey of young people ▪ Reports of relevant implementing agencies	▪ Same as above	▪ Same as above
Lead activities: ▪ Conduct training in life skills ▪ Develop/adapt, disseminate and distribute appropriate BCC-related materials ▪ Conduct community awareness campaigns on ARH issues ▪ Establish and upgrade youth centres and clubs	▪ Number and type of trainings conducted ▪ Number of people trained ▪ Number of organizations conducting training ▪ Number and type of BCC-related materials developed ▪ Number and type of BCC-related materials disseminated ▪ Number of organizations and individuals reached ▪ Number of community awareness campaigns conducted ▪ Number of individuals reached through awareness campaigns ▪ Number of organizations conducting awareness campaigns ▪ Number and type of centres established/upgraded ▪ Number and type of functional centres	▪ NCAPD reports ▪ Training reports ▪ DRH reports ▪ Dissemination reports	▪ NCAPD ▪ MOGSCSS ▪ Gender Commission ▪ MOEST ▪ Ministry of Labour	▪ Relevant FBOs, NGOs and CBOs
OUTPUT 2.2: Reduced risky behaviours among young people	▪ Proportion of young people involved in risky behaviour reduced	▪ Same as in Output 1	▪ Same as in Output 1	▪ Same as in Output 1
Lead activities: ▪ Integrate ARH with livelihood programmes ▪ Develop and support mechanisms for sustained behaviour change	▪ Number of institutions providing leadership training ▪ Number of personnel with capacity to train young people in livelihood skills ▪ Number of young people trained in livelihood skills	▪ MOGSCSS ▪ MPND		

Continued

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTCOME 3: *Quality and sustainable youth-friendly reproductive health and development services provided*	▪ Proportion of young people with STIs reduced ▪ Proportion of young people accessing ARH services increased ▪ A functional RH database in place ▪ Contraceptive prevalence rate among women aged 15–24 increased ▪ Age at first sex	▪ Comprehensive survey of young people ▪ BSS, DHS ▪ HMIS ▪ NASCOP and NACC reports	▪ DRH, NASCOP, NACC, MOEST	
OUTPUT 3.1: Increased availability, accessibility and utilization of integrated quality ARH services	▪ Number of facilities providing integrated adolescent RH services ▪ Number of facilities offering youth-friendly services ▪ Number of targeted programmes for special youth groups ▪ Number of young people seeking RH services	▪ KSPA, BSS, DHS ▪ HMIS	▪ DRH, NASCOP, NACC, MOEST	
Lead activities: ▪ Establish an essential service package for ARH ▪ Create demand for youth-friendly reproductive health services ▪ Provide essential ARH commodities and services ▪ Establish youth-friendly centres ▪ Develop programmes for young people in special circumstances (those in prisons, approved schools, the military, children's homes, etc.)	▪ Standards and guidelines on essential service package in place ▪ Number of sites offering integrated ARH services ▪ Number of implementers using essential services package ▪ A social marketing strategy in place ▪ Number of functional youth-friendly centres ▪ Number of functional programmes developed for special youth groups ▪ Number of institutions providing special programmes for young people ▪ Number of functional VCT sites ▪ Number of community sensitization sessions conducted	▪ Reports of the implementing agencies and institutions ▪ DRH reports	▪ DRH, NASCOP, NACC, MOEST, Office of the President (Department of Defence) ▪ MOHA (Prisons Department, Children's Department)	

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTPUT 3.2: Enhanced human and infrastructural capacities of public, private, NGO and faith-based institutions to provide youth-friendly services	▪ Number of facilities providing a full range of youth-friendly services	▪ KSPA, BSS, DHS ▪ HMIS ▪ DRH reports	▪ DRH	
Lead activities: ▪ Train and retrain service providers in youth-friendly service provision ▪ Establish and strengthen infrastructure and supplies at service delivery points	▪ Training needs assessment conducted ▪ National ARH training curriculum in place ▪ Number of refresher courses conducted ▪ ARH curriculum integrated into teacher training institutions ▪ Inventory of available infrastructure and supplies for youth-friendly services compiled ▪ Number of ARH programmes scaled up ▪ Number of institutions with the necessary supplies	▪ DRH reports	▪ DRH	
OUTPUT 3.3: Increased availability and utilization of quality data and information for planning, monitoring and evaluating ARH programmes at all levels	▪ Functional MIS at DRH in place	▪ DRH reports	▪ DRH	
Lead activities: ▪ Develop and implement an information system for youth-friendly reproductive health programmes ▪ Undertake operations research on youth-friendly RH issues ▪ Monitor and evaluate provision of youth-friendly RH services	▪ An assessment of youth-friendly RH information systems conducted ▪ Number and type of tools designed ▪ Number of service providers trained ▪ Research priorities on youth-friendly RH services identified ▪ Number and type of research conducted ▪ Number and type of best practices documented and disseminated ▪ M&E plan for ARH service delivery in place ▪ Number and type of M&E tools being utilized ▪ Number of M&E meetings held	▪ DRH reports ▪ NCAPD reports ▪ CBS reports	▪ DRH ▪ NCAPD ▪ CBS	

Continued

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTCOME 4: *Enhanced capacity of key national coordinating agencies to manage the ARH&D programme effectively*	▪ Funding for ARH&D programme increased ▪ Number of institutions effectively using the POA to implement the ARH&D Policy	▪ NCAPD and DRH reports	▪ DRH, NCAPD	
OUTPUT 4.1: Effective coordination of all programmes achieved	▪ Number and type of functional technical working groups on ARH issues ▪ Number and type of meetings held ▪ A database on ARH&D programmes set up	▪ NCAPD and DRH reports	▪ DRH, NCAPD	▪ CBS
Lead activities: ▪ Develop resource mobilization strategy ▪ Organize regular planning and review meetings	▪ Resource mobilization strategy in place ▪ Number of joint planning and review meetings held ▪ Number of reports disseminated	▪ Dissemination reports ▪ NCAPD and DRH reports	▪ DRH, NCAPD	
OUTPUT 4.2: Networking and collaboration among stakeholders enhanced	▪ Expanded network of various organizations actively involved in managing and debating youth issues and activities ▪ An updated database of all partners in ARH&D in place	▪ NCAPD and DRH reports	▪ NCAPD, DRH	
Lead activity: ▪ Strengthen partnerships and networks among government departments, development partners, NGOs, FBOs and communities involved in ARH&D programmes	▪ Number and type of functional partnerships/networks ▪ Number and type of best practices, new ideas and collaborative efforts documented and disseminated	▪ NCAPD and DRH reports	▪ NCAPD, DRH	
OUTPUT 4.3: Increased availability of quality data and information for planning and management	▪ A functional information database in place ▪ A research agenda in place	▪ CBS, NCAPD reports ▪ HMIS ▪ Department of Civil Registration reports	▪ DRH, CBS, DRH, Division of HMIS ▪ Department of Civil Registration	
Lead activities: ▪ Identify priority research areas ▪ Conduct relevant research to inform policy, programme management and service provision ▪ Promote use of evidence-based data and information in decision making	▪ Number and type of research studies conducted and disseminated ▪ Number of organizations using evidence-based data for decision making	▪ CBS, NCAPD reports ▪ HMIS ▪ Department of Civil Registration reports	▪ DRH, CBS, DRH, Division of HMIS ▪ Department of Civil Registration	▪ Relevant national research institutions

Narrative summary	Verifiable indicators	Sources of verification	Responsible institutions/agencies	Supporting institutions
OUTPUT 4.4: Monitoring and evaluation system for ARH&D programme developed and utilized	▪ A functional M&E system in place	▪ DRH and NCAPD Reports	▪ DRH, NCAPD	
Lead activities: ▪ Set up a Technical Working Group for the implementation of the Policy ▪ Develop M&E plans ▪ Conduct external evaluations	▪ A functional Technical Working Group in place ▪ Number of key players trained on M&E framework ▪ Number and type of M&E plans developed ▪ Number of implementers with annual work plans ▪ Number and type of M&E reports prepared and disseminated ▪ Number and type of evaluations conducted	▪ DRH and NCAPD Reports	▪ DRH, NCAPD	

Annex B: Monitoring and Evaluation Plan

Narrative summary	Indicators	Sources of verification	Timing of data availability	Facilitating and constraining factors
GOAL: *To contribute to the improvement of the well-being and quality of life of Kenya's adolescents and youth through advocacy, creation of positive health awareness, and expansion of quality services within the context of national health and development programmes*	▪ Unplanned pregnancies among women aged 15–24 reduced ▪ Per cent of women aged 15–24 undergoing FGC reduced	▪ DHS	▪ 2009	▪ Behaviour surveillance studies conducted ▪ DHS conducted ▪ Government conducts census on schedule ▪ Functional structures for monitoring and evaluation in place ▪ NASCOP continues with surveillance data collection ▪ DRH begins to conduct surveillance for fistulae and other special surveys
	▪ HIV prevalence among young people aged 15–24 reduced	▪ DHS	▪ 2009	
	▪ STI prevalence among young people aged 15–24 reduced	▪ DHS, BSS ▪ Sentinel surveillance reports	▪ DHS reports by 2009, BSS reports by 2010 ▪ Annual sentinel surveillance reports	
	▪ Ratio of girls to boys in the education sector increased ▪ Ratio of literate women to men aged 15–24 increased	▪ Ministry of Education, Science and Technology reports ▪ Census, DHS ▪ Special surveys on literacy and schooling	▪ Annual MOEST reports ▪ Census reports by 2010 ▪ DHS reports by 2009	
	▪ Unemployment rate among 15–24-year-olds reduced	▪ Census ▪ DHS ▪ Ministry of Labour reports ▪ Economic Surveys	▪ Census reports by 2010 ▪ DHS reports by 2009 ▪ Annual Ministry of Labour reports ▪ Annual Economic Surveys	
	▪ Proportion of young people marrying before age 18 reduced	▪ DHS, census	▪ Census reports by 2010 ▪ DHS reports by 2009	
	▪ Reduced prevalence of fistulae among women aged 15–24	▪ DRH reports	▪ Proposed date when surveillance system is fully functional is 2008	

Continued

Narrative summary	Indicators	Sources of verification	Timing of data availability	Facilitating and constraining factors
OUTCOME 1: *Improved policy environment for effective implementation of adolescent reproductive health and development programmes*	▪ Increased resource allocation to youth programmes ▪ Number of development and implementing agencies collaborating in planning, implementation and monitoring of ARH at all levels	▪ Programme reports ▪ Public expenditure tracking (PET) surveys	▪ Annually ▪ Every three years	▪ PET surveys conducted ▪ Number of implementing partners continue focusing on young people's issues
OUTPUT 1.1: National and sub-national institutions effectively integrating youth issues into their programmes	▪ Number of implementing partners mainstreaming and integrating youth issues into their programmes	▪ Programme reports	▪ Annually	
OUTPUT 1.2: Increased community participation and ownership of youth programmes on a sustainable basis	▪ Number of organizations and implementers incorporating communities and young people into planning and management of youth programmes	▪ Programme reports	▪ Annually	
OUTPUT 1.3: Relevant legislation on reproductive health and rights protecting adolescents and young people enacted and enforced	▪ Number of regulatory mechanisms in place that protect young people's rights and health ▪ Laws and legislation on youth issues effectively enforced ▪ Increased positive pronouncements against harmful practices by opinion leaders in public forums	▪ Programme reports ▪ Programme reports ▪ Programme reports	▪ Annually ▪ Annually ▪ Annually	
OUTPUT 1.4: Increased level of involvement and participation by young people in youth programmes on a sustainable basis	▪ Expanded and active network for youth development	▪ Programme reports	▪ Annually	

Continued

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Narrative summary	Indicators	Sources of verification	Timing of data availability	Facilitating and constraining factors
OUTCOME 2: *Empowered young people able to develop, adopt and sustain healthy attitudes and behaviours towards reproductive health and development*	▪ Proportion of young people engaged in risky behaviour (unprotected sex, multiple sexual partners, substance abuse, etc.) reduced ▪ Number of young women experiencing obstetric complications reduced	▪ BSS reports ▪ DHS reports	▪ DHS 2009 ▪ BSS conducted by 2010	
OUTPUT 2.1: Increased knowledge and awareness of risky behaviour	▪ Per cent of young people who know about contraceptives and where to get them ▪ Proportion of young people who can cite at least 3 misconceptions about HIV/AIDS ▪ Proportion of young people aware of at least 2 types of STIs ▪ Proportion of young people who know where to get VCT services ▪ Proportion of young people who know how HIV is transmitted	▪ BSS reports ▪ DHS reports	▪ DHS 2009 ▪ BSS conducted 2010 and 2015	
OUTPUT 2.2: Reduced risky behaviours among young people	▪ Proportion of young people involved in risky behaviour reduced	▪ BSS reports ▪ DHS reports	▪ DHS 2009 ▪ BSS conducted 2010 and 2015	
OUTCOME 3: *Quality and sustainable youth-friendly reproductive health and development services provided*	▪ Proportion of young people with STIs reduced ▪ Proportion of young people accessing ARH services increased ▪ A functional RH database in place ▪ Contraceptive prevalence rate among women aged 15–24 increased	▪ Comprehensive survey of young people ▪ BSS, DHS, HMIS, DRH, NASCOP and NACC reports	▪ Comprehensive survey of young people by 2010 and 2015 ▪ Annual DRH, HMIS, NASCOP and NACC reports ▪ DHS 2009 ▪ BSS conducted by 2010	
OUTPUT 3.1: Increased availability, accessibility and utilization of integrated quality ARH services	▪ Number of functional VCT sites established ▪ Number of facilities providing integrated adolescent RH services ▪ Number of facilities offering youth-friendly services ▪ Number of targeted programmes for special youth groups ▪ Number of young people seeking RH services	▪ Comprehensive survey of young people ▪ DRH, KSPA, BSS, DHS, ▪ HMIS Reports	▪ Comprehensive survey of young people by 2010 and 2015 ▪ Annual DRH reports ▪ DHS 2009 ▪ BSS and KSPA conducted by 2010	

Continued

Narrative summary	Indicators	Sources of verification	Timing of data availability	Facilitating and constraining factors
OUTPUT 3.2: Enhanced human and infrastructural capacities of public, private, NGO and faith-based institutions to provide youth-friendly services	▪ Number of facilities providing integrated adolescent reproductive health services ▪ Number of referral facilities providing adolescent reproductive health services ▪ Number of functional youth centres/clubs	▪ KSPA, BSS, DHS, ▪ HMIS, DRH reports	▪ Annual DRH and HMIS reports ▪ DHS 2009 ▪ BSS and KSPA conducted by 2010	
OUTPUT 3.3: Increased availability and utilization of quality data and information for planning, monitoring and evaluating ARH programmes at all levels	▪ Functional MIS at DRH in place	▪ DRH reports	▪ Annually	
OUTCOME 4: *Enhanced capacity of key national coordinating agencies to manage the ARH&D programme effectively*	▪ Increased funding for ARH&D programme ▪ Increased number of institutions effectively using the ARH&D policy and implementation plans	▪ PET surveys ▪ NCAPD and DRH reports	▪ Every three years ▪ Annually	
OUTPUT 4.1: Effective coordination of all programmes achieved	▪ Number and type of functional technical working groups on ARH issues ▪ Number and type of meetings held ▪ A database on ARH&D programmes set up	▪ NCAPD and DRH reports	▪ Annually	
OUTPUT 4.2: Networking and collaboration among stakeholders enhanced	▪ Expanded network of various organizations actively involved in managing and debating youth issues and activities ▪ An updated database of all partners in ARH&D in place	▪ NCAPD and DRH reports	▪ Annually	
OUTPUT 4.3: Increased availability of quality data and information for planning and management	▪ A functional information database in place ▪ Number and type of documented best practices and lessons learnt ▪ A research agenda in place ▪ Number and type of research studies conducted and disseminated	▪ CBS, NCAPD and HMIS reports ▪ Department of Civil Registration reports	▪ Research agenda by mid-2006 ▪ Functional database by 2006 ▪ Annual CBS, NCAPD, HMIS, DRH and Department of Civil Registration reports	
OUTPUT 4.4: Monitoring and evaluation system for ARH&D programme developed and utilized	▪ A functional M&E system in place	▪ DRH and NCAPD reports	▪ Annually	

Annex C : Phase 1 Monitoring and Evaluation Calendar

M&E activity*	2005 Q1	Q2	Q3	Q4	2006 Q1	Q2	Q3	Q4	2007 Q1	Q2	Q3	Q4	2008 Q1	Q2	Q3	Q4	2009 Q1	Q2	Q3	Q4	2010 Q1	Q2	Q3	Q4
Establish TWG	x																							
Baseline survey	x	x																						
Develop M&E tools & plan			x	x																				Develop phase II M&E plan
Analysis of M&E data				x	x	x																		
Quarterly monitoring and supervisory reviews and updates																								
Midline survey																								
Other surveys				Facility assessment of youth-friendly services									DHS	Situation analysis					Census KSPA				Comprehensive survey of young people	
End line survey by 2015																								
M&E plan reviews and updates								x								x		Seminars on M&E system						
Formulate next M&E system																								
Capacity development																								
Research																								

* Calendar is illustrative. Because this is for a nationwide programme, with a wide range of implementing organizations, many key dates for M&E activities will be filled in at project level.

Annex D : Characteristics of Youth-Friendly Services

Youth-friendly services (YFS) are services that can effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining young clients for continuing care. While there is no standard definition for youth-friendly health services, a simple definition could be "Broad based health and related services provided to young people to meet their individual health needs in a manner and environment to attract interest and sustain their motivation to utilize such services" (MOH, 2004).

The World Health Organization (WHO) describes youth-friendly as:

Services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.

The minimum conditions for youth-friendly services:
- Affordability and accessibility
- Safe and basic range of services
- Privacy and confidentiality
- Provider competence/attitude
- Quality and consistency
- Reliability and sustainability
- Inbuilt monitoring and evaluation system

Recommended essential service package for youth-friendly services based on the most common models of service provision in Kenya (MOH, 2004) are:
- Clinic based
- Youth centre based
- School based

In all cases, each model MUST put in place a strong and effective referral system for services not available at the site/model. The table below shows how service delivery might be conducted in each of the three models.

Clinic-based model	Youth centre model	School-based model
1. Counselling services on: a. Sexuality b. Growing up c. Relationships d. Pregnancy e. Abstinence f. Abortion and prevention g. STIs and HIV/AIDS h. Substance and drug abuse i. Contraception j. Career k. Rape prevention 2. Screening and treatment of STIs 3. Voluntary counselling and testing (VCT) 4. Provision of information and education on reproductive health 5. Availability of IEC, audio/visual materials 6. Curative services: a. Focused antenatal care b. Postnatal care 7. Comprehensive post rape care 8. Provision of contraceptives 9. Promotion of community-based and school-based outreach services 10. Recreational facilities (in/outdoor) where possible 11. Referral for other sevices as necessary	1. Counselling services on: a. Sexuality b. Growing up c. Relationships d. Prevention of pregnancy e. Abstinence f. Consequences of unsafe abortion g. STIs and HIV/AIDS h. Substance and drug abuse i. Contraception j. Career k. Rape prevention 2. Provision of information and education on reproductive health 3. Training in livelihood and life skills 4. Availability of IEC, audio/visual materials 5. Promotion of community-based and school-based outreach IEC activities 6. Provision of contraceptives 7. Recreational facilities (in/outdoor) where possible 8. Working with peer youth educators 9. Screening and treatment of STIs/HIV/AIDS where possible 10. Voluntary counselling and testing (VCT) 11. Curative services for minor illnesses, including ante- and postnatal care 12. Comprehensive post rape care 13. Referral for other sevices as necessary	1. Life skill training on: a. Goal setting b. Decision making c. Negotiation d. Moral values e. Saying no to bad influences f. Communication skills 2. Counselling services on: a. Sexuality b. Growing up c. Relationships d. Pregnancy e. Abstinence f. Prevention of pregnancy and abortion g. STIs and HIV/AIDS h. Substance and drug abuse i. Contraception j. Career k. Self esteem 3. School health talks: a. Personal hygiene b. Sexuality and growing up c. Reproductive health d. STI prevention e. HIV/AIDS prevention f. Communication skills 4. Post rape care 5. Referral for treatment and/or management of illnesses, or other services as necessary

Annex E : Glossary

Access – The extent to which services are available at a cost and effort that is acceptable for those who need them.

Adolescence – The transition between childhood and adulthood defined to include ages 10–19. The term "adolescence" is defined as people aged 10–19 years. A distinction is drawn between early adolescence (10–14 years) and late adolescence (15–19 years).

Assessment – A systematic process of gathering information, analysing and then making judgements. Assessment in this document is meant to be a procedure taken before initiating a programme or project activities.

Community participation – An educational and empowering process in which people, in partnership with those able to assist them, identify problems and needs and increasingly assume responsibility themselves to plan, manage, control and assess the collective actions that are proved necessary.

Counselling – The process of providing professional guidance or advice to an individual or a group of individuals.

Chain of results – The sequence of a development intervention that stipulates the necessary steps to the desired objectives – beginning with inputs, moving through activities and outputs, and culminating in outcomes, impact and feedback.

Data – Facts and information collected for a special purpose.

Evaluation – A process that measures whether a programme's outcomes were achieved and determines the impact the programme has had in a target population.

Goal – The higher order objective to which a development intervention is intended to contribute.

Hard-to-reach young people – Segment of young people who are difficult to reach because of lack of a fixed abode or any other psychosocial barriers.

Inputs – Set of resources (or raw materials), including service personnel, finances, space, policy orientation and programme service recipients, that contribute to capacity at each level (system, organization, health personnel and individual/community).

Logical framework – Management tool used to improve the design of a programme or project. It involves identifying strategic elements (inputs, outputs, outcomes and impact) and their causal

relationships, along with the indicators of achievement and the assumptions and risks that may influence success or failure. It thus facilitates planning, execution and evaluation of a development intervention.

Monitoring – A routine process used to determine the extent to which a project is being implemented effectively at different levels, in time and at what cost.

Network – A pattern of formal or informal links among individuals, organizations and other sources of information, or a group or system of interconnected or cooperating individuals.

Outcome – The immediate behavioural or other changes observed among the clients of a project (project based) or among the members of the target population (population based) as a result of a given programme or intervention. Outcomes are the medium-term effects of the outputs requiring the collective effort of several agencies or institutions. In this POA, an outcome must have two features: it can be influenced by the intervention, and if it changes it should have a direct effect on the status of reproductive health in the target population.

Output – The results of activities achieved at the programme level, that is, the deliverables of the programme/project.

Peer – A person who is of equal standing to another, often of same age, economic background and educational level.

Peer education/promotion – Programmes that feature people educating or promoting services among their peers. In our case, they refer to programmes involving young people at school, the workplace or elsewhere.

Performance indicators – Measures of inputs, processes, outputs, outcomes and impacts (goals) for development projects, programmes or strategies.

Policy – A formal statement, usually written down, of the general goals and acceptable procedures of government or an organization in a particular area.

Public expenditure tracking surveys (PETS) – Process of tracking the flow of public funds to determine the extent to which resources actually reach the target groups. The surveys examine the manner, quantity and timing of releases of resources to different levels of government, particularly to the units responsible for the delivery of social services such as health and education.

Young people – A young person is one who is in transition from childhood to adulthood, particularly those between 15 and 24 years old. The term "'teenager" refers specifically to those aged 13–19 years. The use of the term "young people" is not always definitive, however, and often includes all those aged 10–24 years.

Work plan – A detailed outline of the activities that will be undertaken in order to achieve specified objectives, outcomes or outputs.