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Evaluation of the Processes, Practices and Effects from the Activities of Women Fighting AIDS in Kenya (WOFAK) within the Access, Services and Knowledge (ASK) Programme

Final Report

Rutgers For sexual and reproductive health and rights · amref flying doctors · choice. FOR YOUTH & SEXUALITY · dance 4 life start dancing stop aids · IPPF International Planned Parenthood Federation · Simavi Basic health for all. · STOP AIDS NOW!

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The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.

Abbreviation and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ASK	Access, Services and Knowledge
AVSI	International Service Volunteers Association
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
DHO	Director of Health Officer
EMTCT	Elimination of Mother to Child Transmission
FGD	Focus Group Discussion
FP	Family Planning
FSG	Family Support Group
HC	Health Centre
HCT	HIV Counselling and Testing
HIV	Human Immune Deficiency Virus
ICPD	International Conference on Population and Development
IGA	Income Generating Activities
KIIs	Key Informant Interviews
LC	Local Council
LG	Local Government
NGO	Non-governmental Organisation
PHC	Primary Health Care
PHWA	Person Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
PNC	Post-Natal Care
RHU	Reproductive Health Uganda
SRHR	Sexual and Reproductive Health Rights
STD	Sexually Transmitted Diseases
TOR	Terms of Reference
VHT	Village Health Team
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organisation
WLHIV	Women Living with HIV
WOFAK	Women Fighting AIDS in Kenya
YEA	Youth Empowerment Alliance
YFS	Youth Friendly Service

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Executive Summary

Young people face greater reproductive health risks than adults, yet they are less willing and able to access reproductive health services. Lack of awareness, inadequate information and poor quality of reproductive health services that are not responding to young people's specific needs, are barriers to young people. Given that the consequences of poor reproductive health in young people, such as those arising from early pregnancies or acquiring sexual transmitted infections (STIs), have serious implications for the future as well as the present, health facilities need to find practical ways to ensure that they are youth friendly and of good quality.

As part of the Access, Services and Knowledge (ASK) programme in Kenya, Women Fighting Aids in Kenya (WOFAK) contributes to: Increasing the number of HIV+ pregnant women accessing prevention of mother-to-child transmission (PMTCT) and antenatal care (ANC); Increasing acceptance and support of young people's rights to access sexual and reproductive health (SRH) services at community level, and; Improving the quality of HIV and sexual and reproductive health and rights (SRHR) health care services by running Youth Friendly Service (YFS) desks and maternal health and PMTCT desks at health facilities.

This study was conducted by the Joysila Consultancy team to document, analyse and evaluate the approaches, processes and practices Women Fighting AIDS in Kenya (WOFAK) employed in their activities in ASK that contribute to successfully identifying, addressing and preventing rights violations of the sexual reproductive health rights (SRHR) of young women living with HIV (<25 years) in sexual reproductive health (SRH) settings (especially PMTCT and antenatal care (ANC).

Qualitative research methodologies were used to generate both primary and secondary data. It involved document review; key informant interviews with service providers and health officials; focus group discussions with programme beneficiaries; and, observations at health facilities. The primary data collection was conducted from March to May 2014 in Mombasa, Nairobi and Kisumu Counties. Data was analyzed using content analysis.

The research revealed that WOFAK's approaches, practices and processes comprises of; SRHR talks to clients in the health facility, networking and collaboration, one on one service provision, counseling, community outreaches, group discussions, referrals and follow ups. It is difficult to fully attribute outcomes on access of sexual reproductive health rights (SRHR) service to the

access, services and knowledge (ASK) programme, because there are many players in the field and the program was still in the early stages during data collection. However, records at the YFS show that clients referred to the health facility for antenatal care (ANC) and prevention of mother to child transmission (PMTCT) complete the minimal clinical visits (at least four visits) and several youths testified that they are no longer afraid to access services at the youth friendly services (YFS). Furthermore, it was found that the programme have helped in improving the attitudes of health service providers.

An **overall observation** is that access, services and knowledge (ASK) programme activities aiming to improve adolescents' reproductive health rights are often small in scale and short lived to realise significant impact. They are also generally poorly monitored, evaluated, and documented. There is also little evidence of involvement of the young people as the target population at the programme design.

As an overall recommendation, there is need for interventions to disaggregate the impact of their interventions for 10 -14, 15-19-year-olds separate from 20- to 25-year-olds according to age, recognizing that the developmental needs and legal situations of 10-14, 15-19 and 20-25-year-olds differ from each other. Other **key recommendations** are; increasing incentives for community mobilizers, ensuring and increasing confidentiality, increasing and expanding outreaches especially to schools, revising the sustainability of the program and incorporating livelihood enhancement aspects into the program among others.

1 Introduction

The Joysila Consultancy team's mandate was to document, analyse and evaluate the approaches, processes and practices of Women Fighting AIDS in Kenya (WOFAK) that contribute to successfully identifying, addressing and preventing rights violations of the sexual and reproductive health rights (SRHR) of young women living with HIV (<25 years) in SRH settings (especially prevention of mother-to-child transmission (PMTCT) and antenatal care (ANC)[1].

ASK program

The Access, Services and Knowledge (ASK) programme is a three year programme that started in 2013. It is implemented in seven countries; Ethiopia, Ghana, Kenya, Senegal, Uganda, Indonesia and Pakistan. ASK is led by the Youth Empowerment Alliance (YEA), consisting of Rutgers WPF (lead agency), AMREF Flying Doctors, CHOICE for Youth and Sexuality, dance4life, IPPF, Simavi and STOP AIDS NOW!. The overall aim of the programme is to improve the SRHR of young people (10-24 years) by increasing their uptake of SRH services by taking a comprehensive and inclusive approach to removing the barriers young people face in taking up SRH services.

ASK programme focuses on youth participation and the participation of selected underserved groups, young people living with HIV (YPLHIV), lesbian, gay, bisexual, transgender, intersex, and questioning (LGBTIQ) youth, young mothers, disabled youth, hard to reach youth in remote areas and young people in the age group 10-16 years. The ASK programme also focuses on enabling young people to make safe choices by directly receiving or seeking information or services, without the need of intermediaries, such as peer educators or teachers. ASK makes use of text messaging, mobile phone applications, web-based information platforms, chat and telephone help lines and non-traditional office campaigns to build young people's knowledge. ASK seeks to improve the quality of youth friendly services and referral systems. ASK also makes specific efforts to enhance access to reproductive health commodities, including ARVs and contraceptives, as well as safe abortion.

Women Fighting AIDS in Kenya (WOFAK) activities in ASK

Within ASK in Kenya, Women Fighting AIDS in Kenya (WOFAK) contributes to increasing the number of HIV-positive pregnant women receiving PMTCT and ANC in targeted areas and health facilities. WOFAK also contributes to increasing acceptance/support of young people's rights to access sexual reproductive health (SRH) services at community/local level. WOFAK works on

[1] See annex 4, Terms of Reference, p.3

improving the quality of HIV and sexual reproductive health rights (SRHR) health care services by running Youth Friendly service (YFS) desks and maternal health and prevention of mother-to-child transmission (PMTCT) desks at health facilities. Both types of desks consist in a Women Fighting AIDS in Kenya (WOFAK) counsellor assigned to a government health facility to provide information, encourage clients to be proactive in seeking services, support couples' counselling, record and follow up on alleged rights violations. The program has the following objectives:

- To build young people's individual capacity to make safe choices,
- To make SRH services better adapted to young people's individual needs, and
- To strengthen the linkages between information and service provision.

WOFAK has worked with the government to adapt various health facilities to provide youth friendly services to young people. WOFAK through the ASK programme has recruited and staffed the selected government/public health facilities with counsellors, community mobilizers and assisted in building health providers' capacity to provide youth friendly reproductive health services to young people. The programme has been assessed through these adapted health facilities for this evaluation.

Context and Background

2.1 Background to the problem

According to the Kenya Demographic Health Survey (KDHS) 2008-2009, 3% of women aged between 15 and 19 years are infected with HIV, compared with less than 1% of men of the same age, while the prevalence among women aged 20-24 years is over four times that of men in the same age group. Data also shows that women aged 15-24 years are more vulnerable than their male counterparts.

In Kenya as in other parts of Africa, young people face severe threats to their health and general well-being. They are vulnerable to sexual assault and prostitution, early pregnancy and childbearing, unsafe abortion, malnutrition, female genital cutting, infertility, anaemia, and sexual transmitted infections (STIs) and HIV/AIDS.

With the continued increase in the number of young people and the lengthening period of years spent unmarried, young people are having longer periods of premarital sexual activity. These changes can put young people at an increased risk of adverse reproductive health issues, which may manifest as high rate of unintended pregnancies, rising prevalence of unsafe abortions, high prevalence of STIs and HIV, and increased sexual and gender based violence. There is therefore a growing need for accessible information and reproductive health services, so that young people can protect their health, avoid pregnancies and delay child bearing until they are ready.

The Kenya Demographic and Health Survey (KDHS) 2009, shows that sexual activity among Kenyan young people begins early. It is, moreover, often characterized by what might be called serial monogamy - one partner after another. Adolescent liaisons are usually brief and easily replaced; so that by the time a person is ready to consider settling into marriage they have already experienced many partners. Despite this multiplicity of partners, sexual activity is usually unprotected, giving rise to early pregnancy and unsafe abortion, school dropout, STIs including HIV/AIDS, and economic hardship. According to KDHS 2009, over 50 per cent of girls aged 15-19 years have had sexual intercourse and 19 per cent are sexually active. Sixteen years is the average median age at first sex for men, same as women. Although men enter into sexual unions on average five years later than women, they start sexual activity at about the same age. In spite of high fertility and early sexual debut, contraceptive use among adolescents is relatively low. Only 12 per cent of persons aged 15-19 were using any method of family planning in 2009. Of

these, only 4 per cent were using modern methods. Among 20-24-year-olds, only 27 per cent were using any method while 19.9 per cent were using modern methods.

Reproductive health services are mostly not designed to take into account the special needs of young people. Where services exist, providers lack capacity to deal effectively with adolescent reproductive health issues and the range of services provided is also limited. Consequently, the majority of adolescents are hesitant to use them. While emphasizing access to reproductive health information and services, it is important to note that not all young people have the same environmental or life experiences - for example, not all are sexually active. Too many reproductive health programmes for adolescents have left out the needs of this group. The content of information and services provided must therefore cater for the diverse needs of young people. There are those whose needs are restricted to education, counselling, life-skills building, decision making and negotiation skills to delay sexual debut, while others require a wide range of clinical services.

2.2 Objectives of the evaluation

The major aim of this study is to document, analyse and evaluate the approaches, processes and practices employed by Women Fighting AIDS (WOFAK) in the access, services and knowledge (ASK) programme that contribute successfully to identifying, addressing, and preventing rights violations of the SRHR of young women living with HIV (<25 years), to enable replication and inform future programming developments.

The specific objectives of the assignment are as follows;

- Documenting in explicit detail the approaches, processes, and practices that contribute to identifying, addressing and/or preventing rights violations of the SRHR of young women living with HIV;
- Document the successes and challenges and their accompanying remedies to achieving the desired outcomes;
- Relate approaches, processes, and practices to the works that have been done by others to identify, address, and/or prevent SRHR violations of young women living with HIV in SRHR settings;
- Relate the approaches, processes, and practices to changes in uptake or demand of ANC and PMTCT especially EMTCT services; and,
- Identify if and how the successful approaches, processes and practice can be replicated by others.

2.3 Limitations of the Study

The major limitation for the researchers was the language barrier, especially in the focus group discussions (FGDs) where the participants would only speak in their local language–Luo, to which the researcher was very pitiable. However, in such circumstances, the researcher sought assistance from any of the members of the group who would comprehend what is asked, translate it for the respondents and provide the feedback. In most cases, the translators used were counsellors, because of their ability to read and communicate in English.

Literature review

The concepts of sexual reproductive health (SRH) and reproductive rights were adopted for the first time by governments under the aegis of the United Nations at the International Conference on Population and Development (ICPD) in Cairo in 1994. ICPD laid out a bold, clear, and comprehensive definition of reproductive health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (Patton et al, 2009). The ICPD Programme of Action (PoA) was forward looking in many areas of SRHR and notably in relation to adolescents and young people. It called for meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. The ICPD Program of Action further describes services under the umbrella of SRH, such as family-planning; prenatal and postnatal care and delivery; abortion and post abortion care; treatment and prevention of sexual transmitted infections (STIs) and HIV; and information and counseling about sexuality.

Adolescence is often considered a period of relatively good health. The adolescence period provides an important turning point of life to capitalize and maximise on the potential and resources. However, in reality, adolescents between the ages of 10 and 19 are faced with health risks in relation to sexuality and reproduction. Larke et al (2011) argue that 11% of all births and 14% of maternal deaths at the global level are among this age bracket of 15-19 year old female and adolescent births represent 95% in the developing nations. Adolescents and young people are more vulnerable to unwanted pregnancies. Worldwide, 41% of the young people account for the new infections between the ages of 10 to 30 years. Adolescent girls are especially vulnerable to HIV and other sexual transmitted infections (STIs) (Dick et al).

For the purpose of this report, the International Planned Parenthood Federations (IPPF) definition of youth friendly health services will be used, which is those that attract young people, respond to their needs and retain young clients for continuing care (IPPF, 2007). Youth friendly services that are offered should be based on an understanding of what young people in a given community want and need, and must have respect for the realities of young people's diverse backgrounds (IPPF, 2008). Young people refer to anyone between ages of 10-24 years old, while adolescents refer to people between ages of 10-19 years of age (Bearinger et al, 2007).

Although youth friendly health services (YFHS) consider all aspects of health and well-being of young people, of particular concern is sexual reproductive

health (SRH), which includes sexual development, reproductive health, interpersonal relationships, intimacy, body image and gender roles (Baloyi, 2006).

3.1. Why the need for youth friendly services (YFS)

Reproductive health programs targeted at youth in Sub-Saharan Africa were first developed in the late 1970s, in response to the growing recognition that young people were poorly informed on SRH. Initial programs focused mainly on providing information to young people and improving the capacity of parents and teachers to convey such information (Erulkar et al, 2005). Unfortunately, to date, programs on young people's actual access to SRH services are less developed in the region. This is mostly because of political sensitivity and socio-cultural biases (Ibid). Access to YFHSs is vital for ensuring SRH and well-being of adolescents.

3.2. Legislative background to YFHS

The issue of YFHS should first be considered from a human rights perspective. All people regardless of race, age, gender, sexual orientation, marital status, religious or political beliefs, ethnicity or disability, have the right to information and access to health services (IPPF, 2007). According to IPPF, it is unethical to give information and education on SRH without providing access to appropriate services, including contraceptives and counselling (IPPF, 2008).

It is based upon these human rights perspective that significant international agreements have been passed. These include:

- 1979- UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW). According to this convention, all signatory states have the duty to ensure that women and men have the same rights to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to access these rights.

  1994- UN ICPD-POA, which urges governments and health systems to remove barriers preventing adolescents from accessing SRH information, education and services. In addition, the document emphasizes that governments should establish, expand or adjust programs to ensure that adolescents have access to services and information and that their SRH needs are met. Among the international legislation, the ICPD-POA is particularly significant because it has led to a notable increase in efforts to provide appropriate SRH services to young people (UNFPA 2011). A

major success has been the consensus on the concept of sexual reproductive health (SRH); however, putting this in practice has remained a major challenge (Askew and Boreu 2003).

- 2001: UN General Assembly Special Session on HIV/AIDS (UNGASS): Declaration of Commitment on HIV/AIDS. This declaration outlines clear goals and targets related to increasing young people's access to interventions necessary for the prevention of HIV, and decreasing the prevalence of HIV among young people.

In addition to the international guidelines, The Kenyan Constitution, (2010), well covers sexual and reproductive rights for all people without discrimination based on age, gender, marital status and status in society, among other universal human rights enshrined in the constitution.

3.3. Barriers to access SRHSs by young people

A study conducted in Malawi, Ghana, Burkina Faso and Uganda in 2007, found that along with financial cost, social-psychological/stigma issues (e.g. embarrassment or fear) are the most common barriers to adolescents accessing health services (Biddlecom et al 2007). In the study, adolescents reported that it was often the social context surrounding adolescent sexuality that most discouraged them from accessing sexual reproductive health (SRH) services (Biddlecom et al 2007). In another study conducted in Burkina Faso, results showed that adults were supportive of young people accessing SRH information, but they were less supportive of young people accessing actual services (Ouedraogo et al 2007). This further illustrates the fact that stigma still exists related to young people accessing SRH services. In particular, there is often a negative attitude toward young unmarried women who are sexually active (Erulkar et al 2005).

Because of this stigma toward adolescent sexuality, adolescents often report that they do not access sexual reproductive health (SRH) services due to fear of being chastised, stigmatised or punished for sexual involvement (Bearinger et al 2007, WHO 2009). This is especially the case for adolescent females (IPPF 2008), who often have a fear of being recognized in the waiting room by adults from their community (WHO 2009, UNFPA 2011).

Another barrier preventing adolescents from accessing SRH services is lack of knowledge about where to access these services and lack of knowledge about what services are available (Biddlecom et al 2007). Many adolescents do not have adequate information on SRH, especially with regards to contraceptives

and sexual transmitted infections (STIs). For example, a significant proportion of sexually active adolescents do not know where or how to obtain contraceptives or get STI treatment (Biddlecom et al 2007). Unfortunately, many adolescents get information on SRH from each other, and this information is often incorrect (Baloyi 2006). According to Oxfam (2007), poor knowledge and lack of awareness are the main underlying factors for adolescents not using SRH services.

Other barriers include cost, which is usually expensive and unaffordable for most young people; inconvenient hours and location of health facilities, lack of privacy and confidentiality; and legal and policy constraints related to age and marital status. Providers may impose age restrictions on family planning methods even when these are not medically justifiable or officially sanctioned (Erulkar et al 2005).

3.4 Youth friendly services (YFS) operations by other organizations

Case study of FHOK

Family Health organization Kenya (FHOK) has a strategic organization goal to strengthen commitment on support for sexual reproductive health rights (SRHR) and needs of adolescents/young people. To achieve this strategic area, FHOK uses various strategies including provision of youth friendly integrated services, sexuality education, peer education, advocacy, and empowerment of young people. It has youth centers located in Nairobi, Mombasa, Kisumu, Eldoret and Nakuru. Integrated activities include VCT/SRH mobile and moonlight, which provided an avenue for the young people to access the services with reduced barriers.

With support from United Nations Population Fund (UNFPA), Family Health organization Kenya (FHOK) provided integrated SRH and HIV prevention services in Nairobi and Mombasa youth centers. This was accompanied with a better Options project that targeted vulnerable women in Nairobi's Kibera slums.

The other strategies and practices FHOK use include peer education, training of peer educators, open forums, and discussions among spouses. To improve sexual reproductive health rights of young people, FHOK implements the Young Men as Equal Partners (YMEP) project. Activities in this project included inter school debates, health club activities, exchange visits, and outreaches by health service providers to schools among others.

FHOK partners with organizations providing sustainable livelihood skills. In Nairobi, 120 youths were trained on ICT skills through Nirobits Company, while in Nakuru 86 young people were trained through Digital Opportunity Trust. Mombasa youths centres received a donation of embroidery machines and refurbish of a vehicle ROYAC- a group of volunteers from Kuwait. Recreation activities provide an opportunity to provide ASRH services and information to young people. Further in providing a wide range of activities in youth centres, FHOK holds an annual youth camp, which is an opportunity for educating youth on sexuality.

3.5 Prevention of Mother To Child (PMTC) Transmission

PMTCT has been progressively realized in a number of developed nations across the globe. Kenya is among the 22 countries which collectively account for 90% of pregnant women living with HIV. The Kenyan PMTCT framework is in line with the global PMTC and elimination of mother to child transmission (eMTCT) plan which focuses on strategies for the elimination of new HIV infections among children by the end of 2015 and keeping mothers alive. (Global Plan for EMTCT, 2011-2015)

In Kenya, the estimated number of pregnancies every year is 1.5 million, with an ANC prevalence of 6.2% (87,000 HIV positive pregnant women). The Kenya national PMTCT Programme started in 2002, and since then over 60% of health facilities countrywide provide PMTCT services (Master Facility list. 2009). As a result, over 80% of pregnant women are counselled and tested for HIV and 79% of the HIV positive women receive anti-retrovirals (ARVs) for prophylaxis, (Annual Program Review, NASCOP 2011). However, 33% still receive single dose Nevirapine, a regimen being phased out in response to new WHO guidelines (Universal Access-UA Report, 2010). Kenya has been implementing the four-pronged approach to elimination of mother to child transmission (MTCT). This involves primary prevention among women of reproductive age, family planning for all HIV+ women who want to delay their next birth, ARV prophylaxis during pregnancy, delivery and breastfeeding, and care and treatment. Implementation has been through a phased scale-up system and the involvement of multiple stakeholders (KSPA 2011).

According to the International Community of Women Living with HIV (ICW) Global and the Global Network of People Living with HIV (GNP+) (2010), prevention of mother-to-child transmission (PMTCT) needs a comprehensive approach through four key components that include(a) Primary prevention of HIV among women of childbearing age; (b) Preventing unintended pregnancies among women living with HIV; (c) Preventing HIV transmission from a woman

living with HIV to her infant; and (d) Providing appropriate treatment, care and support to women living with HIV and their children and families. Unfortunately, implementation of the four components has been skewed at the global level with components three and four receiving greater emphasis and demonstrating significant progress, while components one and two have not benefited from appropriate recognition, commitment, or programming support (GNP+, 2010).

Historically, the PMTCT services have been provided in parallel to maternal and child health services, however, it has been argued that to maximize efficiencies and leverage resources, integration of services and strengthening of linkages is of utmost importance. PMTCT forms a component of a wide spectrum of services including ante, intra and postpartum care, family planning, HIV testing and counseling, antiretroviral therapy, infant and young child feeding and child(growth monitoring and immunization services). Retention in care of the mother-baby pair is critical to ensure adherence to interventions and documentation of outcomes (WHO and UNAIDS, 2006).

3.6 Consensus of Sexual and Reproductive Health Rights

Reproductive health rights are human rights recognized by the International Conference on Population and Development- ICPD (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995). The UN Convention and the Elimination of all Forms of Discrimination against Women (CEDAW) recognizes that rights to reproductive and sexual health include the right to life, liberty and security, the right to healthcare and information, and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility.

In this study sexual reproductive health rights (SRHR) is understood as a concept of human rights applied to sexuality and reproduction. It is a combination of four fields that in some contexts are more or less distinct from each other, but less so or not at all in other contexts. These four fields are sexual health, sexual rights, reproductive health and reproductive rights. In the concept of SRHR, these four fields are treated as separate but inherently intertwined.

According to the World Health Organisation (WHO), sexual health is defined as a stage of physical, mental and social well-being in relation to sexuality. It includes sexual development, equitable and responsible relationships and sexual fulfilment, freedom from illness, disease, disability, violence and other harmful practices related to sexuality. Sexual rights are defined as the rights of

all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual health, be free from discrimination, coercion or violence in their sexual lives and in all sexual decisions, expect and demand equality, full consent and mutual respect and shared responsibility in sexual relationships. It also includes the right to say 'no' to sex if one does not want it.

Reproductive health is the complete physical, mental and social well-being in all matters related to the reproductive system including a satisfying and safe sex life, capacity to have children and freedom to decide if, when and how often to do so. Reproductive rights is defined here as the right of couples and individuals to decide freely and responsibly on the number and spacing of their children. To have the information, education and means to do so, attain the highest standards of sexual and reproductive health, and make decisions about reproduction free of discrimination, coercion and violence.

Methodology

This section briefly outlines the methodology and approach that were employed in evaluating the processes, practices and effects from the activities of Women Fighting AIDS in Kenya (WOFAK) within the access, services and knowledge (ASK) programme.

4.1. Document Review

The study involved in conducting a Global desk review of the related literature (see list of references attached) to collect data and information on existing successful approaches, processes and practices for identifying, addressing and/or preventing sexual reproductive health rights (SRHR) violations of women living with HIV. The researcher also carried out review of WOFAK's Documents on access, services and knowledge (ASK)-specific activities and related current activities. This initial review of literature was important in further understanding of the ASK Programme, Designing and updating the study framework, and Data Collection Tools.

4.2. Data collection

The Researcher, together with the program manager selected four facilities in Mombasa, Nairobi and Kisumu counties from which data was collected. These field-based consultations which took place from March to May 2014 helped to unpack the process of implementing the ASK programme, the results (outputs and outcomes) realised so far against the set targets, key success factors, challenges and remedies, lessons learned and recommendations for future adoption and replication.

4.3. Data collection tools

4.3.1. Questionnaire

An in-depth questionnaire was used to gather information on various issues related to this evaluation of the ASK program. This tool captured information from respondents in their respective stations of operation. The questionnaires were self-administered to field officers, counsellors and health officers.

4.3.2. Focus group discussion

Four focus group discussions (FGDs) were held in four health facilities providing youth friendly services (YFS) with assistance of WOFAK under the ASK programme. The FGD guideline was used to gather information from respondents in group setting. In this evaluation, the FGD comprised between

12 to 15 respondents who consisted of male and female youths, young mothers, and in and out of school youths. All the respondents were aged between 10 and 24 years.

4.3.3. Key informant guidelines

Key informant guidelines were used in interviewing key informants who included the field officers, counsellors and community mobilizers, who are charged with the direct day to day implementation of the access, services and knowledge (ASK) program under Women Fighting AIDS in Kenya (WOFAK). They were administered at their respective working stations on a one on one basis.

4.4. Observations

The consultants arrived early in the Health facilities and keenly observed the body language of the youth desk officer and counselors to the recipients (youth, both male and female) of the youth friendly services in the ASK programmes. The facial expressions signified the friendliness and created a good environment for open dialogue without being afraid.

4.5. Data analysis

The collected data from individual qualitative responses complemented by the literature was done as follows:

i) Textual data was explored using content analysis. It was read and re-read by the research analyst in order to identify emerging themes from the responses;
ii) All relevant data to each theme was identified and examined using the process of constant comparison, in which each item was checked or compared with the rest of the data in order to establish the analytical theme;
iii) Typical quotes were also selected and included in this report in order to emphasize the response given without losing the original context of the meaning;
iv) Triangulation of responses with the Literature was conducted to ensure consistency and reliability of the information gathered.

The above actions on data collected helped the researcher in conducting a confirmatory factor analysis to determine if there is a relationship between the approaches, processes, and practices by WOFAK and the prevention of sexual reproductive health rights (SRHR) violations.

After a thorough analysis of the data from the rapid-field based consultations and in-depth Literature Review, this report, which, highlights the approaches, processes and practices employed by Women Fighting AIDS in Kenya (WOFAK) that have successfully contributed to identifying, addressing and preventing rights violations of sexual reproductive health rights (SRHR) of young women living with HIV was developed. It also identifies key operational considerations to guide WOFAK and other partners in the access, services and knowledge (ASK) alliance for better programming in line with the ASK project goal.

4.6. Respondents profile

Out of the total of 94 respondents from WOFAK, 69.1% were female while male comprised of 30.9%. The disparity in sex is attributed to the fact that the ASK program targets mainly young women though it incorporates male youth in some activities and their views were equally important to the study.

Table 4.1: Response Rate

Response	Gender-Male	Female	Number
Respondent	**29**	**65**	**94**
Percentage	30.9%	69.1%	100%

The respondents were aged between 10 and 24 years with the majority falling between age 15 and 22 years (63%). Most of the respondents were single comprising 78.4% with few married ones. Out of these respondents, 42% were young mothers, with 92% of the young mothers being unmarried. The youngest mothers were 14 years old.

The level of education of the respondents was average with most focus group discussion (FGD) respondents having some secondary school education. Out of the FGD respondents, only 43% had completed their O level education. 20% were out of school youths who had either dropped out of school at some stage of secondary education, with a few who had dropped out at standard eight. The remaining were in school youth in primary six, to secondary form three.

The key informants were twenty-two in total. Out of these, field officers were four, 3 females and 1 male; while CHWs (mobilizers) were eight, 4 males and 4 females, counsellors were five, 1 female and 4 male and volunteers were five who comprised 3 females and 2 males.

Findings and analysis

Introduction

This study was commissioned in order to document, analyse, and evaluate the approaches, processes, and practices, of Women Fighting AIDS in Kenya (WOFAK) in the access, services and knowledge (ASK) programme that contribute to successfully identifying, addressing, and preventing the rights violations of the sexual and reproductive health and rights of young women living with HIV. This section presents the results.

5.1. Overall understanding of the ASK program

The study evoked the respondent's understanding of the ASK programme. It was found out that both the implementers and beneficiaries/target population demonstrated a clear understanding of the ASK program.

Respondents' responses to their understanding of the program included:

"*the ASK program runs youth friendly services (YFS) rooms in health facilities. The program gives information on SRH. It facilitates linkage between the youths and health services and networks between the youth and other health services beyond the ASK program facilities. The program reaches to the community through outreach activities"* Edith Atieno (field Officer- Kayole)

"the YFS gives us information on STIs and how to prevent ourselves from getting infected. I was also tested for HIV and counselled at the YFS. The counsellor was very nice and he encouraged me to be coming to the YFS and also bring my friends. I am a member and I have brought many of my friends and cousins. I enjoy attending the group sessions" Mercy Njoki (Participant FGD- Kayole)

The responses clearly demonstrated knowledge of the program. Most of the respondents articulated different aspects of the program in terms of what the program stands for, its objective, activities and target groups. In their perspective, the programme is about access to reproductive health services and enjoying sexual reproductive health rights (SRHR) by young people. This they said is achieved through giving the young people information and knowledge about their reproductive health rights, issues of violations of these rights and where to seek and access the services. The finding is in line with the terms of reference. The response can be linked to the awareness created by both the counsellors and field officers regarding the ASK programme. The clear understanding of the programme by the WOFAK staff in the field had an

impetus to the beneficiary knowledge and understanding on the programme activities.

Women Fighting AIDS in Kenya (WOFAK) has succeeded in creating awareness of the program among the beneficiaries. The beneficiaries are well aware of the target populations of the program and their roles and responsibilities in the programme. However, there was a general feeling among the, counsellors and field officers that ASK program was small in scale and could not create a significant impact. Monitoring and Evaluation not fully incorporated in the programme. Apart from filling in the reporting template, there was no lesson learning.

5.2. Knowledge and existence of violations of SRHR

Table: 5.1 Awareness of sexual reproductive rights violations

	Gender-Male	Female
Denial to use contraceptive/pills	22	60
Restrictions on abortion	0	62
Insufficient information awareness	28	63

63.8% (Female) and 23.4% (male) respondents were of the opinion that they had no access to use available reproductive health methods like the use of contraceptive pills for girls/female and the condoms for boys/men. This was a total of 82 respondents. 12.8% (12) out of the total number of respondents neither agreed nor had contrary opinion. 62 respondents out of the total of 65 girls expressed concern that they were normally restricted from abortion, especially below the age of 18, though the sentiments were same across all the age groups. According to respondents, 67% female and 29.8% male of the total population indicated that they had insufficient information due to limited awareness on the available reproductive health methods. It was only one male respondent could not suggest whether there was limited information. It appeared that he was not free to express himself.

For one to protect his or her reproductive health rights, one must be aware of the right he or she is protecting. The research therefore went ahead and tested the knowledge of respondents on their SRHR and the existence of violations of these rights within their communities. Based on the responses, it appears respondents were well informed about the issues surrounding SRHR. However, the problem lies with the inability to exercise those rights.

Sampled below are some of the responses;

"Sexual and reproductive health rights are the entitlement on reproductive services that are worldwide recognized and protected by the Kenya Constitution'' Susan (Mlaleo-Mombasa focus group discussion (FGD) participant).

According to Mondela (Mlaleo-Mombasa)*, "it is decisions by individuals on their body and access to reproductive services like family planning."* This is in line with the argument of Baloyi, (2006) as mentioned in literature review that SRH is all aspects of health and well being of young people that comprise of sexual development and all choices they take on their reproductive health. The response could be because of the experience of sexual violence based on the cultural issues that do not allow women to freely make decision regarding personal sexual reproductive matters. Some that are living positive with HIV and AIDS are victims of stigmatisation by the community when they choose a particular method of reproductive health contrary to the societal expectation based on their status. Two teenage mothers noted that the community links the use of sexual reproductive services to prostitution.

At Rabuor health facility youth friendly service (YFS), participants in the FGD pointed out shortage of condoms and denial to use condoms by partners as a right violation. One girl in the FGD lamented that "*sometimes our boyfriends refuse to use protection (condoms). When we carry our own, (female condom) they refuse us to use it. Sometimes they say it is ugly".*

A young man in the same FGD pointed out that sometimes they go to the YFS only to find that there are no condoms*. He lamented that "you know some of us are big engines and the price of condoms has gone up, it forces you to have sex without one, and that puts your life at risk"*

On sexual consent, one FGD participant from Baba Dogo illustrated that the violation exists in the community "*young girls are usually coerced by older men to have sex with them in exchange of gifts because their parents do not provide all the good things they need. This has resulted into a lot of unwanted pregnancies of girls as young as 12 years. Some of these men or the girls' mothers force the girls to carry out abortions. I know of two girls who died as a result of these abortions. If you visit these houses in this area you will find many young mothers and they have dropped out of school"*

Another violation that was pointed out by several respondents was rape and defilement. A counselor at Kayole YFS related these- "*the most common violation has been sexual gender based violence (SGBV) and defilement. There was a case*

in this area in a local school that a youth friendly service (YFS) was asked to intervene. A teacher had impregnated three girls in class 5 and 8. They were between 13 and 15 years. We took up the case and counselled the girls, gave them the right information and gave them assisted referral to antenatal care (ANC). They completed their visits and we made sure they delivered in hospital. We had to involve their parents whom we counselled and gave information on how to assist the girls even after they had delivered. Two of these girls are now our regular clients and participants in the group discussions. They always come with their babies"

Denial of and lack of access to information on family planning and contraceptives was pointed out by many respondents in Kayole and Baba Dogo. One girl pointed out that "*I thank the YFS so much. I looked everywhere for information on contraceptives or any sexual education but I got nothing. I am so grateful for the opportunity the YFS gives us because I can now get answers to many questions".* Another one in the same FGD confirmed this lack of information by saying that *"we do not know which contraceptives are good or bad. We just use what our friends are using. Nobody gives you advice on this. When my friends and I need pills we just buy from the chemist"*

5.3. Approaches, processes and practices that contribute to identifying, addressing, and or preventing rights violations of the SRHR of young women living with HIV

All the 94 respondents were aware of the existing approaches, processes and practices that contribute to identifying, addressing and preventing rights violations of the sexual and reproductive health rights of young women living with HIV. The various approaches identified are in line with Family Health organization Kenya (FHOK's) approaches and the literature that mentions various approaches and specific to certain responses to sexual reproductive health (SRH).

1) Giving Health Talks at the health facility

When we asked counsellors what they do on a daily basis, counsellors in all the facilities said that they give health talks every Monday morning between 8.00 am and 8.30 am at the waiting area before the medical staff start attending to the patients. Monday is the most appropriate day due to the high numbers of patients who come on Monday mornings. The talks usually focus on a specific

reproductive health issue. They also use this opportunity to publicize the youth friendly services (YFS). The talks target the whole patient population in the health centres at that particular time. They help the counsellors reach parents and other significant others, who are not directly targeted by the program, with information on reproductive health. After the talk all the youth in the target age bracket are invited to the YFS room

The field officer of Kayole said, "*our counsellors give health talks in the morning at the waiting area of the facility. They target the general patient population. Some of the topics have included importance of attending antenatal care (ANC), prevention of mother to-child-transmission (PMTCT), knowing one's zero status and under age pregnancies, (*Edith-Kayole)

The YFS counsellor (Zainab) in Mlaleo affirmed same sentiments as Edith, that they always have the health talks combined of different topics on SRH, ANC and PMTCT.

The counsellor at Baba Dogo affirmed that "*we give health talks to the patients in the waiting area on Monday mornings. You know the facility does not operate on weekends so we have very many patients at the waiting area on Monday mornings. We focus on a specific topic and we target the general public. This helps us bridge the gap between parents and the youth".*

2) *One on one client service*-

This happens throughout the working hours. The clients come after the health talks and after they have been attended to by the medical staff. The medical staff work in partnership with the YFS counsellors and they send all the young people in the age bracket of the program to the YFS room or YFS desk after they have attended to them. Two younger mothers in Mombasa noted that whereas the Youth Friendly Services were helpful in the one on one client service, the young people were not engaged at the design of the program. They emphasised on the need to disaggregate the intervention based on the age. The developmental needs and legal situations of 10 -14, 15 -19 and 20 -25 years differ from each of the categories. They were also of the opinion that these services be extended to schools. Many of the young people can only access the sexual reproductive services while out of school. The teenage mothers noted the importance of incorporating income generating activities as a way of livelihood for the beneficiaries. As an indirect outcome of the program, the young mothers in Mlaleo had formed a livelihood group in which they were looking for potential support from the women enterprise fund and the Constituency Development Fund.

The station manager at the Kayole health facility confirmed that "*we now work hand in hand with the YFS. All the health officers here now know of the youth friendly services (YFS) and they refer all the youth to the YFS after they have attended to them. Some youth also visit the YFS before they come for our services at the health facility because this way, they do not follow the queue. We attend quickly to the youth from the YFS"*

In Zainab's (Mlaleo) *words, "a lot of youth from 14-22 years are not free to open up to the medical officers on their health needs and the desired services. They find confidence in the YFS desk with fellow youth talking to them and refer them to the medical officer for specific sexual reproductive health (SRH) service without following the queue''*. However, she noted that some of the youth were still not free at the youth desk because it is in the open area.

Services given to the clients are dependent on the clients' needs. They range from counseling, HIV testing, guidance, information and education on SRHR and issues, handling boy-girl relationships among others. A participant in the focus group discussion (FGD) at Kayole affirmed this by saying

"*I came here to the YFS when I had a problem. I realized that I did not know many things. I was given information on sexual transmitted infections (STIs) and how I can prevent myself from getting STIs and HIV. I was also tested for HIV and I was counselled. The counsellor was very friendly and I was very happy".*

During the one on one session the clients' needs are attended to. Those needing referral are directed to the right section in the health facility or to the relevant organization. Referrals are usually made for antenatal care (ANC), prevention of mother to-child-transmission (PMTCT) (where the expecting woman has tested HIV positive), voluntary male medical circumcision (VMMC) and treatment of STIs and sexual transmitted diseases (STDs). The counsellor at Rabuor health facility confirmed this by saying that

"*clients come with some issues which the YFS does not handle. These include Family Planning, pregnancy issues like abortion, ANC, post- abortion, VMMC among others. At the YFS we only give information and then we refer them to the relevant departments in the health facility or other organizations that offer these services".*

3) Group discussions-

The counsellors at the YFS organize group sessions. These are done once a week. Regular clients and the new ones visiting the facility on that day are

given a group session. A participant at Baba Dogo focus group discussion (FGD) confirmed this. He said,

"I had come for treatment at the hospital; the doctor talked to me about the youth friendly services (YFS) room and invited me to a meeting at the YFS. Since then I have kept coming for the group discussions. I really like them."

It is during these sessions that information and education on sexual reproductive health rights (SRHR) is shared. A particular SRHR issue is picked as the focus of the day. The participants also get a chance to share and learn from each other. Participants at these group discussions are charged with publicizing the YFS in their locality and for bringing new clients to the YFS.

One participant in the FGD at Rabuor revealed that "*through the group discussions at the YFS, I have learnt that I have SRHRs and I know the procedure to follow in case of rape. I protect myself from contacting sexual transmitted infections (STIs) and I also use the information I get from YFS to advise my friends in school".*

Another FGD respondent in Kayole confirmed that *"the YFS has enabled me to know that I have SRHRs, one of them being the right to sexual health. I am never afraid to come to the YFS. I have come many times to pick condoms, counseling, HIV testing- in fact since I started coming I have done three tests- and I also like coming for the group discussions to share and learn from others".*

4) Conducting follow-ups with clients

This is done for most of the clients, especially those who are referred to other service providers. The follow ups are done by the counsellors and community mobilizers.

The follow ups enable the counsellors to ensure that the young people get the services they require and those on medication programmes and other programmes like antenatal care (ANC) to ensure adherence to the programmes until completions. They also create room to build trust between the clients and the counsellors and create opportunities for more sessions. It is through these follow ups that the YFS gets its regular clients.

5) *Conducting community outreaches*-

Community mobilizers, the youth friendly services (YFS) counsellors and regular YFS clients conduct community outreaches in areas surrounding the health facility. They use these outreaches for publicity of the access, service and knowledge (ASK) programme and YFS facilities, to give information, and awareness on sexual reproductive health rights (SRHR) and other reproductive health issues to the larger community. Through the outreaches they also manage to reach a wider population of the target young people who may not come to the health facility.

A community mobilizer in Baba Dogo had this to say:

"In my course of work I meet youth and talk to them about ASK and the YFS. During the door to door visits am able to identify youth with sexual reproductive health (SRH) issues especially those with sexual transmitted infections (STIs) and young pregnant girls. I refer them to the YFS and some other health facilities like Pumwani hospital where they access antenatal care (ANC), prevention of mother to child transmission (PMTCT), family planning, counselling and treatment services"

6) Networking/ collaborations-

In this ASK program, Women Fighting AIDS in Kenya (WOFAK) has developed solid networks and collaborations with both government and other nongovernmental organisations (NGOs) and civil society organisation (CSOs). Edith, the ASK field officer in Kayole confirmed that-

"We reach the community through organized groups and we rely on the good will of other organizations. When other organizations are having their community events, our mobilizers take the opportunity to talk about the ASK program and YFS. Sometimes our counsellors are involved in the activities of other organizations and popularize our program."

They collaborate with the government in terms of provision of space; where by each of the public health facilities data collected has provided a room for YFS. The program also utilizes government community health workers (CHW) who are assigned several households in their communities. The program uses some of the CHWs as their community mobilizers for the program. They identify clients for the YFS, do referrals, outreaches and also engage in the follow up of clients. Networking with civil society organisations (CSOs) and non-governmental organisations (NGOs) helps in synergies and lesson learning.

7) Systematic referral-

When clients come to the youth friendly services (YFS) referral room, their details are taken down for the services that are not offered at the YFS and the health facilities, referrals are made to other NGOs and health facilities that offer these services. Edith, the field officer of Kayole contented that-

"*We refer clients for voluntary medical male circumcision* (*VMMC), prevention of mother-to-child transmission (PMTCT), family planning and antenatal care (ANC). We also refer clients to Lea Toto, who mainly target youth with their programmes. They do linkage with Women Fighting AIDS in Kenya (WOFAK) for they have* an *IGA program for youth from very poor backgrounds*. Mostly referrals are done for Family Planning, PMTC, ANC, voluntary medical male circumcision (VMMC), and safe abortion among others.

The counsellors also do what is called physical assisted referrals, where by the referred client is accompanied by someone from Women Fighting AIDS in Kenya (WOFAK). This ensures that the client accesses the service at the other institution, and it also reduces the waiting time. When the client is accompanied, they do not follow the queue, but are attended to immediately.

The arrangement between the health facility and the YFS is the start of referrals where by all clients that visit the facility and are in the target age of the access, services and knowledge (ASK) programme are all referred to the YFS room.

The practices discussed above have been employed by Women Fighting AIDS in Kenya (WOFAK) and they are in agreement with the Family Health Organization Kenya (FHOK) as discussed in literature review. FHOK argues that there are different approaches that are used in addressing rights violations of individuals. Among the approaches listed by FHOK include; health service outreaches, young peer education groups, forums. The respondents easily mentioned the approaches because they are engaged in the ASK programme as beneficiaries. They appeared honest in their responses, thus confirming the existence of these approaches. There is no single approach used but combinations of the various approaches are used with aim of maximising strengths in each of the applied approach.

5.4. Differences between the current ASK approaches, practices and process and those of other programs

1) H*aving a YFS within the health facility*-

Women Fighting AIDS in Kenya (WOFAK) had a programme that involved youth before the access, services and knowledge (ASK) programme. In this programme, WOFAK operated a youth centre, which was a stand-alone resource centre as opposed to the ASK program that has a YFS room within a public health facility. The advantage of having the youth friendly services (YFS) within a health facility is that the youths can access other services that are offered by the health facility and one does not have to set aside a separate day for visiting the YFS, which saves on time. Being in a health facility enables the implementers to reach other people who would not have come to the youth resource centre and it also makes referrals easier. The ASK programme was well received among the beneficiaries because some of them had been involved in the youth centre activities. Much as the YFS program was unique, it had a close resemblance to the earlier WOFAK programme.

A participant in the FGD at Kayole said that "I *Know Family Health organisation Kenya (FHOK) had a program that focused on YFS, but it was different. With FHOK the YFS was a stand-alone facility and it had many other things that attract the youth like games and videos. ASK YFS is within a health facility and apart from the sexual reproductive health (SRH) there are no activities that the youth can identify with."*

2) Comprehensive service-

The access, service and knowledge (ASK) programme, unlike other similar programmes offers more comprehensive services. At the youth friendly services (YFS) room the beneficiaries get information, counseling, testing, condoms, advice, group discussions and hence experiencing peer education and learning, there is effective follow-up with the beneficiary until the problem is resolved, and proper referrals which ensure that the client is seen by the right professional and access the required services.

The field officer at Kariobangi confirmed this. She said- "*there are many organizations that run youth reproductive health programs but they focus on one thing. Like the Catholic Church just deals with HIV counseling and testing, other organizations will focus on condom distribution or using community theatre. The ASK program offers comprehensive services ranging from information and*

education to services like counseling and testing and referrals where we do not offer the service needed". (Helen- Kariobangi)

3) Specific focus on young people-

Many programs that are implemented by other organizations and other Women Fighting AIDS in Kenya (WOFAK) programmes integrate youth. However, the ASK program specifically focuses on the young people. This makes the young people free to access the services and participate in the programme activities because they believe the program is for them and they own it. For instance young mothers, most of who are under age, feel accepted and assisted to cope with their situation.

A young mother other participant at Rabuor had this to say about the program "*I have attended programmes of other organizations. This access, services and knowledge (ASK) programme is different. The counsellors are few here. It also targets the youth mainly. The other programmes focus on everybody and they teach many things. There is confidentiality in this place and I like coming here."*

4) Youthful counselors-

Programmes that offer similar services to those offered by ASK, like counseling, testing, referrals and condom distribution among others, employ older members of society who the youth do not identify with. More over these staff do not know how to deal with young people. They have a negative attitude and prejudices; hence the young people do not feel free or welcomed to access the services. The youthful counsellors and community health workers employed by WOFAK in the ASK programme encourage the youth to open up, are friendly, understanding and approachable hence the youth feel free to come to the YFS. The counsellors at the youth friendly services (YFS) are also good at keeping the confidentiality of the client unlike in many other programs where the service providers discuss the clients with other people.

A participant at the Kayole focus group discussion (FGD) said "*at the YFS we are more free. We are given the opportunity to talk about issues. There is more bonding and trust. People do not make you a topic and what we discuss at the YFS remains at the YFS."*

Another participant at Baba Dogo FGD said "*this ASK YFS has friendly and youthful counsellors that I can easily identify with. Just go to the Catholic Church VCT in this neighbourhood and you will know what I mean. The counsellors there are just old women who do not know how to talk to young people. They*

judge you before you even say your problem and they do not keep your issues confidential. I went there once and I have never gone back, but I like coming here because I am treated well and no one judges me."

5) Free services at YFS-

Many organizations charge for services that they provide. Some charge full costs while others offer subsidized rates. All the services offered at the YFS are free. In the event that the client needs a service that is not offered at the YFS, the program offers assisted referrals with their partners and the young people access the services at subsidized rates. This was demonstrated by one field officer (Helen in Kariobangi) who said-

"*You know that services are free at the ASK YFS. But other organizations that offer YFS and other RHS are not entirely free. The Women Fighting AIDS in Kenya (WOFAK) has agreement with some of these organizations so that they give our clients services at subsidized prices."*

5.5. Relationship between the approaches, processes, and practices done by others to identify, address and/or prevent successfully SRHR violations of young women living with HIV in SRH settings

In the ASK programme like in previous programmes, networking is one of the practices that has been maintained by WOFAK. This enables ease of referrals and access of materials e.g. information, education and communication (IEC) materials developed by other organizations, and it also strengthens synergies. This argument is supported by Family Health Organization Kenya (FHOK) in the literature review that outlines some of its approaches.

This programme like others before it, utilizes referrals. This enables the beneficiaries to access services that are not offered at the YFS e.g. family planning, voluntary male medical circumcision (VMMC), safe abortions, antenatal care (ANC) and prevention of mother-to-child transmission (PMTCT) among others. However, unlike in the other programs the referral system in ASK is more elaborate. The details of the client are recorded, including contacts of next of kin and locator forms which enable the counselors and community mobilizers trace the client up to their physical location. This makes it a lot easier to do follow ups. They also do assisted referrals in the ASK program to ensure that the client reaches the facility he is referred to and accesses the services referred for.

Like in many other programs by Women Fighting AIDS in Kenya (WOFAK) and other organizations e.g. FHOK, PSI, and I Choose life, ASK program involves young people. In fact its sole focus is on young people, hence they are not just involved but they are the focus and key beneficiaries of the program. In running the ASK program, WOFAK, like many others organizations undertakes outreaches, counseling and awareness creation. Only that they approach it differently.

At the international level, there has been much emphasis on the linkages with service delivery integration, strengthening systems and policy. Service delivery integration- integrating SRH and HIV services recognizes the importance of creating opportunity for the empowerment of people in making informed choices and decisions regarding their sexual and reproductive health, as well as the important role that human sexuality plays in the lives of people. The 2005 Sexual and Reproductive Health and HIV/AIDS; A framework for priority linkages gives four levels of programme strategic interventions; 1) learn HIV status and access services 2)integration of maternal and infant health with HIV 3)Optimizing connection between STI and HIV services 4)promotion of healthier and safer sex.

The approaches to the integration of services depend on a variety of factors. The success of integration services is linked to the practical realities faced by different service providers. The SRH and HIV integration services range from being provided by one service provider to innovative partnerships. The success of the integrated SRH and HIV services depends on the quality and the effectiveness of referrals (Chakibul *e tal*, 2009). Many traditional HIV services providers have begun to address the SRH needs of their HIV positive clients. The private sector is also increasingly providing integrated services. Meeting the sexual and reproductive health needs of diverse group of the people; the young people and couples living with HIV are varied and require specific and innovative approaches in meeting the needs of the target group.

Providing comprehensive services beyond the health centre is Vitol; The reality of people's lives comprise of a series of issues and needs that go beyond the scope of health services provided. However, it is becoming clear that health services are the entry point to address other needs like food security, microfinance and education. In integration of the SRH and HIV services, there is need for referrals that address the social and economic concerns like skills development, nutrition, access to psycho-social support, micro-finance and gender transformation to improve relationships aimed at addressing gender

based violence. Women Fighting AIDS in Kenya (WOFAK) is privy to these international practices and trajectory hence similar practices in the implementation of the ASK program. These practices in themselves are best practices that can be borrowed by other organizations while at the same time need refining to maximize on impacts.

5.6. Attribution of WOFAK approaches, practices and strategies to the uptake of PMTCT and ANC (success stories)

It was clear that at the stage of the program during data collection, it is difficult to determine the attribution. However, the records at the YFS show that clients referred to the health facility for ANC complete the minimal clinical visits (at least four visits), and all of them deliver in a health facility. For those referred for PMTCT, follow ups are done so that they also adhere to the ART.

A community mobilizer at Rabuor health facility confirmed that "*adherence and completion of ANC services has improved due to the YFS. We accompany the underage mothers and we also make sure that their parents are part of the process to reinforce adherence. Some of them have gone back to school after delivery*

Several youths in the focus group discussions (FGDs) testified that they are no longer afraid to access services because the counsellors at the YFS are young, friendly and keep confidentiality and therefore they feel free even to discuss their issues.

A participant in the FGD at Kayole testified that "*before coming to the YFS I was very scared, but the facility made me comfortable and I have promised to test every three months. I am never afraid to come because I know I am received well and what I discuss with the counsellor is kept confidential*

The program has also helped in improving the attitudes of health providers to youth who are seeking SRH services. This is especially so at the facilities where the youth friendly services (YFS) are integrated. At each of the facilities, a focal person has been appointed who interfaces between the YFS and the Health facility. These focal persons have been trained in YFS provision and they participate actively in the ASK activities.

The in charge officer at Kayole said that "*the access, services and knowledge (ASK) program through this YFS has helped improve the attitude of health providers to the youth especially in this facility. This makes youth free to access services.*

Challenges in Implementing the ASK program and emerging issues

6.1. Challenges faced by WOFAK in Implementing the ASK Programme

High expectations from clients make it difficult to break even. Some clients want incentives that the programmes cannot provide. For instance there are expectations of refreshments and transport refund during group discussions, yet the program does not provide for these. Lack of incentives drives away some clients.

Client –partner tracking- some clients who test positive are not in a position to determine which partner infected them for many of them have multiple partners. It is usually not easy for them and the counsellors to track the partners hence not possible to reach them with the services.

Burn out-this is mostly experienced by the counsellors. Clients are at times too many and some of the issues they deal with are traumatizing. The counsellors often experience burn out yet they have no supervision to help them deal with this.

Very few facilities have adapted YFS hence the question of accessibility to many beneficiaries is a challenge. WOFAK cannot reach out to as many young women with the services as it would have wished.

Feed back

Most of the participants expressed confidence in the ASK programme activities. One of the beneficiary in Mlaleo CDF Health Center, Mombasa County, had this to say "*the ASK programme has brought us together as young mothers and ensured a good atmosphere for peer sharing of experience. I got pregnant at the age of 14 leading to family discrimination and rejection by my boyfriend. I dropped out of school and became a laughing stock in the family; leading to loss of hope in life after was diagnosed with HIV AIDS. A friend introduced me to Women Fighting AIDS in Kenya (WOFAK). The ASK programme has brought us together as young women in sharing ideas and life experience regarding young motherhood*". As indirect outcome, the young mothers had formed young mothers' group. She said "we have a group of 13 young mothers that have been trained in entrepreneurship, now planning to apply for UWEZO funds for a tomato source making project".

6.2 Emerging issues: Socio-cultural norms and religious doctrines on SRH and PMTCT

During the data collection, the researchers were informed that socio-cultural norms, religious doctrines, poverty and lack of education have and continue to hamper the effectiveness of the implemented ASK program approaches in sexual reproductive health rights and PMTCT. In Mombasa, the Muslim youth are encouraged to use withdrawal method during sexual intercourse as opposed to other methods. According to the female respondents in Mombasa, Muslims were initially not keen to sexual reproductive health. This is linked to their practice of a traditional form of family planning known as 'azl' which refers to withdrawing before ejaculation. During the time of the Prophet, his companions used to practice 'azl'. Although initially without Prophet's consensus, they later decided to seek his approval and he permitted doing so, saying that 'azl' would not stop the creation of a child, should Allah's will that the child be born. There has been a strong objection towards the modern sexual reproductive health practices until recently. To them, this was seen as altering the creation of Allah. According to the majority of girls' respondents and two of them that had used SRH method, it is permissible for example to perform abortion before completing the four months of the pregnancy. The idea is that the termination of pregnancy should take place before the embryo becomes a human in the fourth month since conception.

The protestant and Catholic Church in Mombasa, Nairobi and Kisumu have encouraged youth to abstain from sex and selectively in either support or against specific SRH methods based on their doctrines. According to researchers' observation and information triangulation during the field data collection, despite a high knowledge of sexual risks, fear of HIV/AIDS and awareness of the protective value of condoms, young people still exhibit high risk sexual behavior. Many adolescents and youth still choose unprotected sex rather than using SRH services like the use of condoms. Cultural factors play an important part in the determination of sexual behavior. Individuals are active recipients of signals conveyed through continuous interactional processes. So, individuals living in the same home or community and receiving the same message on a particular topic will come to hold the same beliefs, values and meanings on the issue. This means that groups can develop their own systems of significant symbols that are value systems held in common by members. For example, most adolescents from educated mothers in both Mombasa and Nairobi experienced socio-cultural and religious inhibitions which hindered them from receiving meaningful sex education during both pre-adolescent and adolescent stage. Cultural standards regarding sexuality, for

instance, may influence when to have sex, with whom, with how many people or times and whether or not to use condoms.

The adolescent girls described little or no control over how, when and where having intercourse (playing sex) occurred. They were of the view that boys viewed them as readily available to satisfy their sexual needs. They felt playing sex was their duty, Girls on the other hand described sex as just an ordinary part of life, an obligation to boys and men. The researchers found that young men exhibited high risk sexual behavior because they felt the need to conform to social prescriptions of male prowess which involved early sexual experience, non-condom use and having more than one partner. The boys in Mombasa expressed concern that if they were not involved in playing sex at a young age they would not be able to impregnate a wife when married. Indeed, the prestige of sexual experience is particularly related to sexual conquest and the ability to seduce many partners.

The researchers found that preventing pregnancy was not the responsibility of the boy but of the girl. This belief allowed the boys to absolve themselves from the need to take preventive measures against pregnancy. As a result, boys did not want to walk around with condoms in their back pockets.

In researchers' analysis, Faith organizations are a crucial building block to achievement of Sexual and Reproductive Health and Rights (SRHR) within the ASK program. They reach large numbers of people with health messages that resonate with their beliefs and local culture, and provide health services through sustained networks of support.

Conclusions

Programs that promote access to and uptake of adolescent sexual and reproductive health services are most effective when adolescent-friendly facility-based approaches are combined with community acceptance and demand-generation activities. More research is needed to determine how best to deliver sexual and reproductive health services outside the facilities, especially to vulnerable and marginalized populations. It is good practice for the youth friendly services to keep the confidentiality of the clients and patient in its services. The Programme is on course, though robust monitoring and evaluation is essential. There are numerous positive human stories from beneficiaries that are not documented. The challenges is in generalising of the sexual needs of age group 10 to 25 in one package yet the needs of 10-14 years is different from 20-25 years, high expectations from clients that include request for incentives and difficulty in client partner tracking to over services.

Recommendations

7.1. Recommendations to WOFAK

Overall recommendation is the need for disaggregated interventions by age; 10-14, 15-19 years; separate from 20- to 24-year-olds recognizing that the developmental needs and legal situations differ from each age group. It is important to identify the existing gaps in each age category and provide interventions based on the specific needs rather than using a general approach.

Development of a logical or conceptual framework is vital for ease of tracking the results achieved. A clear and detailed logframe creates opportunity for analysing the pace of achieving deliverables and triggers for payments.

Based on the challenges and gaps identified in the program, the following key recommendations are made to improve the effectiveness:

Increase outreaches especially introduce school outreaches- many of the young people in the access, services and knowledge (ASK) programme are in school. This means that they can only participate in the program or access the services during the school holidays. The youths feel that the program is not adequately meeting their needs during the time they are in school. The school is also a platform where the program can reach many youth at the same time; especially with sexual reproductive health rights (SRHR) information and also address problems of rights violations because many rights are also violated in the school.

Increase incentives especially for community mobilizers- the community health workers form an integral part of this program. They deal with identification of rights abuse, identification of clients, awareness creation, referrals and follow ups. However they are de-motivated by the negligible allowance they are given hence don't feel appreciated. Some of them do not do follow up as required because of the de-motivation.

Sustainability of the programme and buy in by the government- the Youth Friendly Service (YFS) is incorporated in very few facilities, hence very few young people can access them. The program also relies heavily on human resource supported by Women Fighting AIDS in Kenya (WOFAK). There are concerns that after the life of the program in 2015, the YFS services will not be available. WOFAK is requested to, jointly with the government; increase the capacity of most health providers on youth friendly service provision. In the same breath, WOFAK should increase advocacy for YFS so that the government

can buyin to the program and scale it up in all health facilities, and support capacity building of the health service providers.

Incorporate livelihood enhancement aspects e.g. income generating activities (IGAs) programme- many of the beneficiaries of the program come from poor backgrounds and they have no form of income. It has been discovered that this poverty leads to the unintended pregnancies, violations of SRHR, and rise in infections. The young mothers also need some form of income generation otherwise the cycle of sexual gender based violence (SGBV) will continue. Economic empowerment in addition to the knowledge and information on SRHR will create assurance of livelihood security and protection.

Increase privacy and confidentiality-most facilities have not set aside days or specific hours for serving the young people. Most of the youth friendly services (YFS) at referral level are also integrated within the health facility and the position of the room is such that one has to pass the waiting area and other clinics to access the YFS. The young people advised that they want either stand alone facilities or a room separate from the other services so that they are not seen by people from their communities as they go to the YFS room; for fear that the people may tell their parents that they are accessing sexual reproductive health (SRH) services.

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Annexes

Annex 1: Success stories

Story 1

Reproductive Health is one of the issues with the greatest impact on the youth. Some related problems and side effects include teenage pregnancies and abortion. As a youth centre we promote youth participation with youth centred approaches*(meaningful youth participation)* so as to build mutual beneficial partnerships with young people to increase fit with their realities and rights and to increase programme effectiveness; to empower youth *(change agents/advocates)* because it is their right to input on matters that affect them.

Amina (real name withheld) a 17 yrs old girl who is a form two student and a fifth born in a family of seven unfortunately got pregnant. She wasn't ready to have the baby at the time she visited the youth centre but after continuous sexual reproductive health and rights sessions there was a change of mind. This was achieved due to the fact that at the Youth centre there has two very competent staff who are equipped with knowledge on Sexual Reproductive Health and Rights issues. We empowered and encouraged her to look at her situation as a challenge in life that she was able to overcome and succeed in life. The good news about this girl is that she gave birth to a very beautiful baby girl on the 29th April 2014 at Rabuor Health Centre in the company of her beloved grandmother, who informed us that she was going to take care of the granddaughter's child as she goes to school. Coincidentally the same day the WOFAK Director and Programmes Officer had visited our youth centre and was happy to witness an achievement of the Ask (Access Service and Knowledge) Programme.

Story 2

In our next story we are going to see the outcome of lack of information. There were two girls aged 16yr and 17yr who were very good friends. Both the girls were six months pregnant and had never visited the Health Facility for ANC services .Due to the stigma, shame and burden that comes with unintended teenage pregnancy. They had the thought of aborting. One day one of the girls visited the Youth Centre and we did what we know *best to build young people's individual capacity to make safe choices".* She was counselled on matters pertaining to SRHR issues and pregnancy and abortion. During the session she informed the counsellor that her 17yr old friend had performed an abortion with the help of a traditional birth attendant, which turned tragic after she over bleed to death. The counsellor took the opportunity to educate her on the side

effects of abortion. The girl realised there is more to lose than gain if one aborts. The ending of this encounter is both sad and happy because the girl who went to the birth attendant to abort developed complications and succumbed to over bleeding. A life was saved and at the same time a life was lost.

Story 3

He came into the room a worried 19yr old man not knowing what to do or say. He was angry, confused and lost. He had unprotected sex with a woman who roomers claimed that was HIV positive. Seventy two hours had passed and he was torturing himself with the thought of having contracted the virus. It took much counselling to make him relax. He narrated his story and was wondering how to approach the lady so as to make her come with him to be tested .As a counsellor an intervention was required and through the counselling process the young man overcame his fear and went to the lady who in turn agreed to accompany him to the youth centre. They both went through counselling session which was so helpful and productive as they agreed to be tested together so as to get rid of the notion that either of them was HIV positive. The outcome brought a smile and relief to both of them because none was found to be positive. After three months they then came back to retest and the results were just as the first time, this meant that surely both were negative. The moral of this story is due to lack of information , peer group, not knowing your status and practicing unsafe sex can put an individual at risk of getting Sexually Transmitted Infections and Unintended pregnancy.

Therefore it is evident that the youths in our area have found refuge where they can come to present their issues that burden them and eventually are helped to overcome them positively through creating an enabling environment and building young people's individual capacity to make safe choices**.**

Annex 2: Data Collection tools

Focus Group Discussion Guide (FGD)

Introduction:

Good morning/ afternoon, my name is …… . I am conducting a research on the processes, practices and effects of WOFAK'S activities within Access, Services Knowledge (ASK) Programme.

This FGD is administered for the purpose of collecting data on activities within Access, Services Knowledge (ASK) to evaluate and document the lessons learnt in this programme. Any information volunteered by you will be held in confidence and not used for any other purpose apart from the one stated.

Overall knowledge on WOFAK's activities

I. What are the activities/programmes that you benefit from this organisation?

II. How important are these activities/programmes important to you?

III. Have you ever been a beneficiary to the above activities in other programmes before ASK?

IV. If yes, how different or similar were the above activities?

V. Before this current activities/programme, were there any previous activities of WOFAK that you were a beneficiary?

VI. If yes, how were the previous activities different from the current ones under the ASK programme?

Sexual and reproductive health rights activities

I. Does WOFAK's approaches/strategies identify, address your need and prevent violations of sexual and reproductive health rights?
II. If yes, how is this done/addressed? If not why do you think it's so?
III. Are you sure your needs have been/were identified, addressed in preventing SRH under the current ASK activities?
IV. If yes, how has this been done?
V. Which activities have contributed most in meeting your need as a beneficiary?

VI. Which activities have contributed the least in meeting your need as a beneficiary?

VII. How different/ similar are these activities from what is offered in other organizations that you could be aware?

Assessing the Access, Services Knowledge (ASK) Programme

I. How effective are the activities as discussed?

II. What is the success story to you as a beneficiary of the activities/programmes offered?

III. What recommendation could you give?

THANK YOU!

Questionnaire

Introduction:

Good morning/ afternoon, my name is ..... I am conducting a research on on the processes, practices and effects of WOFAK's activities within Access, Services Knowledge (ASK) Programme.

This KII is administered for the purpose of collecting data on activities within Access, Services Knowledge (ASK) to evaluate and document the lessons learnt in this programme. Any information volunteered by you will be held in confidence and not used for any other purpose apart from the one stated.

(a) General information

Name of the Health facility/programme

.....

Geographical location

.....

Position at the Health facility/ organisation

.....

(b) Overall ASK Programme

What is your understanding of ASK Programme?

.....

What activities did/do you carry out in this ASK programme? List them

.....

.....

Have you ever carried out these activities in other programmes before ASK?

……

If yes, how different or similar were the activities?

……

……

Did you develop new activities for this ASK programme or are you implementing new activities?

……

If yes above, what are the new activities? List them and please explain why you developed each of the new activities?

……

……

……

If No in the previous question above, explain why you did not develop new activities or practices

……

……

c) Sexual and reproductive health rights

Are there violations of sexual and reproductive rights of young women living with HIV in the areas of your programme operation?

……

If yes, which ones, list them and expound on them?

……

Did the approaches, practices and processes you used in this ASK programme help to identify violations of sexual and reproductive health rights of young women living with HIV? Yes/No

If yes, how? List the practices, processes, or approaches and explain how they contributed to the identification

.....

If No, why? List those practices, processes, or approaches that did not and explain why not

.....

.....

Have you, during the ASK programme addressed any of the violations identified? Yes, No

If yes above, which violations did you address and how? List the specific violation and explain how each of them was addressed.

.....

.....

Has the ASK programme prevented any violations of sexual and reproductive health rights of young women living with HIV? Explain your answer.

.....

.....

In your view, which practice, activity or process of the ASK programme contributed the most to identifying, addressing and/or preventing SRHR violations? List them and explain why you think they contributed the most.

.....

.....

Which ones contributed the least and why. List them and explain.

.....

.....

In your view, what conditions, factors or challenges have hindered WOFAK's abilities to identify, address and/or prevent SRHR violations? Explain your answer.

.....

.....

In your view what are some of the achievements that the ASK program made as far as the uptake of PMTCT and ANC on the part of young mothers living with HIV? Explain your answer.

.....

.....

How would you compare the approaches, processes, and practices of WOFAK's for identifying, addressing and/or preventing SRHR violations to other organizations that have been successful? How similar are they? How different are they?

.....

.....

.....

How would you rate the ASK project in terms of success? Please explain your answer.

.....

.....

If WOFAK's club was to run a similar program, what would you like them to improve on? Please explain your answer.

.....

.....

.....

What strategy, activity, practice or process would you like to be used in future projects? Please explain why.

.....

.....

……

Any other information?

……

……

THANK YOU!

Annex 3: Terms of Reference for Applied Research

1. Summary of Assignment

Assignment	Evaluation of the processes, practices and effects of the activities of Mama's Club and WOFAK's activities within the Access, Services Knowledge Programme
Location	Uganda and Kenya
Duration	Tbd
Budget	Tbd

2. Introduction

About ASK and STOP AIDS NOW!

The Access, Services and Knowledge (ASK) programme is being implemented from 2013 to 2015 in seven countries: Ethiopia, Ghana, Kenya, Senegal, Uganda, Indonesia and Pakistan. ASK is led by the Youth Empowerment Alliance (YEA), consisting of Rutgers WPF (lead agency), AMREF Flying Doctors, CHOICE for Youth and Sexuality, dance4life, IPPF, Simavi and STOP AIDS NOW! The overall aim of the Programme is to improve the SRHR of young people (10-24 years) by increasing their uptake of SRH services by taking a comprehensive and inclusive approach to removing the barriers young people face in taking up SRH services. ASK targets young people in the age group 10-24 years, including underserved groups.

ASK focuses on youth participation and the participation of selected underserved groups, YPLHIV, LGBTIQ youth, young mothers, disabled youth, hard-to-reach youth in remote areas and young people in the age group 10-16 years. The ASK programme also focuses on enabling young people to make safe choices by directly receiving or seeking information or services, without the need of intermediaries, such as peer educators or teachers. To that end, ASK makes use of text messaging, mobile phone applications, web-based information platforms, chat and telephone help lines and non-traditional offline campaigns to build young people's knowledge. ASK also seeks to improve the quality of youth-friendly services and referral systems. ASK makes specific efforts to enhance access to RH commodities, including ARVs and contraceptives, as well as safe abortion.

STOP AIDS NOW! is an independent and partnership-driven organization, founded in 2000 by Aids Fonds and four Dutch development organisations: Cordaid, Hivos, ICCO, and Oxfam Novib. Our aim is to expand and enhance the quality of the Dutch contribution to the AIDS response in developing countries. STOP AIDS NOW! operates at the crossroads of fighting poverty, eliminating exclusion, and responding to the AIDS epidemic in countries with a

generalized epidemic. We particularly focus on women, youth, and children. STOP AIDS NOW! supports projects using learning by doing approach, sharing knowledge and expertise and by using local level results to influence international policies and government.
As a member of the YEA, STOP AIDS NOW!'s role in ASK is as follows. STOP AIDS NOW! Supports the overall programme in all countries by providing technical support to the other Alliance members and selected partner organisations in Kenya and Uganda on strengthening youth friendliness and SRHR and HIV integration in services addressing of rights violation and increasing access to ARVs and other commodities (supply chain management national government)

- Developing integrated, comprehensive HIV-prevention and SRHR programmes and building capacity to measure effects at outcome level;
- Increasing access to ARVs and other RH commodities (supply chain management with the national governments);
- Strengthening youth-friendliness and SRHR and HIV integration in services;
- addressing the needs of young people living with HIV by supporting them in advocacy and gathering evidence to articulate their needs;
- Increasing political commitment to improve sexual health outcomes for young people; and
- Addressing rights-violations of HIV+ young pregnant women in the context of SRH activities related to the prevention of mother to child transmission of HIV (PMTCT) and antenatal care.

The area of work listed last is the focus of the applied research project to be rolled out under these terms of reference.

About Mama's Club and WOFAK

Mama's Club

Mama's club Uganda was founded in 2004 as a local community based organization to provide psychosocial support to HIV positive mothers and their families. Mama's club's network of HIV positive mothers operates in twenty five districts. Clubs has 50-70 members, and most of them are under 24 years of age.

Mama's Club trains and supports young mothers living with HIV to be "Mentor Mothers". Mentor Mothers provide information on maternal health, prevention of mother to child transmission of HIV, infant care, family planning, and sexual and reproductive health and rights. They encourage them to attend antenatal clinics and services for the prevention of mother to child transmission of HIV (PMTCT). In addition, they help strengthen their life and parenting skills, and provide them with psychosocial support. Once trained by Mentor Mothers, trainees become Mentor Mothers as well. Furthermore, Mama's Club works with men to engage them in antenatal care and maternal health.

Mama's Club also works with service providers to improve the quality of HIV and SRH services and address cases of stigma and rights violations. Mentor Mothers are a liaison to the formal health system and to health care providers. Mama's club holds regular dialogue sessions and orientation workshops with health care providers on services and the quality of care.

As part of ASK in Uganda, Mama's Club contributes to increasing the number of young HIV+ pregnant women receiving PMTCT (in the targeted areas) and to increasing the number of young (<25 yrs) HIV+ pregnant women receiving antenatal care (in the targeted health facilities in targeted areas). Activities center on rolling out the Mentor Mothers approach (up-scaled to new districts) and providing support for and oversight on SRH and HIV care of young women living with HIV. Mama's Club also builds the capacity of service providers to improve the quality of HIV and SRH services and address cases of stigma and rights violations. These activities are designed to integrate prevention of rights violations, in particular violations of the sexual and reproductive health and rights of young women living with HIV in the context of PMTCT and maternal health services.

WOFAK

Women Fighting AIDS in Kenya (WOFAK) was founded in Kenya in 1994 by a group of women who had tested positive for HIV. WOFAK provides comprehensive care, counseling, and support services to women, youth and children living with and affected by HIV and AIDS. WOFAK operates in 13 centers throughout Kenya.

WOFAK provides medical services through referrals and close collaboration with public and private hospitals and facilities. WOFAK also provides counseling and support services, include nutritional care, vocational training and income generating activities. In addition, WOFAK takes up peer-education based Behavior Change Communication (BCC) for HIV prevention and to mobilize communities to take up antiretroviral treatment.

Within ASK in Kenya, WOFAK[2] contributes to increasing the number of HIV+ pregnant women receiving PMTCT (in the targeted areas) and antenatal care (in the targeted health facilities in targeted areas). WOFAK also contributes to increasing acceptance/support of young people's rights to access SRH services at community/local level1. WOFAK achieves these results by improving the quality of HIV and SRHR health care services for young women living with HIV, in particular with regard to rights-related issues.

[2]WOFAK contributes to result area 3:Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using; and result area 4:Greater respect for the sexual and reproductive rights of people to whom these rights are denied.

WOFAK works on improving the quality of HIV and SRHR health care services by running Youth Friendly Service (YFS) desks and maternal health and PMTCT desks at health facilities. Both types of desks consist in a WOFAK counselor assigned to a government health facility to provide information, encourage clients to be proactive in seeking services, support couples' counseling, and record and follow up on alleged rights violations. Both types of desks are supported through group counseling and community-based activities.

Activities for ASK including: providing peer-led refresher training to YFS and Maternal Health & PMTCT desk officers, respectively, to strengthen their capacity to support the HIV and SRHR needs of young pregnant women living with HIV; integrating the YFS and maternal health and PMTCT desk models to form Young Mother desks (at eight facilities); and running dialogue sessions (three per year) at health facilities between young positive mothers and health providers on the quality of HIV and SRH services.

3. Aim and objectives of the applied research

The aim of the applied research is to document, analyse and evaluate the approaches (focus on .content), processes and practices Mama's Club and WOFAK employed in their activities in ASK that contribute to successfully identifying, addressing and preventing rights violations of the sexual and reproductive health and rights (SRHR) of (young) women living with HIV (<25 yrs) in SRH settings (especially PMTCT and antenatal care (ANC).
The specific objectives of the applied research are as follows

- Document in explicit detail the approaches, processes, and practices that contribute to identifying, addressing and/or preventing rights violations of the sexual and reproductive health and rights of young women living with HIV (<25 yrs) in SRH settings. Document successes and challenges to achieving these outcomes
- Relate these approaches, processes, and practices to work that has been done by others to identify, address and/or prevent successfully SRHR violations of young women living with HIV in SRH settings (see for example work by ICW, GNP+, OSI).
- Relate the approaches, processes and practices to changes in uptake or demand for PMTCT and ANC services.
- Identify if and how the successful approaches, processes and practice can be replicated by other stakeholders.

4. Questions to be addressed by the research

- What are the current approaches, processes, and practices of Mama's Club and WOFAK—part of the ASK programme—and how do they quantitatively and qualitatively differ from each other?

- How do these approaches, processes, and practices differ in relation to what Mama's Club and WOFAK did before the ASK programme? Did they develop new (for them) activities especially for ASK?
- Did Mama's Club and WOFAK adapt their respective activities during the ASK programme? If so, how and why?
- Do the respective approaches, processes, and practices of Mama's Club and WOFAK contribute to identifying, addressing and/or preventing violations of the sexual and reproductive health and rights of young women living with HIV in SRH settings (<25 yrs)? If so, how so? If not, why not?
- Can we be sure the contribution to identifying, addressing and/or preventing SRHR violations is due to their ASK activities? If so, how so? Which ones contributed the most? Which ones contributed the least?
- Which conditions or factors have hindered Mama's Club and WOFAK's respective abilities to identify, address and/or prevent SRHR violations? Why?
- Did Mama's Club and WOFAK succeed in increasing significantly the uptake of PMTCT and ANC on the part of young women living with HIV? If there is a significant increase, can it be attributed to their ASK activities? Link to M&E.
- How do WOFAK and Mama's Club's approaches, processes and practices for identifying, addressing and/or preventing SRHR violations differ from those projects or organisations known to have been successful?

5. Proposed elements of the research method (to be finalized with the researchers)

- Global desk review to collect data and information on existing successful approaches, processes and practices for identifying, addressing and/or preventing SRHR violations of women living with HIV in SRH settings.
- Desk review of WOFAK and Mama's Club's ASK-specific activities and related current activities, respectively.
- Interviews with key informants (to be determined) from WOFAK and Mama's Club to obtain additional data and information.
- Focus groups discussions with the target group.
- Observation in the clinics.
- Confirmatory factor analysis to determine if there is indeed a positive relationship between increased uptake or demand for PMTCT and/or ANC services on the part of young women living with HIV and WOFAK and Mama's Club's ASK-specific activities

Deliverables

- Research proposal with description of protocol
- Data collection tools: interview, FGD and observation guides
- Research report

6. Intended use of the research findings

WOFAK will work with STOP AIDS NOW! and Mama's Club in Uganda to develop a tool articulating the most successful methods to allow for replication of their most effective methods. Through a regional training meeting of partner organisations in ASK and distance learning-e-learning and e-coaching—WOFAK will collaborate with Mama's Club and STOP AIDS NOW! to support other partner organizations that are part of the ASK programme to implement the tool.