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Multisectoral youth RH interventions: The scale-up process in Kenya and Senegal

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As in many developing countries, young people in Kenya and Senegal—those between ages 10 and 20—account for about 25 percent of the population. To ensure their future contribution to their countries, it is thus of vital strategic importance to safeguard the welfare of these young people. Rapid social change in both countries exposes youth to sexual and reproductive health risks, including unintended pregnancy, sexually transmitted infections (STIs) including HIV, and sexual violence. In Kenya, the greatest risks are from unplanned pregnancy and STIs, including HIV. In Senegal, family members and the health care system often are ill-equipped to provide youth with information on reproductive and sexual health or to advise them on how to sexual risks (Askew, Chege, Njue, and Radeny 2004; Diop et al. 2004).

A community health peer educator and two young men look through a publication on adolescent reproductive health.

Beginning in 1999, the Population Council's Frontiers in Reproductive Health Program (FRONTIERS) conducted operations research (OR) studies that tested the feasibility, acceptability, and cost of a public-sector, multisectoral intervention to enhance young people's reproductive health knowledge and behavior. Study findings showed improvement in young people's reproductive health behavior and knowledge, successful engagement of government ministries, and increased understanding of the reproductive health needs among communities.

Communities and the participating ministries in both Kenya and Senegal expressed interest in incorporating elements from these interventions into their routine operations. FRONTIERS and its local partners launched follow-on projects in both countries to adapt, expand, institutionalize, and scale up the activities. This *Program Brief* describes the processes involved in institutionalizing and scaling up the multisectoral interventions.

- *Protecting youth reproductive health is an important strategy for developing countries.*
- *Multisectoral approaches that engage government agencies, communities, and youth are vital for sustainable change.*
- *It is critical for implementing agencies to institutionalize, budget for, and monitor interventions within their routine job responsibilities.*

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The interventions

The Kenya Adolescent Reproductive Health Project (KARHP) and the Senegal Adolescent Reproductive Health study were part of FRONTIERS' four-country Global Youth Study (conducted also in Bangladesh and Mexico). The global study's overall goals were to develop and test similar interventions in a variety of sociocultural and programmatic settings that would (a) improve reproductive health knowledge and behavior, (b) delay the onset of sexual activity among younger adolescents, and (c) meet the needs of sexually active adolescents while reducing risky behavior.

In each country, the project used a multisectoral, multidisciplinary approach and a quasi-experimental design using pre- and post-intervention testing. Researchers compared the reproductive health knowledge and behavior of youth in control groups, who received no intervention, with that of youth in two experimental groups, who received combinations of the following interventions:

- Clinic-based "youth-friendly" services in designated spaces
- Community outreach and mobilization to foster a supportive environment for youth
- School-based education using a life skills curriculum that included reproductive health.

Implementation for the four studies was tailored to fit the country context. Table 1 shows the similarities and differences in the Kenya and Senegal projects.

The interventions were carried out through existing public institutions—a strategy designed to control and reduce costs—with the goal of eventually integrating ARH activities within the institutions' routine activities and also within national policies and programs. Outreach and advocacy also involved community institutions and resources (including religious organizations, women's groups, public events, dramas, and community meetings, among others). Staff of government ministries participated in all phases of the design and implementation; youth, community, and religious leaders were key actors in providing information and discussing sensitive issues.

Contents

Findings from the initial studies showed that the ARH interventions addressed a recognized need. Community response was overwhelmingly positive. Local civic and religious leaders—critical gatekeepers for social change—strongly supported the ARH initiatives and played major roles in the intervention activitities.

Table 1.
Site-specific characteristics in Kenya and Senegal interventions

	Kenya	Senegal
Participating ministries	– Gender, Sports, Culture & Social Services (MGSCSS) – Health (MOH) – Education, Science and Technology (MOEST)	– Education (MOE) – Health (MOH) – Youth (MOY)
Setting	6 rural communities Western Province	3 urban communities (Louga, Saint-Louis, Diourbel)
Community intervention	– Community activities facilitated by social development assistants – Outreach by religious and community leaders and peer educators – Sensitization for parents and provincial administrators	– Community activities and outreach by *Aide Ados* [youth workers] – Sensitization for community and religious leaders – Outreach to parents through women's groups
School intervention	– 34-part *Tuko Pamoja* [We Are One] curriculum for in-school youth (teachers, peer educators, and guidance counselors) – Extracurricular youth clubs – Life skills curriculum for out-of-school youth – Sensitization for parent-teacher associations	– *Le Devenir Acompagné* [A Guide to the Future] curriculum for in- and out-of-school youth (teachers and peer educators) – *Grandir en Harmonie* [Growing up in Harmony] life skills curriculum for training peer educators – Life skills outreach by peer educators
Clinic intervention	– 16 clinics – Youth-friendly services offered in designated spaces by providers and peer educators – Informational material on youth RH provided	– 12 clinics – Youth-friendly services offered in designated spaces by providers and peer educators – Outreach by *Aide Ados*

Table 2.
Findings from first phase projects in Kenya and Senegal

Kenya	Senegal
Activities reached half of adults and two-thirds of youth in project areas	Activities reached about one-third of youth in project areas and about 40 percent of parents
Strong community support for ARH	Strong community support for ARH
Strong support by religious leaders	Strong support by religious leaders
Knowledge of ARH by youth increased	Knowledge of ARH by youth increased
Average number of partners decreased slightly among sexually active youth	Average number of partners decreased slightly, and reported intercourse decreased, among sexually active youth
Little use of youth-friendly services	Youth-friendly services and use of health centers increased
	Strong contribution by peer educators

Comparisons of the pre- and post-intervention surveys showed that the multisectoral, multidisciplinary approach yielded numerous positive outcomes. Table 2 shows general findings from ARH activities in Kenya and Senegal.

Findings differed depending according to individual study site and gender, and there were wide differences between the younger (10-14 years) and older (15-19 years) cohorts. Findings on specific indicators revealed significant changes among subgroups in the study—for example, in Senegal:

- Boys aged 10 to 14 were much more likely to seek information on reproductive health if they had been exposed to the intervention (83%) than if they had not (36%).
- Awareness of contraception increased significantly (from 74% to 85%) among boys and girls aged 15 to 19 in the intervention areas, while remaining under 70% in the control area.
- Knowledge about condoms and pills increased significantly in both intervention areas among youth exposed to the interventions (between 50% and 75%) and was much lower among those not exposed (3% to 50%) (Diop et al. 2004).

In Kenya, contrasts between youth exposed to the intervention and nonexposed youth included the following:

- Significantly more boys and girls in the intervention sites (67% to 96%) knew of at least one STI, compared to knowledge at the control sites (52% to 83%).
- Exposure to the school-based intervention was associated with significantly lower rates of sexual activity—for example, 73 percent of exposed youth reported no sexual activity, compared to 61 percent of nonexposed youth.
- Among sexually experienced adolescents, the median age at sexual debut showed a statistically significant increase in specific experimental sites between baseline and endline—increasing from 13.9 to 14.3 for boys in one project area, for example, and from 14.5 to 15 for girls in the same site. Age at sexual debut remained unchanged at the control sites, suggesting that the ARH interventions exerted an inhibiting effect (Askew et al. 2004).

These findings convinced communities and collaborating ministries in both countries to sustain and extend implementation of these multisectoral ARH interventions.

The scale-up process

With funding from the United States Agency For International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR), FRONTIERS initiated follow-on projects in Kenya (2003–2008) and Senegal (2004–2008) to institutionalize and scale up the ARH interventions (and in Kenya, additional HIV prevention activities) within the routine duties of the participating ministries. FRONTIERS (and in Kenya, its partner PATH) provided technical support in both countries to:

- Identify and adapt the practices, tools, and materials that proved successful in the first phase projects
- Build the capacity of ministries and partners to plan, budget for, and implement ARH and HIV prevention activities
- Incorporate ARH and HIV prevention activities in routine ministerial procedures
- Support the phased expansion or scale-up of these activities

The expansion projects followed different models. The Kenya project was a large scale-up effort, focused on institutionalization, replication, and rollout of KARHP activities within the three participating ministries at district, provincial, and national levels —including planning and budgeting (see Box 1).

A schoolgirl and KARHP peer educator teaches life skills in Western Province.

Box 1.

From pilot to scale-up in Kenya: Estimating costs

Combined costs for all phases of the Kenya pilot project (planning, implementation, monitoring, and service delivery) totaled US$153,000. Kenyan ministerial partners based their decision to scale up the KARHP approach both on the positive findings from the pilot project and on projections made of the costs of scaling up.

In estimating costs for scale-up, FRONTIERS and its ministerial partners made assumptions of cost savings based on the participation of staff in public institutions who already received a salary. Mainstreaming KARHP activities within their routine work duties would constitute another savings. Planning costs ($28,000 in the pilot phase) would be eliminated, and training materials and tools were already developed. Training of trainers, monitoring and information systems, and supervision could be integrated into existing infrastructure and budgets.

For the MOEST, introducing KARHP in new schools would require $240 per school per year. About 50 percent of these costs would be incurred during training of implementation personnel and 40 percent in organizing and conducting planning activities.

To expand KARHP activities to new locations, the MGCSS required $6,900 per administrative location annually, with the ministry contributing labor and infrastructure.

Expenditures by the MOH were not explicitly tracked, but are discussed in Box 2.

In Senegal, the focus was on institutionalizing ARH activities within a range of governmental and nongovernmental organizations and on replicating the multisectoral model to several other African countries.

Scale-up in Kenya

In Kenya, FRONTIERS worked throughout the expansion process with PATH. Participating ministries included the Ministry of Gender, Sports and Social Services; the Ministry of Health, and the Ministry of Education. In 2007, the newly created Ministry for Youth Affairs took on the role of reaching out-of-school youth with ARH information and life skills.

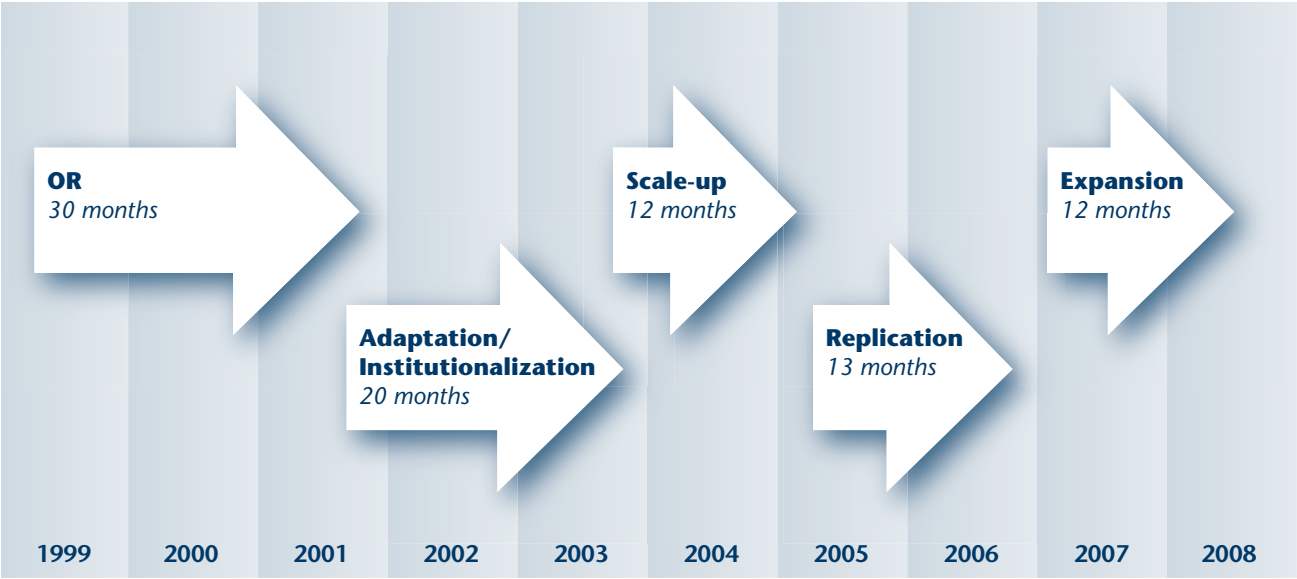
The Kenya expansion took place in several overlapping phases (see Figure, below, for approximate durations).

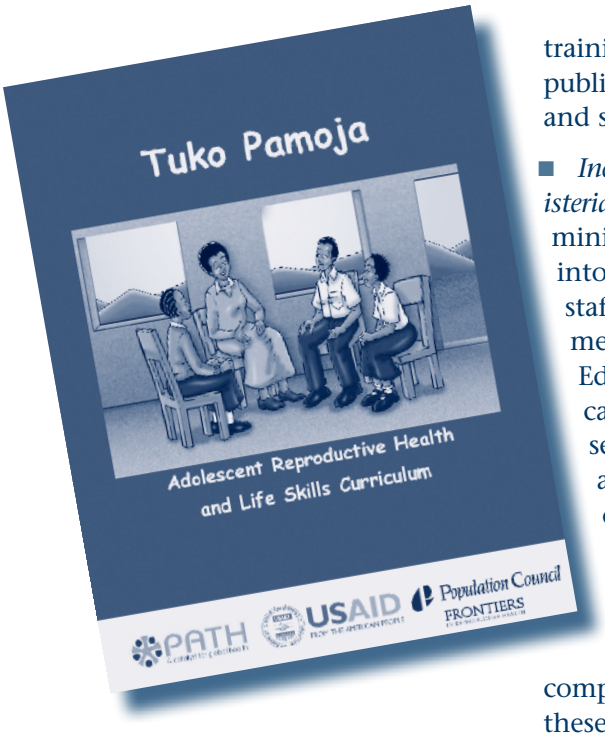
2003-2005: Adaptation and institutionalization

During this 20-month phase, the three ministries identified a package of cost-effective ARH strategies from the initial interventions for institutionalization in two districts (Vihiga and Busia) in Western Province, followed by scale-up throughout Western Province, and finally replication and expansion nationwide.

After identifying the package of activities, all partners began adapting the approaches and revising the curriculum, tools, training materials, and monitoring instruments for use by each ministry. The activities included: revision of a life skills and reproductive health curriculum for schools (*Tuko Pamoja* [We are One] curriculum); peer education to reach in- and out-of-school youth; provision of youth-friendly health services by the Ministry of Health (see Box 2 on adapting the health services); and community mobilization by social development assistants from the Ministry of Gender, Sports and Social Services.

Timeline: Institutionalization and scale-up in Kenya





In the next step, the ministries incorporated the package of activities into the routine procedures of staff throughout Vihiga and Busia, ensuring coordination among the three ministries. The following activities were vital to the institutionalization process:

- *Forming an interministerial coordination group.* This group guided epxansion of KARHP activities. Group members facilitated networking within and among the ministries, reduced duplication of effort, which made it easier to leverage technical and financial resources.
- *Training.* Training used a cascade approach through cadres of master trainers created at national and provincial levels. FRONTIERS, PATH, and the ministries shared the costs of training community-level staff, public health and clinical staff, and school personnel.
- *Incorporation of ARH in ministerial work plans.* The three ministries incorporated ARH into their work plans and staff performance requirements. The Ministry of Education took over cascade training, including sensitizing head teachers and school management committees, incorporating life skills education within school curricula, interschool ARH activities (games, dramas, and competitions), and monitoring these activities. The Ministry of Gender, Sports and Social Services absorbed the monitoring tools and took over community activities, while the Ministry of Health adopted the training manuals and conducted multisectoral collaboration with other ministries and stakeholders in its reproductive health interventions. Subsequently, the Ministry of Youth Affairs adopted the life skills curriculum and monitoring tools for use in polytechnic schools for youth.
- *Regular monitoring of program activities.* Monthly reports by local-level ministry staff (guidance counselors, teachers, social development assistants, and public health officers) were collected at the district level, entered into a database, and collated into quarterly reports discussed at the interministerial meetings. A management information system (MIS) was developed to allow the ministries to track KARHP activities and progress toward

Box 2.

Adapting for scale-up: Using lessons from the first-phase study on youth-friendly health services

The Kenyan health center intervention, while included in the scale-up, was modified from its original design to address problems with feasibility, effectiveness, and cost.

The first-phase intervention required peer educators to meet young people at the MOH clinics in "youth-friendly" rooms equipped with videos and computers. However, this approach gave poor results in the Kenyan setting. The MOH objected to the expense of equipping the youth-friendly rooms; participating clinics objected because they could not spare the rooms. Also, use of clinics was limited. Young people who were not sexually active did not use the clinics, seeing them as adult facilities; and the minority of sexually active youth (less than 30% of boys and 18% of girls) obtained their main service—condoms—at kiosks, not at clinics.

To address this problem, the MOH decided to place youth services within communities through its community-based public health officers and public health technicians, with links to clinical staff, as a more affordable alternative.

set goals. Routine participation in implementation and monitoring allowed the ministries to plan, budget, and leverage support for the activities carried out.

- *Cost- and resource-sharing.* Intersectoral committees were created at district and provincial levels. During quarterly meetings, the participating ministries shared experiences and planned jointly for future budgeting and implementation.
- *Advocacy.* To secure support from the top government levels for the province-wide scale-up, FRONTIERS and PATH conducted advocacy with senior staff at various levels within the three ministries. They held regular briefing meetings to discuss programmatic, financial, and policy aspects of ministry activities during all phases of the institutionalization, replication, and scale-up.

2005-2006: Scale-up in Western Province

Experience from the testing and institutionalization phases helped to refine project tools and streamline the process of replication into other districts in Western Province. Between 2005 and 2006, the three ministries expanded the KARHP education, community, and health activities and tools into the six remaining districts. Over the course of expansion throughout Western Province, the master trainers trained more than 1,100 teachers, community workers, clinical and community health technicians, and other ministry personnel. By early 2006, the *Tuko Pamoja* curriculum had been approved for reproductive health education throughout Western Province.

2006-2008: Replication in other provinces

- *Eastern and Nyanza Provinces.* In May 2006, replication of KARHP began in two districts each in Eastern Province and Nyanza Provinces. Introduction of the ARH activities in two districts in each province provided sufficient experience to build a "critical mass" of trained ministry personnel, who could then introduce KARHP throughout all districts. In April 2007, the MOEST allocated Ksh2.1 million ($32,308) for the rollout of the KARHP curriculum in 502 schools in six districts each in Nyanza and Eastern Provinces. Beginning in June 2007, PATH continued scaling up the KARHP intervention to all other districts in the two provinces.
- *Central and Nairobi Provinces.* Also in June 2007, FRONTIERS received support from PEPFAR/Kenya and USAID/Kenya to facilitate replication of the KARHP model in Nairobi and Central Provinces. Again, the replication followed the strategy of introducing KARHP into two districts in each province; incorporating proven strategies, such as cascade training for master trainers at all four ministries (MOEST, MGSCSS, MOYA, and MOH); creating district- and provincial-level intersectoral coordination bodies; and developing MIS systems.
- *Additional replication.* In April 2008, the Ministry of Youth Affairs rolled out the KARHP approach and the *Tuko Pamoja* life skills curriculum to 70 polytechnic schools for youth. The MOEST allocated Ksh1.5 million ($23,077) to expand the program to schools in all ten districts in Coast Province, and approved the teaching of life-skills education as a stand-alone subject in schools.

Expansion of the KARHP approach through institutionalization, replication, and scale-up is still underway and had reached more than 200,000 young people and adults by May 2008 (see Table 3). The *Tuko Pamoja* curriculum also is being used by international organizations, including World Vision, Population Services International, and USAID bilateral projects.

Review of policies and procedures on ARH and HIV prevention

At the national level, FRONTIERS continues to conduct advocacy and provide technical assistance to help the ministries

mainstream ARH in their annual operations plans and budgets. The assistance included support to the MOH for developing youth-friendly service guidelines and national ARH training manuals for service providers and peer educators. FRONTIERS also works with the Ministry of Education to develop national guidelines for a guidance and counseling curriculum.

Table 3.
Training and orientation during institutionalization and replication of KARHP in Kenya

Implementing agencies	2003–2005 *Institutionalization* Western Province	2005–2006 *Scale-up* Western Province	2006–2007 *Replication* Eastern and Nyanza Provinces	2008 *Replication* Nairobi and Central Provinces
Ministry of Education, Science and Technology	Guidance/counseling teachers: **222** Heads of schools: **214** In-school peer educators: **474**	Guidance/counseling teachers: **662** Heads of schools and parent-teacher association members: **1,324**	Provincial- and district-level officials: **45** Guidance/counseling teachers: **121** Heads of schools and other administrators: **234**	Ministry officials trained: **45**** Guidance/counseling teachers: **90** Members of school Boards of Governors: **180**
Ministry of Gender, Sports, Culture and Social Services	Religious and community leaders: **228**	Ministry officials: **255**	Ministry officials: **72**	Ministry officials: **60** Community members: **510**
Ministry of Health	Public health officers: **22**	Public health officers and clinical staff: **372**	Public health officers and clinical staff: **169**	Provincial- and district-level health officials: **35** District health management teams: **36**
Ministry of Youth Affairs				Ministry officials: **78**
Community members receiving ARH message		**199,351***	**59,964****	**2,681****

*The numbers of people reached change based on updates received from the ministries and updated in the MIS.

**These numbers represent community members reached in the first two districts. The flow of reporting was slow in 2008 because of political disturbance in the first quarter.

Expansion in Senegal

The institutionalization and expansion of the Senegal ARH project built on the accomplishments demonstrated during the first phase: a strong response to youth-friendly health services and the development of a cadre of committed peer educators. In the Senegal model, the health system is the center of a multidisciplinary network that links health centers with youth, communities, schools, and the media. In the follow-on project, FRONTIERS worked with the World Health Organization (WHO) and the Ministries of Health, Education, and Youth to (a) institutionalize ARH programs in the two districts, (b) develop action plans, (c) leverage funding for youth programs, (d) scale up the intervention in Senegal, and (e) expand the ARH strategy beyond Senegal.

Institutionalization of ARH within MOH policies

2004-2006: Institutionalizing ARH

In 2004, the Ministry of Health (MOH) established a multisectoral steering committee to follow up on the recommendations from the first phase study. The committee, composed of 13 member organizations representing the government, nongovernment organizations (NGOs), development partners, research organizations, and youth groups, guided the development of ARH activities and the expansion of intervention elements to other areas of Senegal. The process entailed the following elements:

- *Integrating ARH in national policy.* In 2004, the MOH incorporated youth reproductive health into the national health norms and standards, which are updated every five years. Findings from previous OR projects were used to propose a framework and procedures for ARH in Senegal. The framework defined ARH, described the major goals of ARH programs, outlined principal strategies for achieving those goals, and listed essential services for adolescents. The updated guidelines also described the infrastructure, equipment, and personnel training requirements for offering adolescent reproductive health services. The guidance was distributed to all Senegal's health districts.
- *ARH strategy paper.* In 2005, the MOH identified ARH as a strategic priority for increasing contraceptive prevalence and reducing maternal mortality in Senegal. The ARH steering committee worked with international partners and other ministries (including the Ministries of Youth, Planning and Sustainable Development, and Social Development) to draft a policy document outlining strategies to improve and safeguard adolescent health. This strategy paper is designed to guide national- and local-level ARH programs. It lays out general and specific objectives for improving adolescent health; outlines an institutional framework; identifies high-priority activities (such as training for *Aides Ados* or AAs,[1] creating youth-friendly spaces in health facilities, informing parents and teachers about ARH, and raising funds to support ARH activities); and describes approaches for monitoring and evaluating ARH projects. The National Strategy on Adolescent Reproductive Health was finalized and publicly launched in 2006.
- *Operationalizing ARH.* The MOH developed a total of 15 "technical forms," or guidance and planning documents, for distribution to all 56 health districts. These technical forms are standardized one-page documents, intended to help districts incorporate ARH activities into their annual work plans. Each technical form describes major ARH activities for the districts, such as providing youth-friendly services, identifying staff training needs, training

[1] AAs are local young people selected by health facility staff to serve as providers' aides who welcome, counsel, and refer adolescent clients within the health facility, or to conduct classes with groups of adolescents, under the supervision of the director of the health facility.

Youth networks in Senegal

During the initial project, the peer education component played a significant role in advancing community understanding and desensitization of ARH issues. The partnership between youth organizations and health facilities resulted in an unusually high level of commitment and retention of peer educators: of the initial 70 recruited, 57 remain active (the 13 who left did so mainly because of marriage or jobs). As a result, a large proportion of peer educators continued working on ARH activities following their initial recruitment. Many peer educators now train new groups of peer educators and are frequently consulted by other international organizations, including Plan International, Family Health International, and Management Sciences for Health.

Several factors contributed to the strength of the peer educator component of the Senegal ARH project:

- The project built on existing institutions: organized, officially recognized youth associations that operate in all communities under the auspices of the Ministry of Youth.
- The project solicited participation by the most dynamic youth organizations, and participating groups signed an agreement on their role with the MOH.
- Youth from each participating organization were involved from the outset in the project's steering committee.
- Peer educators were officially introduced to the community by MOH and Ministry of Health staff.
- Peer educators received systematic training and refresher training.

Youth organizations are now using the training delivered during the initial project to attract funding from donor agencies and work with a range of organizations. Links created among the peer education groups and the Ministries of Justice, Health, Youth, and Social Development led to new projects. In the town of Louga, for example, the youth groups participated in establishing a system for medical, psychological, and legal management of sexual assault cases.

providers in ARH, selecting peer educators, or conducting outreach and promotion on ARH. FRONTIERS provided guidance for developing operational plans and cost estimates. Additionally, the MOH developed three adolescent health indicators for inclusion in the MIS.[2] Nine of Senegal's 11 health regions and 55 districts have developed work plans for ARH activities based on these forms.

[2]ARH indicators are: (1) the number of adolescents using health facilities, (2) the number of youth-friendly centers, and (3) the percentage of youth receiving life skills training.

- *Fundraising for ARH activities.* The MOH and the Ministry of Youth developed action plans and solicited support from various agencies, including WHO, the World Bank AIDS program, the Africa Development Bank, and the reproductive health program of the United Nations Population Fund (UNFPA). The ongoing activities are cofinanced. For example, the World Bank provided $92,000 to support the MOH action plan, while the MOH provides funds for training and furnishes spaces for ARH activities.
- *Developing core trainers.* The project developed a core group of national trainers for MOYA staff, health care providers, youth workers (AAs), peer educators, and staff from Ministry of Social Affairs and other ministries.

Scaling up ARH

The educational and training curricula developed during the first-phase study were revised and adopted as national documents in 2006. The ARH orientation manual for providers is currently used for in-service training on young people's reproductive health needs. The youth curricula (*Grandir en Harmonie* for training peer educators and *Le Devenir Accompagné* for in-school youth)

were integrated into a variety of programs, including the following:

- *School curricula*. The Ministry of Education and its NGO partner, the Group for Population Studies and Education (GEEP), introduced *Le Devenir Acompagné* into five high schools in three regions. Outside of schools, GEEP is introducing *Grandir en Harmonie* and a training manual, *Brisons le Silence* (Let's Break the Silence). GEEP is also implementing a "health space" in 12 schools with services for youth provided by a multidisciplinary team.
- *Pre-service and in-service training*. The Ministry of Sport integrated ARH issues into its pre-service training curriculum for schools and into its master's-level degree in sports education. ARH training has been added to the curricula for the training of primary and secondary school supervisors. In-service training in ARH has been developed for school health nurses.

- *Expanded use of the ARH curricula*. The curricula are being used by the Ministries of Youth and Justice and also by local faith-based organizations. The Ministry of Youth uses the *Grandir en Harmonie* curriculum in 13 youth centers and in the centers created through the Youth Spaces program, an initiative of the President of Senegal that seeks to provide a center for cultural and sports events, skills training, and internet access in all of Senegal's 11 regions. The Ministry of Justice uses the curriculum in outreach to vulnerable adolescents, such as domestic workers, shoeshine boys, teen mothers, and youth in prison, who are normally not reached by peer educators.
- *Replication of the ARH approach*. FRONTIERS and the MOH provided technical assistance to representatives of Guinea and Mauritania on adapting the ARH training and strategic approach.
- *Adoption of the curricula by other organizations and beyond Senegal*. The African Development Bank, UNFPA, and other agencies support the use of project materials and their expansion into new areas or audiences. For example, Save the Children/Sweden uses the *Grandir en Harmonie* curriculum and the youth-friendly services model in its regional programs in 18 countries.

2007-2008: Expanding the ARH model beyond Senegal

The Senegal model envisioned establishing Senegal as a center of expertise in ARH, and a technical resource for other West African countries that are interested in improving services for adolescents. FRONTIERS presented the findings and process information from the Senegal ARH project at a meeting of francophone countries in 2007. FRONTIERS and the Senegalese MOH provided technical support for governments interested in adapting the material. Since then, the government of Guinea has developed a strategy for adolescent reproductive health, and the *Grandir en Harmonie* curriculum has been translated into Arabic by the Mauritanian Ministry of Education with financial support from the United Nations Children's Fund (UNICEF) and UNFPA. Three Mauritanian youth organizations also use the curriculum.
In 2008, FRONTIERS and WHO organized a regional consultation on community-based ARH interventions, with the goal of contributing lessons from the FRONTIERS multisectoral approach to a guidance document for African countries wishing to implement community-based interventions to support youth-friendly health services. As of May 2008, participating governments had formed a steering committee and began to finalize this document.

Table 4 shows the number of trainers and community members reached through the expansion of the Senegal ARH program.

Table 4.
Training and orientation during institutionalization and replication of the Senegal ARH program

	2003–2005 *Institutionalization*	2005–2008 *Expansion*	2007–2008 *Replication* Guinea and Mauritania
Ministry of Education	Schools: **13** School nurses: **5** Teachers: **26** Student peer educators: **52** School officials: **47**	Master trainer: **1** High schools: **40** Teachers: **300**	
Ministry of the Family and Social Affairs		Regional master trainers: **4**	
Ministry of Health	Regional and central master trainers: **10** Health care providers: **32**	Master trainers: **49** Health care providers: **170**	Ministry officials (Guinea): **20**
Ministry of Youth		Regional and central master trainers: **8** Youth spaces created: **8**	
Ministry of Justice	Master trainers: **4** Peer educators: **10**	Youth reached: **820**	
Ministry of Sport		Masters of sport : **25**	
Youth community–based organizations	Peer educator supervisors: **11** Peer educators: **70** Aide Ados: **11** Youth reached: **20,000**	Master trainers: **22** Aide Ados: **25** Youth organizations: **200** Youth reached: **8,300**	Master trainers: **26** Youth organizations: **3** Peer educators: **15** Youth reached (Mauritania): **200**
Development partners		International agencies (including United Nations agencies): **8** Master trainers within regional NGOs: **2**	
Community	Opinion leaders: **1,433** Parents: **1,679**	Parents: **1,365**	
Media	Community and national radio stations: **54**	National TV station: **1**	Regional radio programs (West African Democracy Radio): **4**

Scale-up: Lessons learned

- *Multisectoral, multidisciplinary engagement.* A vital success factor in Kenya and Senegal was engaging with and supporting multiple agencies: from local through national levels, from public and nongovernmental sectors, and from conceptualization through scale-up.
- *Response to local needs and context.* The ARH activities responded to government priorities and were sensitive to specific community needs and concerns in each country.
- *Use of existing institutions and customs.* Mobilizing respected and recognized leadership (such as religious leaders) and working through existing institutions (public institutions, churches, and formal youth organizations) enhanced commitment to and sustainability of these ARH activities.
- *Institutionalization of ARH.* Helping government ministries to incorporate and cover the costs of these ARH activities within their own plans and budgets was critical. Cofinancing by the participating agencies was an important part of normalizing ARH within the ministries.
- *Cascade training.* The training-of-trainers strategy helped to create a durable core group of master trainers. In Kenya, for example, donor funding supported training of about one-third of all ministry staff in the province, which provided sufficient expertise to enable comprehensive province-wide training of all staff.
- *Monitoring and evaluation.* Developing appropriate and feasible monitoring systems and evaluation indicators allowed several agencies with different interests to track their progress toward reaching strategic and programmatic goals.
- *A long-term process.* A long-term commitment to advocacy and technical assistance, by both the government ministries and USAID, was essential to creating a supportive and stable environment within which scale-up and replication could occur.

Conclusions

Communities and governments are aware of the need to address young people's reproductive health. Multisectoral interventions involving various government ministries, community and religious leaders, families, and youth themselves proved effective in improving the reproductive knowledge and behavior of youth. Such interventions create a supportive environment for these sensitive issues and offer appropriate, acceptable, and sustainable approaches for communicating behavior change messages and delivering reproductive health services. Models in Kenya and Senegal—featuring (1) institutionalization of ARH within a network led by government ministries and (2) phased adaptation, expansion, and scale-up—are succeeding in permanently integrating ARH within public and community institutions. The nine-year effort involved in this process suggests the need for long-term commitment from government ministries, donors, and participating communities to ensure sustainable policies to invest in, protect, and nurture young people's reproductive health.

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Preserving reproductive health is of vital importance in guiding young people into a productive adulthood.

The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.

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