

# implementation story:



## The After Hours Adolescent Project: Expanding Access to Sexual and Reproductive Health Services in Western Kenya



AHAP project team (Collins Juma, Paula Tavrow, Emmanuel Manyati) with AHAP nurse (on left) in front of Mt Elgon Sub-County Hospital, an AHAP facility.

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## Background and Context

In rural Kenya, as in much of Africa, about one-third of the population is between the ages of 10 and 24 years. Despite efforts to make sexual and reproductive health (SRH) services more accessible to young people, use of these programs is still very low.

Kenya faces high rates of unwanted pregnancies and transmission of sexually transmitted infections (STIs), including HIV, among adolescents. A 2019 report found that two-thirds of the 345,000 pregnancies among adolescents (ages 15 to 19) were unintended and that about 357,000 Kenyan adolescents have an unmet need for modern contraception (Guttmacher Institute, 2019). Pregnancy and poverty are the main causes of school dropouts:

***“This is the best project I have ever engaged with. The community appreciated it so much, because the [AHAP] nurse was resourceful and captured the attention of the youth.”*** In-charge at AHAP facility

only 10 percent of Kenyan students who give birth return to school (Undie, Birungi, Odwe, & Obare, 2015). Early childbearing is associated with larger families, lower use of contraception, and fewer career options, and therefore contributes to a vicious cycle of poverty and high fertility. Kenya also has a high HIV prevalence (nearly 5 percent) among people of reproductive age (ages 15 to 49), and women experience the majority of infections (65 percent) (UNAIDS, 2020). In 2018, new HIV infections among Kenyan women ages 15 to 24 were more than double the number of infections among young men of similar age (UNAIDS, 2020).



If all sexually active Kenyans were to obtain SRH services, unwanted pregnancies and STI transmission would decline significantly. However, young people—especially in rural areas—face numerous daunting barriers, both geographic and psychosocial.

First, some young people are anxious about how health care providers will treat them. Adolescents worry that providers will be rude or judgmental, ask embarrassing questions, or not accord them privacy and confidentiality. Unfortunately, some providers in Kenya, especially in more conservative rural areas, consider it immoral or promiscuous for adolescents to seek SRH services. They believe providers should actively discourage adolescents from engaging in premarital sexual activity (Tavrow, Karei, Obbuyi, & Omollo, 2012).

Second, adolescents are concerned that community members or extended family may see them waiting for SRH services. This occurs frequently in rural settings, where health centers are few and clients can be seen waiting for services during daylight hours. Because parents often oppose premarital sexual activity, adolescents may risk punishment if they are known to have obtained SRH care. Moreover, health facilities are often open only during school hours, which means students would need to miss classes to get services.

Finally, many adolescents believe contraceptives have severe side effects, such as infertility and cancer. Although condoms and contraceptives are free in public health facilities, distrust of these methods make young people reluctant to use them. These misconceptions are common in rural areas, where accessing accurate information is more difficult.

## THE HIGH IMPACT PRACTICE

The After Hours Adolescent Project (AHAP) sought to emulate the [Adolescent-Friendly Contraceptive Services](#) High Impact Practice (HIP) (USAID, 2015), which incorporates adolescent-friendly service delivery elements into existing services. AHAP is a cost-effective program introduced in public health facilities in rural Western Kenya that could be implemented in other localities to increase young people's access to SRH services. AHAP consisted of these main components:

- Extend clinic hours into evenings and weekends, so participants do not have to miss school or worry about being seen by adults
- Place in each facility one young, newly minted nurse (male or female) who works after hours
- Train nurses how to offer comprehensive sexuality education (CSE), be adolescent-friendly, and dispel SRH myths



AHAP nurse with client.

PHOTO CREDIT: Tavrow

Young person receiving implant from AHAP nurse.



PHOTO CREDIT: AHAP

- Have nurses work part-time giving CSE in nearby schools and localities, both to advertise the after-hours program and build rapport with students
- Train rovers (unemployed recent secondary school graduates) to assist nurses to bring CSE into communities
- Ensure adequate supplies of condoms for facilities
- If needed, equip facilities with electricity to allow services to occur at night
- Assist facilities to develop an adolescent corner with board games to make the facility more welcoming
- Introduce AHAP clinic registers to record after-hour visits and anonymous client satisfaction cards to monitor quality of care

## Implementation Story

With funding from the Lalor Foundation and Save the Children Sweden, the Centre for the Study of Adolescence in Kenya in partnership with the University of California at Los Angeles launched AHAP. The project was a one-year randomized controlled trial in two sub-locations of Bungoma County, Kenya. After signing a memorandum of understanding with the Kenyan Ministry of Health, nine public health facilities were randomly assigned as AHAP intervention sites and four as comparison sites.

Prior to AHAP's launch, the team collected baseline information about the facilities' infrastructure and the use of services among adolescents. During this assessment, the team learned that 54 percent of facilities had a separate room for adolescents, 92 percent had electricity, but only 77 percent had lighting. The project installed basic solar power to facilitate after-hours care and provide security lighting. In several facilities, the project also partitioned and painted rooms to create adolescent-friendly spaces.

In June 2018, AHAP recruited and trained 12 newly graduated nurses, ages 23 to 29 and about 40 percent female. All were looking for work, but because of limited funding, AHAP nurses received approximately US\$150 per month, substantially less than the typical US\$200 per month starting salary, which contributed to retention difficulties.

Before being placed in facilities, nurses received a three-day training on SRH knowledge, skills, and values clarification using the [Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients](#) (WHO, 2009). Specifically, AHAP trained nurses on the importance of ensuring equitable, accessible, acceptable, appropriate, and effective care. In a pretraining assessment, AHAP found that nurses harbored many common misconceptions, such as believing contraceptive use could cause infertility or that parental approval was required. During the training, these misconceptions were discussed thoroughly and nurses learned the latest information. In addition, the project hired and coached local actors to portray harsh or humiliating providers during role plays, while the nurses took the part of young clients. This helped nurses appreciate how it felt to be a shy adolescent. Nurses also practiced adolescent-friendly counseling techniques and critiqued each other, under the guidance of trainers.

After the SRH training, the nurses received a five-day CSE training led by the Centre for the Study of Adolescence, using the Centre's Youth for Youth curriculum. This curriculum covers the topics of puberty, abstinence, consent, contraception, STIs, peer pressure, sexual harassment and rape, and young people's rights to SRH services. None of the nurses had previously received CSE. The Centre also trained 10 rovers (recent secondary school graduates) in CSE who assisted the nurses in setting up similar trainings at schools and other locations. All rovers and nine nurses remained with



**“SINCE AHAP WAS STARTED ONE YEAR AGO, WE HAVE NOT HAD ONE PREGNANCY IN OUR SCHOOL. THIS HAS NEVER HAPPENED BEFORE.”**

Assistant principal in Bungoma County, Kenya



Training of AHAP nurses.

AHAP throughout the project and received one refresher training at the midpoint.

Meanwhile, in addition to painting and lighting, AHAP outfitted intervention facilities with basic furniture, AHAP client registers, adolescent satisfaction cards, signage about the new later hours for adolescent-friendly care, AHAP nurse lab coats, condoms, and two board games. All nurses received a locked drawer to store their AHAP client register and after-hours SRH commodities, such as implants, pills, and injectables. At the end of each consultation, nurses gave clients anonymous satisfaction cards to be deposited into a locked box. Project staff collected the cards during monitoring visits.

During the one-year implementation period, nurses in half of the intervention clinics spent some time during the day giving CSE talks at schools and elsewhere, together with the rovers. They became well known in the community and adolescents asked for them by name when they arrived at facilities. Nurses typically stayed until 6 or 7 p.m., about two to three hours after normal facility hours. Most AHAP nurses also saw adolescent clients on Saturdays.

AHAP nurses could provide young people with a range of health care after hours—both SRH and treatment of common illnesses and injuries. They administered HIV, STI, and pregnancy diagnostic tests at a nominal cost that could generally be waived if prohibitive. Some adolescents came for SRH counseling only, but many were also interested in obtaining free contraceptives. If some methods were not available, the nurses gave condoms and encouraged the client to return in a few weeks when supplies were restocked. Referrals were rare because young people did not have the means or willingness to travel long distances to other facilities.

To assess the impact of the project, one year after AHAP's launch an evaluation team compared facility registers from 2019 to 2018, conducted focus group discussions with adolescents and AHAP nurses, analyzed satisfaction cards, interviewed facility in-charges (directors), and tested nurses' knowledge and attitudes.

The key finding was that adolescent visits for any reason (e.g., malaria or injuries) increased by 84 percent in the nine intervention facilities, but just 27 percent in the four comparison facilities. Even more dramatic, adolescent visits for SRH services rose 87 percent in the intervention facilities, but did not change at all in the comparison facilities. Moreover, having nurses perform health education in the community apparently increased adolescents' comfort with visiting the facility: in the five AHAP facilities where nurses conducted CSE in the schools and community, SRH visits increased by 97 percent, compared with 77 percent in the four facilities where nurses did not do CSE.

In addition, at AHAP facilities, 49 percent of adolescents accessed SRH care outside of normal business hours, suggesting that having the option to visit after hours was important. For facilities where AHAP nurses performed CSE in schools and the community, even more adolescents visited the facility after hours (57 percent vs. 41 percent).

The evaluation team also analyzed the 1,987 AHAP satisfaction cards collected at intervention sites (53 percent female, 44 percent male, 3 percent unknown). They found that 98 percent of young people reported feeling comfortable with the provider, 96 percent had enough privacy, 95 percent received their desired SRH supplies, and 97 percent would come again. Of the 26 percent who wrote optional comments at the end, only two were complaints, both related to stockouts. Among female adolescents, 57 percent came mainly for family planning (including counseling), 11 percent for pregnancy tests or antenatal care, 4 percent for condoms, and 25 percent for HIV or STI



PHOTO CREDIT: Tawrow

Path to reach an AHAP facility – Chemworemwo dispensary.



PHOTO CREDIT: AHAP

AHAP nurse educating youth in CSE.

testing. Among male adolescents, 9 percent came mainly for family planning (including counseling), 62 percent for condoms, and 26 percent for HIV or STI testing. Of those who received family planning, 71 percent obtained oral contraceptives, 12 percent injections, 11 percent implants, and 6 percent emergency contraceptives.

In focus groups, adolescents said they considered AHAP nurses to be very friendly. They found it empowering to ask for AHAP nurses by name when they visited the facility for SRH services. If the AHAP nurse was not present, adolescents reported leaving without being seen to avoid being embarrassed or “made small” by other health care providers. They liked the educative and nonjudgmental approach of AHAP nurses. Privacy and confidentiality were also appreciated.

AHAP nurses in focus groups said they liked how AHAP brought together schools and health facilities through the CSE instruction. They felt privacy and trust were the most important issues for young people, and that providing CSE in the community helped adolescents overcome their shyness. The nurses stressed that “information is power” and CSE helped young people make sound decisions. Adolescents told them that their teachers were biased, and they appreciated having a nurse they could talk to openly about their SRH concerns.

It is noteworthy that the nurses also seemed to have retained post-training knowledge and attitudes. Prior to the training, on average the nurses scored 61 percent on a 30-question survey of SRH knowledge and attitudes. One year later, they averaged 93 percent on the same survey. None of the nurses still believed contraceptives were harmful to adolescents, that condoms had holes in them, or that young people needed parental permission to obtain family planning.

The main challenges faced by AHAP were (1) inadequate initial knowledge and moralizing attitudes of AHAP nurses; (2) nurse attrition due to low pay and benefits; (3) facility infrastructure weaknesses, such as unreliable power supply; (4) frequent SRH commodity stockouts, particularly of injectables and implants; and (5) difficulty in overcoming SRH fears and myths.

Ultimately, AHAP directly addressed some of the most entrenched psychosocial barriers facing young rural Kenyans. It enabled adolescents to obtain SRH services confidentially and privately, ensured that free condoms were always available, and put adolescents on more equal footing with young providers who were not inclined to be harsh or judgmental. Having AHAP nurses deliver CSE in schools and the community helped increase familiarity with them and showed they were not biased. This combination of factors, not any single item, enabled a low-cost activity that relied entirely on public health facilities to significantly increase the use of adolescent SRH services.



“YOUTHS THEMSELVES ARE VERY PARTICULAR. IF IT IS AN AHAP NURSE, THEY COME. IF IT IS SOMEONE ELSE, THEY WON'T COME. AT FIRST, WE HAD SOME CHALLENGES BECAUSE SO MANY YOUNG PEOPLE WERE COMING AFTER HOURS. ONE SCHOOL PRINCIPAL WANTED TO KNOW WHY STUDENTS ARE THERE [AT THE FACILITY] AT 5-6 P.M. WE HELD A STAKEHOLDERS MEETING AND SENSITIZED THE COMMUNITY [ABOUT AHAP]. AFTER THAT, WE HAD NO PROBLEMS.”

In-charge at AHAP facility



An AHAP facility – Khalumuli dispensary.



Nurses do role-playing during AHAP training.



AHAP was a randomized controlled trial that increased adolescent SRH client visits by 87 percent in a single year in intervention facilities, relying entirely on government health facilities and providing no incentives. The project's trainers and implementers were all Kenyan nurses and CSE specialists, with only minimal outside technical support. The major lessons learned were as follows:

**To increase Kenyan adolescents' access to SRH services,** it was vital that they be more convenient and confidential, because premarital use of contraceptives and condoms still is not widely accepted by the community. Most rural health facilities do not stay open even until 5 p.m., so adolescents have trouble accessing them.

**Adolescents dread being humiliated and judged by health care providers.** Being able to ask for a nurse by name when they come to a facility for SRH services reduces the power differential and makes them feel the nurse understands them and will not insist on meeting with their parents.

**Even newly graduated nurses often harbor several harmful misconceptions about contraception.** Ensuring that nurses spend time on SRH knowledge, skills-building, and values clarification before being placed in facilities is important.

**Two major deterrents to young people are SRH commodity stockouts and fees for tests (such as STI or pregnancy tests).** Ensuring adequate supplies and waiving all costs for adolescents should be a governmental priority.

## recommendations

Recommendations for those who are planning to implement AHAP in other locations include:

- 01 Prior to launching the project, secure a commitment from the Ministry of Health** (or individual health facilities) that they will continue to cover the salary of the AHAP nurses once the concept has been proven successful.
- 02 For better retention, from the outset pay nurses the "going rate" for entry-level providers** and negotiate other benefits for them at facilities (such as housing, teas, lunches, and transport allowance).
- 03 In addition to creating AHAP registers and adolescent satisfaction cards, consider developing AHAP posters and brochures** with adolescents that help to advertise the program.
- 04 Make sure nurses feel comfortable giving CSE talks** and provide them with ample time to practice and role play. Introduce the nurses to nearby school administrators and community leaders to assist them in setting up CSE sessions.
- 05 Seek to ensure that essential SRH commodities** (e.g., contraceptives, condoms, and diagnostic tests) **are adequately stocked at all times.** Train facility in-charges in stock management if necessary.

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