FINAL EVALUATION
Kenya: Healthy Outcomes through Prevention Education (HOPE)

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Evaluation independently carried out by Global Communities.

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The evaluation team would like to thank the many teachers, parents, students, community leaders and education officials who participated in this exercise for giving their time and input. The team was led by and the final report was written by the Global Communities Senior Monitoring and Evaluation (M&E) Specialist, Susan Morawetz, working closely with the DREAMS (and previously) HOPE Chief of Party (COP) Betty Adera and her staff, Luciana Koske, Deputy Chief of Party; Fredrick Nyagah, Gender Advisor; and Ann Wahinya, Program Officer, under the leadership of Country Director, Kimberly Tilock. We would also like to thank M&E Specialist, Chase Coniglio, who prepared all the graphs and tables, and M&E Associate, Samuel Gerstin, who supported editing and data review. The team also cannot forget to thank the Kenyan Ministry of Education Science and Technology for granting permission to conduct the evaluation, and for availing the schools for this purpose and to the HOPE partners whose insights supported this assessment.

HOPE Partners: St. John Community Center (SJCC); Kenya Girl Guide Association (KGGA); national Organization of Peer Educators (NOPE); and Support for Addiction Prevention and Treatment in Africa (SAPTA)
Preface

All data collection and some of the analyses in this report were carried out by Benaphil Consultants Limited, a regional consulting and training firm registered in Kenya, in partnership with Global Communities. The final analyses and report writing were carried out by the Monitoring and Evaluation team at Global Communities’ headquarters with significant input from Global Communities HOPE Team staff in Nairobi.

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Acronyms

AIDS  Acquired Immunodeficiency Syndrome
CHF   Corporative Housing Foundation
ETE   End Term Evaluation
FBOs  Faith Based Organization
FGDs  Focus Group Discussions
FMP   Families Matter Program
GC    Global Communities
HIV   Human Immunodeficiency Virus
HOPE  Healthy Outcomes through Prevention Education
IDIs  In-Depth Interviews
KII   Key Informant Interviews
KGGA  Kenya Girl Guides Association
KAP   Knowledge, Attitudes and Practice
KIE   Kenya Institute of Education
KNUT  Kenya National Teachers Union Trade Union
LSE   Life Skills Education
MoEST Ministry of Education, Science and Technology
NGO   Non-Governmental Organizations
NOPE  National Organization of Peer Educators
PAC   Program Advisory Committee
PE    Peer Education / Peer Educator
PEPFAR United States Presidents Emergency Plan For AIDS Relief
PLWHA People Living with HIV/AIDS
RAs   Research Assistants
SAPTA Support for Addiction, Prevention and Treatment in Africa
SGBV  Sexual and Gender-Based Violence
SHC   School Health Committee
SJCC  St. Johns Community Center
SPSS  Statistical Package for Social Scientists
SRH   Sexual and Reproductive Health
STD   Sexually Transmitted Diseases
STI   Sexually Transmitted Infections
TOTs  Trainers of Trainers
TSC   Teachers Service Commission
USAID United States Agency for International Development
YLHIV Youth Living with HIV and AIDS
I. Evaluation Summary

In Kenya, high poverty, insecurity, poor health outcomes, substance abuse and low levels of education make young people, especially girls, vulnerable to a variety of risks such as Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), other Sexually Transmitted Infections (STIs) and Diseases (STDs), and Sexual and Gender-Based Violence (SGBV).

To help address this crisis, the Healthy Outcomes through Prevention Education (HOPE) Program was designed to help prevent the spread of HIV/AIDS, STIs and STDs, and promote healthy outcomes among at-risk Kenyan students and their families. The HOPE Program was funded by the President’s Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID), from March 2012 through June 2015. HOPE was implemented by Global Communities (GC) in partnership with the National Organization of Peer Educators (NOPE), Kenya Girl Guide Association (KGGA), St. John’s Community Center (SJCC) and Support for Addiction Prevention and Treatment in Africa (SAPTA). The program was implemented in Nairobi and Kiambu counties, and tasked with reaching at-risk youth in informal urban settlements.

This report presents the findings of a summative end-line program evaluation funded by Global Communities and carried out in the summer of 2015.

HOPE Background

The HOPE Program was designed to enhance at-risk students’ Knowledge, Attitudes and Practices (KAP) related to HIV/AIDS and other STIs/STDs, and substance abuse. The program’s stated Goal was: Improved HIV knowledge, attitudes and practices among Kenyan students through peer-, school- and community-based interventions.

The HOPE Program had four main Objectives (Outcomes):

1. Improve students’ HIV and AIDS Knowledge, Attitudes and Practices through Peer-To-Peer support and mentoring;
2. Equip schools with the capacity to provide HIV- and AIDS-related knowledge, information, and support through classroom instruction and extra-curricular activities;
3. Increase involvement of parents and community members in schools in order to promote healthy living; and
4. Equip the Ministry of Education, Science and Technology (MoEST) and new County Education Officers to implement the Ministry of Education’s Revised Sector Policy on HIV and AIDS.

HOPE was intended to be a four-year, $6.3 million initiative that included a control community of 24 schools using a
quasi-experimental research design. Given a 27% USAID budget cutback in Year 2 as PEPFAR moved away from population-based HIV prevention programming, the program was cut to $4.6 million and reduced from four to three years. As a result, services were significantly condensed and the research component was not completed as planned.

**Evaluation Purpose**

Global Communities undertook this internally funded evaluation to document the end-of-project results and because it believed that the Life Skills curriculum, and the peer education (PE) and training approaches used may have resulted in significant and positive unintended outcomes for youth that were not being monitored through the program’s performance monitoring system. These included improvements in youth coping skills, inter-ethnic and inter-generational communications, and academic performance. Global Communities also heard about corresponding improvements in the way teachers and parents interacted with youth and dealt with the unique needs of adolescents. These positive, unintended outcomes of the HOPE Program were being communicated to HOPE staff during continuous supervisory visits to the field and during workshops and interviews with project beneficiaries carried out by the Global Communities’ Senior M&E Specialist in March, 2015. As a result, Global Communities sought to document the project model and achievements, and ascertain whether evaluation data would provide evidence of these positive, transformational outcomes, both intended and unintended. Given that the project had only been tracking planned results related to HIV/AIDS, STI/STD and substance abuse knowledge, attitudes and practices, coupled with the fact that a mid-term evaluation had not been conducted, an end-line evaluation was needed to document and measure any unintended results that had occurred.

Global Communities kept the evaluation objectives broad to focus on both attainment of planned and unplanned results as well as overall program impact and effectiveness, and beneficiary satisfaction with the training and services received. The target populations for the assessment were the primary and secondary school students, teachers, school administrators, parents/caregivers, and other key informants residing in or working in Nairobi and Kiambu counties.

**The four Evaluation Objectives were to:**

1. Establish the extent to which HOPE achieved its Goal and intended Outcomes;
2. Assess the overall effectiveness and impact of the HOPE model in addressing the needs of at-risk youth in the urban slums of Nairobi;
3. Assess and document whether the program had unintended outcomes (positive or negative) beyond the original HOPE Goal and intended Outcomes;
4. Examine whether there are elements of HOPE that can guide future Global Communities efforts at working with at-risk youth within the structure of their schools, communities and families.

**Evaluation Methodology**

This end-line evaluation used a mixed-methods approach that included surveys of 682 individuals, including students, teachers and parents. These quantitative reviews were complemented by qualitative analysis including Focus Group Discussions (FGDs), in-depth interviews, and Key Informant Interviews (KIIs) with 152 outside individuals knowledgeable about the HOPE Program, including community leaders and MoEST officials. The qualitative analyses allowed the reviewers to corroborate and better understand the statistical results. Quotes from some of the qualitative reviews are included in this report.
For measuring the extent to which HOPE had achieved its intended outcomes, the evaluators compared baseline and end-line KAP survey results related to HIV/AIDS, STI/STD and substance abuse prevention. Given there was no baseline data on variables beyond HIV and STI awareness and related practices, for assessing unintended outcomes the consultant collected extensive perception data from survey respondents on perceived changes as a result of HOPE programming.

The data in the retrospective survey was self-reported, reflecting respondents’ perception of KAP changes following their participation in HOPE. There is potentially the risk of bias due to the fact that there was no baseline data to serve as a comparison on questions related to unintended outcomes; and respondents may not have accurately remembered past perceptions and/or events, or may have responded in a manner they believed to be socially acceptable or with responses they believed were anticipated by the evaluator. To minimize this risk, the consultant used a sizeable survey population (for which students were randomly selected) and triangulated survey results with qualitative data. Qualitative data collection tools were designed to probe for candid input and specific details from teachers, parents and students about outcomes attributable to the program and the extent of its impact on Knowledge, Attitudes and Practices.

Evaluation Findings

Evaluation Objective 1: Extent to which HOPE achieved its Goal and intended Outcomes

HOPE effectively met its goals of increasing HIV, STIs and substance abuse awareness; increasing the capacity of schools in the urban slums to teach about HIV, STIs and to support drug abuse prevention and anti-stigma messaging through life skills education; and equipping parents and caregivers to support the process.

Notably, HOPE met or exceeded most of its performance targets, having reached 68,933 students (64,000 planned) and trained 1,137 teachers (1,200 planned), 3,189 Peer Educators or PEs (2,750 planned), and 5,907 parents (5,500 planned). In total, 79,166 individuals participated in HOPE programming, resulting in a moderate cost of $58 per direct beneficiary.
Beyond these targets, HOPE was responsible for tracking changes against four PEPFAR indicators from baseline to end-line (Table 1). These changes were positive overall though the level of reduction in sexual activity among youth respondents (from 65% to 59%) is smaller than one might have expected after a program like HOPE. It is impossible to know if these self-reported figures reflect the true rates of adolescent sexual activity, as it is possible youth were afraid to be honest about their sexuality, especially at baseline before the HOPE Program was implemented. Further, the differences between baseline and end-line results could merely reflect differences between the two randomly selected youth populations at two different points in time. Although there were modest increases in the percent of youth with accepting attitudes towards people living with HIV, these levels were already fairly high at baseline, indicating that there may have already been a moderate level of basic knowledge about HIV at the start of the program.

Table 1: PEPFAR Goal-Level Outcome Indicators

<table>
<thead>
<tr>
<th>PEPFAR Goal-Level Outcome Indicators</th>
<th>Baseline(A)</th>
<th>End-line (B)</th>
<th>Change(B-A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of never-married young men and women aged 15-24 who have never had sex</td>
<td>65%</td>
<td>59 %</td>
<td>- 6%</td>
</tr>
<tr>
<td>Percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15*</td>
<td>45%</td>
<td>27% (&lt;14) 49% (14-16)</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of young men and women who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>Abstinence</td>
<td>65%</td>
<td>93%</td>
</tr>
<tr>
<td>Condoms (secondary)</td>
<td>N/A</td>
<td>57%</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of population with accepting attitudes towards Persons Living With HIV/AIDS (PLWHA)</td>
<td>Remain friends with an HIV+ person</td>
<td>83%</td>
<td>93%</td>
</tr>
<tr>
<td>Allow HIV+ to attend school</td>
<td>81%</td>
<td>85%</td>
<td>4%</td>
</tr>
<tr>
<td>Allow HIV+ teachers to teach students</td>
<td>79%</td>
<td>86%</td>
<td>7%</td>
</tr>
<tr>
<td>Would live with an HIV+ family member</td>
<td>88%</td>
<td>89%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*The indicator measures the number of individuals who, having responded ‘yes’ to the previous indicator, indicate the age of their first sexual encounter. The end-line questionnaire combined 14-16 year-old respondents into one age group, therefore it is impossible to identify precisely which were 15 years or younger.

HOPE carried out planned activities to build awareness within schools of MoEST’s Revised Sector Policy on HIV and AIDS, though this activity was hampered by the budget reduction. Nevertheless, HOPE exceeded its mandate in that it not only supported the policy revision but facilitated rollout at the school level in Nairobi and Kiambu counties, under the auspices of the government’s Economic Stimulus Program.

Evaluation Objective 2: Overall effectiveness and impact of the HOPE model in addressing the needs of at-risk youth in the urban slums of Nairobi

The HOPE Program used an integrated, hybrid approach of peer education, life-skills and parental empowerment, that worked directly with students, their teachers and their parents/caregivers, as well as with outside community and religious leaders. This model allowed HOPE to influence the relationships between youth and the adults in their lives, to reach beyond schools to reinforce school-based activities and messages and to increase ownership of the interventions. HOPE trained peer educators to reach fellow youth with HIV and STI prevention information; built the capacity of teachers and head teachers to deliver life skills education through classroom instruction and support the needs of learners living with HIV; and engaged out-of-school Youth Living with HIV (YLHIV) to connect with in-school youth for stigma reduction efforts. Perception data also indicates that HOPE helped parents and caregivers to increase their skills and comfort in communicating with their children on Sexual and Reproductive Health (SRH) issues and to engage in and support their children’s schooling.

HOPE was designed in a manner that enhanced institutional sustainability. For example, School Health Committees (SHCs) were created and/or strengthened to support program activities in schools, and in a way that was consistent with...
MoEST’s policy. Secondly, the program initiated and supported a Program Advisory Committee (PAC) at the national and county levels, bringing together various stakeholders including the Ministry of Education, the Ministry of Health, parents, teachers and students. Finally, by using the MoE’s Life Skills Education (LSE) curriculum (developed by the Kenya Institute of Curriculum Development (KICD)—formerly known as Kenya Institute of Education—for training teachers in collaboration with the Teachers Service Commission (TSC), the HOPE Program encouraged recognition of the certificate of completion of training as part of continuing education for teachers, and also as an incentive for teachers to access LSE training.

While these initiatives will hopefully facilitate and encourage program sustainability, it should be noted that lack of funding and support at the school and community level means there will be no continued training available for peer educators (who continuously graduate) or new cohorts of parents, limiting the additional reach the program could have. This is particularly unfortunate as parents, students and teachers were quite vocal during the HOPE workshops that there was strong, unmet demand from other schools and communities to access HOPE’s services.

Overall, HOPE proved to be a fairly low-cost approach, having trained 79,166 students, teachers and parents for a cost of $58 per direct beneficiary. Still, this programming model requires continuous MoEST commitment (possibly with outside donor resources) to successfully instill and preserve the interventions, particularly as there is a natural risk of knowledge loss due to PE cohorts graduating and teacher transfers.

**Evaluation Objective 3: Unintended Results Beyond the original HOPE Goal and intended Outcomes**

Both quantitative and qualitative data confirmed overwhelmingly that there were significant, positive unintended outcomes of HOPE beyond increased awareness of HIV/AIDS, STDs/STIs and substance abuse, and corresponding reduction in behaviors that expose at-risk youth to these problems.

Perception data from students, parents and teachers also showed that the HOPE Program improved the ability of youth to cope with life challenges, communicate effectively, peacefully resolve conflicts, make better decisions and avoid engaging in high-risk behaviors (such as having unprotected sex, joining gangs, participating in crime, and using drugs and alcohol). HOPE also improved the ability of trained teachers and parents to cope with these issues and deal with youth holistically rather than as disciplinarians. Thus, the HOPE model proved to be an effective approach for working with youth and helping them and their parents/guardians take responsibility for their lives and the decisions they make.

As the HOPE Program worked through schools where different ethnic, religious and tribal groups come together, there was an opportunity for all voices to be heard in a safe environment. Some believe there is now better communication as a result of the HOPE Program, including between Christian and Muslim students. In interviews, teachers also expressed that schools have become a “safe haven” where issues outside the classroom are no longer ignored. The enthusiasm shown by primary and secondary students about the HOPE Program supported this view.

**Figure 1: Student Perceptions of Changes in Academic Performance**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
<td>No Change</td>
<td>Not Sure</td>
<td>Improved</td>
</tr>
<tr>
<td>Male</td>
<td>86%</td>
<td>62%</td>
<td>18%</td>
<td>77%</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>2%</td>
<td>20%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Primary (n=286)   Secondary (n=121)
Several key unintended Outcomes are described below, and include: Improved Academic Performance, More Effective Communication, Reduced High Risk Behavior, and Improved Parenting and Family Relations.

**Improved Academic Performance:** In survey responses, 86% of primary school males, 62% of primary school females, 77% of secondary school males and 81% of secondary school females reported perceived improvements in their academic performance (see Figure 3). Unfortunately, this data could not be corroborated with actual academic records, given prohibitions by MoEST on sharing public school academic test results.

**More Effective Communication:** Surveyed students and empowered parents stated overwhelmingly that HOPE training significantly enhanced communication among youth and between youth and the adults in their lives over a variety of sensitive subjects (e.g. coping with life challenges and more effectively and peacefully resolving conflicts). Notably, 92% of surveyed secondary school students reported that communication between pupils of different religious groups improved.

![Figure 2: Students and Empowered Parents Perception of Changes in Communication](image)

This is an important finding for the urban settlements in and around Nairobi, which are home for a large number of different ethnic, tribal and religious groups and has seen conflict in recent years. The ability of the HOPE model to improve communications by providing a safe school environment where all voices can be heard reflects highly upon the HOPE model and curriculum as potentially effective tools in addressing cross-ethnic, cross-tribal and interreligious tensions among youth in Kenya and perhaps beyond, and one which merits further research and examination.

**Reduced High-Risk Behavior:** In the end-line assessment, the majority of students, parents and teachers agreed that following the HOPE Program there was less conflict in their schools, more awareness of Gender-Based Violence (GBV) and increased awareness among students of how to protect themselves from HIV, STDs/STIs, drug and alcohol abuse, violence and other problems common in the urban settlements in and around Nairobi. Parents reported a reduction in their children missing school, using drugs and alcohol, having unprotected sex, joining gangs, and engaging in crime, fighting and other undesirable behaviors.

**Improved Parenting and Family Relations at Home:** Parents who participated in empowerment trainings reported having been "transformed" in how they viewed themselves and their lives, their children, and their ability as parents to engage with youth holistically. Many stated they had become less focused on discipline and instead on supporting the developmental needs of their children, and engaging in positive and productive dialogue. They also became more engaged in their children’s education and co-curricular activities. Empowered parents were better able to implement positive parenting practices and gained additional knowledge, skills, and the comfort and confidence to communicate...
with their children about sexuality, reproductive health and other sensitive issues.

**Evaluation Objective 4: Elements of HOPE that can guide future Global Communities efforts working with at-risk youth within the structure of their schools, communities and families**

The HOPE hybrid model of working with youth through their school and home communities represents a low-cost and effective approach for not only providing HIV, STI and substance abuse knowledge and prevention support, but also for addressing many of the other coping, communication, decision making and conflict resolution skills needed by all youth, and particularly those living in high-density, conflict-prone, impoverished, urban settlements.

The HOPE model seems ideal for working in a school-based setting, as youth of various ethnic, religious and tribal backgrounds spend so much of their time together in school, and the school environment naturally provides access to parents and families. Nonetheless, while the school setting and the lens of HIV, STIs and substance abuse provided an effective entrée into the lives of at-risk youth, the HOPE model, curriculum and training materials could be applied in other settings and focused on other issues affecting youth. The model seems particularly well suited for urban areas, where the social-ecological environment does not consistently support healthy behaviors and decision-making; external influences, such as drugs, sexual promiscuity, gang activity, crime and violence are common; and family structures are often void of an extended support system. Given the increasingly diverse nature of such urban centers as found in Nairobi, HOPE represents a model for bringing young people and the adults in their lives together and facilitating programming across religions, tribes, ethnic groups, and countries of origin.

**Key Challenges and Recommendations**

**Need to Expand Outreach:**
Ideally, the PE component could be expanded to reach youth as young as 6 years in order to cultivate more knowledge and skills as early as possible in life, and further expanded between the ages of 19 to 24. A project like HOPE could also engage young people during school holidays and breaks, thus ensuring continuous support. The program approaches would also benefit from the introduction of the use of technology and social media such as Facebook, WhatsApp, and Instagram, not only to enrich access to information but also to attract youth who are already utilizing technology for other uses. In terms of operationalizing the above, MoEST capacity could be strengthened to provide and coordinate PE activities, as indicated in the Revised Kenya Education Sector Policy for HIV and AIDS.

**Prospects for Sustainability and Replication**
Although Global Communities and other NGOs on their own cannot replicate the full HOPE model, as it was school-based, there are nonetheless key aspects of the program that could be replicated. For example, the hybrid approach of working with youth, parents, plus community and religious leaders could be applied in many settings (urban/rural) and used to address a number of problems confronting at-risk youth. In addition to HIV and STIs, these might include gang activity, violence, substance abuse, religious extremism and dropping out of school. By working closely with existing NGOs institutions, curricula and training materials, the prospects for sustainability of HOPE Program services were greatly increased. Although the program faced challenges, there is no doubt that the relatively low-cost PE and LSE components model resulted in transformative, positive influences on the 79,166 students, parents/caregivers and teachers that it served. While the model is not costly, it nevertheless requires continuous MoEST commitment to continue – possibly with outside donor resources to support training and associated services.
Nonetheless, as Peer Educators are continuously graduating, the PE model cannot continue beyond the life of HOPE unless schools and/or a donor assumes responsibility for building and training new PE cohorts; parental empowerment programs will face the same challenge. Moreover, without an expansion of the Life Skills Model to new schools, only schools with trained teachers will benefit.

**Adequacy of Training for Parents and Students**

Concerns were also raised, particularly by parents and PEs, that there was not adequate time allocated to training and follow-up. PEs also identified topics not covered in the training, including sexual orientation, depression and anger management, for which they often received questions from students, described in detailed in the Evaluation Findings chapter.

**Need for more Life Skills Education Training for Teachers**

Although teachers in Kenya are expected to impart the LSE curriculum, many do not because they have not been trained and thus aren’t comfortable with the subject matter. Additionally, Life Skills Education is not currently an examinable subject, thus the LSE curriculum is not effectively included among MoEST’s monitoring tools to ensure it is delivered in schools. Therefore, the evaluation team recommends that MoEST consider inclusion of Life Skills Education among MoEST’s set of school monitoring and evaluation tools. In terms of sustainability, MOEST should consider continuing and expanding the HOPE model to additional schools, including the provision of training for parents and PEs. Without the expansion of the LSE curriculum to new schools, only schools with trained teachers will benefit.

**Need for Better Linkages to Health Service Providers**

Although HOPE made efforts to facilitate referrals for students with HIV, the evaluators found weak linkages between schools and health service providers. Thus, only two young people were referred for HIV-related services, despite the fact that Nairobi County has high HIV rates among youth (and throughout Kenya 16% of all people living with HIV and 29% of all new infections are among adolescents and youth). These weak links were attributed to the fact that the HOPE design did not focus on monitoring the HIV status of students, and the program team could only rely on information from students who came forward to disclose their status.

Given health services access is critical for HIV and STI diagnosis, treatment and prevention, in similar, future programs, schools should consider offering formal linkages and referral systems to SRH services, including HIV treatment, care, support and counseling. This could include teacher trainings on adherence counseling, nutrition for YLHIV, and linking health workers to schools to facilitate access to Anti-Retro Viral Drugs (ARV). Additionally, not all 300 schools reached by HOPE benefited from the school health program that included the HIV referral component. Unfortunately, efforts to strengthen linkages, including production of referral systems and tools, were developed late in the program and couldn’t be further supported when USAID funding was reduced.

**Conclusion**

HOPE’s integrated, hybrid approach of addressing the needs of youth through their schools, peers, parents/caregivers as well as the larger community undoubtedly fueled its success in increasing awareness and knowledge of HIV, STIs and substance abuse, and achieving such impressive Life Skills outcomes (both intended and unintended). By working through the school and home environment, HOPE was able to ensure critical messages were reinforced at home and in the larger community. As demonstrated in this report, HOPE improved the ability of youth to cope with life challenges, communicate effectively with their peers and the adults in their lives, resolve conflicts peacefully, make healthier choices and avoid engaging in high-risk behaviors. HOPE also improved the ability of trained teachers and empowered parents to engage youth holistically, rather than as disciplinarians.

The model seems particularly well suited for urban areas, where constant external pulls of drugs, sex, gangs, crime and violence are common; families often live far from an extended support system; and there is a need to co-exist with people representing a variety of tribes, religions, ethnic groups and countries of origin.

By working closely with existing NGOs, institutions, curricula and training materials, the prospects for sustainability of
the HOPE Program services were greatly increased. Nonetheless, the HOPE model needs continual support to provide training for new cohorts of PEs and parents, in order to be fully sustained in schools that participated in HOPE. Potentially the teacher-led, Life Skills classes will continue as long as teachers remain in schools where they’re implementing the curriculum or teachers take the model to new schools should they relocate. The HOPE model is not costly, but requires continuous MOE commitment (possibly with outside donor resources to support training and associated services) to continue.

Nonetheless, it is unclear whether HOPE reduced the level of sexual activity among teens and there were already fairly accepting attitudes of people with HIV and AIDS at the beginning of the program (indicating that HOPE was likely not the first exposure these Nairobi youth had had to HIV and AIDS education or people living with the disease). There are also several project design elements the evaluators suggested be strengthened in future, similar programs, including a stronger referral system for health services and longer and more in-depth training sessions.

Undoubtedly, the 27% USAID budget cut contributed to some of the challenges faced by the program, as plans needed to be revised and the program was reduced from four to three years. This resulted in many planned services being cut or eliminated. Additionally, because of the budget reduction, the completion of the research component of HOPE (allowing HOPE results to be compared to a control community of 24 schools) was not completed. Given the impressive unintended results of the HOPE model as reported, cancellation of this research arm was particularly unfortunate as being able to return to the control schools with the end-line survey would have potentially yielded critical data about the true impact of the Life Skills model, particularly related to the intended outcomes of improved knowledge, attitudes and practices of students relate to HIV, STIs and substance abuse.

Although the HOPE Program faced challenges, perception data collected illustrates that this relatively low-cost Life Skills training model resulted in transformative, positive influences on the 79,166 students, parents/caregivers and teachers that it served, that there were significant, positive unintended outcomes far beyond what anyone had expected or planned to monitor, and that the schools and communities served will be better off because of HOPE. Thus, The HOPE Life Skills model, approach and curriculum should be examined further for expansion in Kenya and application in other settings and countries. Additionally, the evaluation team suggests that further and rigorous research of Life Skills education should be carried out (perhaps by the Government of Kenya), ideally in a manner that tracks beneficiaries against a control population over the Life of a Program.

...the HOPE life skills model proved to be an effective model for working with high-risk youth and its approach and curriculum should be examined further for expansion in Kenya and application in other settings and countries.
II. HOPE Background and Model

Program Objectives (Outcomes)

**Outcome 1:** Improved knowledge, attitudes and practices among students through improved Peer-To-Peer support and mentoring

**Outcome 2:** Schools equipped with the capacity to provide HIV and AIDS related knowledge, information and support through classroom instruction and extra-curricular activities

**Outcome 3:** Parents and community members promote healthy living through increased school involvement

**Outcome 4:** The Ministry of Education, Science and Technology and new County Education Offices equipped to implement the Ministry of Education's Revised Sector Policy on HIV and AIDS

**PROGRAM GOAL:** Improve students’ HIV and AIDS Knowledge, Attitudes and Practices (KAP) through peer, school, and community-based interventions

**Program Model and Results Framework**

HOPE’s primary target population was 9- to 18-year old youth across 300 primary and secondary schools (and also out of school) in the informal urban settlements of Nairobi and its environs. The secondary target populations were the parents and teachers of targeted youth.

**Introduction**

In March 2012, Global Communities was awarded the four-year, $6.3 million Healthy Outcomes through Prevention Education Program, a USAID four-year Cooperative Agreement (No: AID-623-A-12-00009) funded by the President’s Emergency Plan For AIDS Relief. In Year 2 of the program, USAID revised its HIV prevention strategy and advised Global Communities that HOPE would be cut back one year and its budget reduced by 27%, for a revised award of $4.6 million. To accommodate the cut, Global Communities scaled back services and did not complete the research component as designed (notably, an end-line evaluation of program effectiveness involving 24 control schools).

HOPE was designed to address the fact that young people in Kenya bear the greatest brunt of HIV/AIDS, despite concerted efforts to contain the epidemic. In 2012, when HOPE was developed, within the 15-24 year old age group there were about 5 million individuals living with HIV, with 30% of new infections falling within this cohort.

HOPE programming focused on reaching Nairobi’s informal settlements, where half its population lives and which is riddled with poverty, insecurity, poor health outcomes and low levels of education. Life in Nairobi’s informal settlements has negative effects on young people, particularly girls, who due to numerous physiological, social and cultural factors are more vulnerable to HIV infection and other STIs, SGBV and poor education. Effectively, HOPE’s key target population were youth living in Nairobi’s urban settlements as well as those in the surrounding counties of Kiambu, Machakos, and Kajiado.
The HOPE Program used an integrated, hybrid approach to address youth needs – channelled through schools, homes and the community at large. This expanded model enabled HOPE to reach beyond schools while reinforcing school-based activities and messages, thus increasing the breadth of program ownership (see Figure 3). HOPE targeted learners, teachers, parents, service providers, policymakers, and religious and community leaders. It trained student PEs to reach fellow youth with HIV-prevention information; built teachers’ and head teachers’ capacity to deliver the MoEST’s Life Skills Education through classroom instruction, and additionally support the needs of learners living with HIV; designed a referral strategy to enhance access to services for learners living with HIV; and engaged out-of-school Youth Living

With HIV and AIDS (YLWHA) to reach out to in-school youth, as part of stigma reduction efforts. HOPE also helped parents and caregivers to build their knowledge, skills and comfort communicating with their children on SRH issues. HOPE engaged community leaders, including community health workers, in reinforcing the overall approach in schools (notably through establishing 161 SHCs), thus fostering an environment conducive to the practice of improved health behaviors.

HOPE’s primary target population was youth, in and out of school, aged 9-18 years across primary and secondary schools. HOPE included peer education activities, training of teachers to integrate life skills and HIV prevention education into their classrooms, and training of parents and guardians to increase their engagement in their children’s schools and their understanding of youth sexuality and substance abuse issues. HOPE additionally reached other stakeholders in the school system and wider community, including head teachers and their staff, members of Parent-Teacher Associations and Boards of Management, and church and health staff; each training had a unique curriculum. Most training materials were borrowed from other programs, though some were customized in accordance with the HOPE programming model.

The Life Skills Education taught by teachers in the classroom went beyond HIV/AIDS, STIs/STDs and substance abuse mitigation to focus on general life coping mechanisms. This included communicating more effectively, dealing with emotions, negotiating and resolving conflicts, resisting peer pressure, thinking critically, having empathy and self-awareness, coping with stress, making good decisions and solving problems.

HOPE worked with MoEST to strengthen and roll out the ministry’s Revised Sector Policy on HIV and AIDS, and in doing so helped build the capacity of County Education Officers to implement the policy. This included convening a Technical Working Group and stakeholder fora to validate and approve the policy, as well as After-Action Reviews to understand what worked and did not work during dissemination.

The entry point to the schools was through the Ministry of Education. The schools were mapped out based on the implementing partners’ geographical region of coverage. A five-day training was organized for teachers, after which teachers identified youth they thought would be effective in serving as peer educators and reaching out to other youth.

HOPE’s Results Framework (See Figure 4) is shown on the next page, and illustrates how the original project design focused on tracking improvements in HIV and STD Knowledge, Attitudes and Practices, rather than the unintended outcomes identified as part of this report.
Figure 4: HOPE Results Framework

Ministry of Education (MoE) Strategic Objective (SO) 19: To enhance retention and promote school health and nutrition. MoE SO 20: To deepen the mainstreaming of cross-cutting issues in education. USAID SO: Improved health outcomes and impact through sustainable country-led programs and partnerships

Goal: Improved HIV/AIDS knowledge, attitudes, and practices among Kenyan students through peer, school, and community-based interventions

Outcome 1: Improved HIV/AIDS knowledge, attitudes, and practices among students through peer-to-peer support and mentoring
- # of peer educators trained to conduct individual and/or small group level HIV preventive interventions that are based on evidence and meet the minimum standards required (P8.1 D)
- % of population with accepting attitudes towards PLWHA (P8.22 N)
- % of young men and women who both correctly identify ways of prevention the sexual transmission of HIV and who reject major misconceptions about HIV transmission (P8.1 N)
- % of students sponsored for motivational award ceremonies during MOE-organized meetings/conferences
- % of population with accepting attitudes towards PLWHA
- % of never-married young men and women aged 15-24 who have never had sexual intercourse (P8.9 N)

Outcome 2: Schools equipped with capacity to provide HIV/AIDS-related knowledge, information, and support through classroom instruction and extracurricular activities
- # of teachers trained on HIV/AIDS and life skills curriculum to meet national/ MoE standards
- # of students sponsored for motivational award ceremonies during MOE-organized meetings/conferences
- # of teachers sponsored for existing school HIV prevention programs and national events
- # of school health clubs established and/or strengthened
- % of targeted schools achieving at least 90% of learner outcomes in accordance with the curriculum

Outcome 3: Parents and community members promote healthy living through increased school involvement
- # of PTA, SMBs, school health committees, or similar school governance structures supported/established
- # of PTAs, SMBs and/or school health committees actively involved in school activities
- % of PTAs, SMBs, school health committees, or similar school governance structures supported/established
- # of capacity building plans developed with school communities
- # of MOE personnel participating in capacity building workshops to implement MoE Sector Policy on HIV/AIDS

Critical Assumptions:
- All stakeholders, including Government of Kenya, parents, health workers, and teachers are able and willing to participate in project activities.
- Increased knowledge will lead to improved attitudes and practices related to HIV/AIDS prevention.
Partner Roles and Responsibilities Global Communities worked in partnership with the National Organization of Peer Educators (NOPE), Kenya Girl Guide Association (KGGA), St. John’s Community Center (SJCC) and Support for Addiction Prevention and Treatment in Africa (SAPTA) in designing an approach that would meet the rapidly-changing and modernizing urban environment in greater Nairobi, particularly a high rate of rural-to-urban migration. NOPE and KGGA were responsible for delivering and administering the PE program, SJCC was responsible for the parental empowerment and school management committee capacity-building components, and SAPTA provided technical assistance in drug and substance abuse matters.

Close Engagement with MoEST: The HOPE Program ensured that all its activities were consistent with MoEST’s Revised Sector Policy on HIV and AIDS, and that MoEST’s strategies on PE, HIV and AIDS prevention and Life Skills Education were contextualized for informal urban settlements. Global Communities worked to foster a strong working relationship with MoEST by:

1. Holding meetings with MoEST officials to ensure clear understanding of HOPE’s Goal and Outcomes, strategies and activities, thus facilitating buy-in;
2. Developing a Memorandum of Understanding with MoEST;
3. Integrating HOPE activities into MoEST’s annual work plans;
4. Inviting high-level MoEST personnel to officiate and attend the program launch;
5. Establishing a PAC with MoEST as a key stakeholder; and
6. Holding regular meetings with MoEST to update on progress and share information.

Meaningful Engagement and Participation of Young People: HOPE programming integrated young people as members of PACs in developing and pre-testing SBCC materials, and in various activities such as the program launch, NOPE-Biennial conference and the “ALL IN” campaign, among others. PEs oversaw mentoring activities in their schools by completing data collection forms and identifying challenges and issues affecting their peers. The program also engaged out-of-school YLIVs to share their experiences in facilitating dialogue on HIV prevention and stigma reduction.

Training

HOPE’s primary method of service delivery was through training, delivered to Peer Educators, Teachers, and Parents and Community Leaders, as described below.

Peer Ed Training: Peer Education was selected as a key vehicle to deliver HOPE messages, given students are often more receptive to listening to their peers than to adults, thereby identifying PE as a safe channel through which people of the same age, background and interests can safely share ideas and information. Peer Education is also participatory, recognizes young people as agents of change and provides ongoing engagement and support (as opposed to one-time trainings conducted by out-of-school facilitators).

Peer Ed training was led by HOPE partners, NOPE and KGGA, which already had previously developed peer education manuals being used in schools. KGGA used two in-house developed curricula, which were: KGGA Life Skills Manual and KGGA Peer Educators Manual. NOPE used a curriculum called ‘Tuko Pamoja’ – A Guide for Peer Educators, which is a recognized curriculum within the MOE and is approved by the Kenya Institute of Curriculum Development.

The PE strategy was complemented by a Social Behavior Change Communication (SBCC) approach that reinforced HIV prevention messaging through complementary information, education and communication (IEC) materials such as posters, t-shirts and stickers, and health talks and testimonies from PLWHA.
Teacher Training: Although Life Skills Education is a required topic in Kenyan schools, many teachers did not cover Life Skills because they had never been taught how to deliver it. Thus, a key focus of HOPE was training head teachers and school administrators on LSE, in enabling them to supervise the delivery of HIV, AIDS and substance prevention instruction along with other Life Skills topics. HOPE worked closely with MoEST and the TSC to ensure their buy-in, participation and oversight, as they were using MoEST’s LSE curriculum. The trainings were facilitated by lead trainers from MoEST and the Kenya Institute of Education (KIE), with TSC’s close collaboration.

Parental and Community Leader Training: At the community level, religious leaders and parents of the students in primary schools were trained to reinforce the messages in the religious gatherings and at home. The trainings were carried out by 17 facilitators trained by HOPE partners, using the Families Matter Program (FMP) manual. The parental trainings also incorporated a National AIDS and STIs Control Program (NASCOP)-approved drug and substance abuse component. Moreover, GC’s internally developed curriculum integrated the FMP manual with MenEngage Kenya Network (MENKEN) programming, to encourage male involvement. The trainings were implemented by SJCC, and materials were further revised and tailored to make the trainings more participatory and to better address the needs of parents in informal settlements.

It was particularly important to engage parents, given the strong cultural taboos in Kenyan society against discussing sexuality with children and the fact that many parents lack the skills, knowledge and confidence to initiate and sustain a conversation on sexuality. The HOPE team encouraged the participation of fathers and male caregivers, hoping to bring more awareness to the issue of SGBV. As many children in informal settlements live with grandparents, guardians or other family members rather than their biological parents, it was important to empower the entire spectrum of caregivers. Given many parents and caregivers in informal settlements are less involved in their child’s / charge’s schooling, the trainings also served to further their engagement in the wider school community.
III. Evaluation Purpose

The Objectives of the HOPE evaluation were four-fold:

1. Establish the extent to which the HOPE Program achieved its Goal and Outcomes, particularly relating to reducing risks, increasing knowledge and enhancing positive behaviours (Knowledge, Attitudes and Practices) among primary and secondary school boys and girls regarding HIV and AIDS, as articulated through the Results Framework. This includes comparative results from 2012 (baseline) and 2015 (end-line) for the following USAID PEPFAR outcome indicators:
   - Percentage of never-married young women and men aged 15-24 who have never had sex;
   - Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15;
   - Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission;
   - Percentage of the general population with accepting attitudes toward Persons Living with HIV or AIDS (PLWHA);

2. Assess the overall effectiveness and impact of the HOPE model in addressing the needs of at-risk youth in the urban slums of Nairobi;

3. Assess and document whether the program had unintended results (positive or negative) beyond the original HOPE Goal and Outcomes; and

4. Examine whether there are elements of HOPE that can guide future Global Communities efforts at working with at-risk youth within the structure of their schools, communities and families.

Although HOPE was designed to "enhance students’ Knowledge, Attitudes and Practices related to HIV and AIDS, as well as STIs and substance abuse," Global Communities staff – based on stories and testimonies of HOPE beneficiaries and partners – concluded that the program may have accomplished much more than its stated Outcomes. Part of this assumption was based on end-of-project workshops and interviews carried out by the Global Communities Senior M&E
Specialist in Kenya in March, 2015, where students, teachers and parents reported on improved academic performance, reduction of high-risk behaviors, improved decision-making, reduced high-risk behavior, and an improved ability of youth to communicate with each other and the adults in their lives. If data could be collected to support this, the evaluators believed that HOPE could serve as an effective model for working with youth in a manner that allows them to have a voice and provides them psychosocial support; that addresses cross-cultural and inter-generational conflicts; and which provides parents and teachers a deeper understanding of child development and youth needs (particularly adolescents and pre-adolescents). Thus, a key goal of the evaluation was to test this assumption and determine whether data could be gathered to document the effectiveness of the HOPE model. Given the PMP had called for end-line data only as pertained to HIV/AIDS, STD/STI and substance abuse KAP, Global Communities would need to design the evaluation to collect the desired measures on unintended outcomes.

Key Research Questions (as stated in SOW)

The SOW is attached as Annex I.

1. Can we document whether there was a change in high-risk behaviors among youth who participated in HOPE programming? If so, what were the changes and can they be correlated with HOPE interventions? (Particular focus should relate to HIV, STDs and substance abuse, though other high-risk behaviors should be examined).

2. Can we document any type of psychological transformation/shift of attitudes among those who participated in the HOPE program, including students, parents, teachers, counselors and school administrators? If so, what changes are there?

3. If psychological transformations/shift of attitudes can be documented, are there aspects of the training, curriculum or other inputs that resulted in these changes?

4. How, if at all, did HOPE alter the way targeted schools in urban slums in Nairobi address the needs of youth?

5. How, if at all, did HOPE alter the way parents in targeted urban slums in Nairobi address the needs of their children, particularly adolescents and pre-adolescents?

6. Is there any evidence that HOPE improved student performance in targeted schools?

7. Is there any evidence that HOPE improved cross-cultural, inter-ethnic and inter-generational communications within the school, home and/or larger community settings? If so, why and how?

8. Is there evidence that the program resulted in a reduction of or changed attitudes towards gender based violence?

9. What commitment and capacity is demonstrated by the Ministry of Education, Science and Technology (MoEST), individual schools or other providers to sustain the services that have been provided by HOPE? What elements of HOPE is MoEST most likely to adopt or encourage others to apply?

10. Has HOPE influenced the MoEST’s approach to Life Skills Education and the training needed to support it?
IV. Methodology

Data Collection and Analysis

The end-line evaluation used a mixed-methods approach through quantitative and qualitative data collection instruments. Quantitative data was collected from a total of 682 students, teachers and parents, using clustered stratified random sampling to determine schools, classes and respondents to be surveyed. Qualitative data was collected through interviews, Key Informant Interviews (KII) and Focus Group Discussions (FGD) with 152 individuals, using purposive sampling. The use of both quantitative and qualitative tools allowed the consultants to triangulate data to ensure consistent results and gain a deeper understanding of given responses. The qualitative methodologies in particular enabled the consultants to assess program effectiveness, efficiency, sustainability and impact of the program as viewed by beneficiaries and stakeholders, as well as facilitate documentation of challenges and lessons learned; selected quotes from the qualitative reviews are included in this report.

A total of five questionnaires (survey instruments) were developed and used for students (2), parents (2) and teachers (1), all of which are included in Annex V. The two questionnaires used for students – one for primary schools and another for secondary schools – had essentially the same questions, although additional ones were added for the older youth in secondary schools. There were also two questionnaires used for parents: one for primary school parents trained “or empowered” in effective communication to reinforce positive life choices and at-home behavior, and one for non-empowered parents; all were parents of children who attended HOPE program schools. There was one questionnaire for teachers: both trained and untrained in utilizing the Life Skills curriculum. The instrument also assessed the teachers’ perception of the quality of the HOPE program training in the schools.

For students, surveys were used to collect qualitative data assessing Knowledge, Attitude and Practice (KAP) related to HIV&AIDS, Life Skills and Drug & Substance abuse, including the indicators that had been collected through the HOPE Performance Monitoring Plan (PMP). For survey questions related to HIV, STDs, and sexual behaviors and to get end line data on the four PMP indicators, the consultants asked the same questions asked at baseline so they could obtain comparable data to assess the before and after program results. There were also end-line questions added related to drug and substance abuse and views towards gender-based violence.

Because baseline data only existed for indicators related to HIV, STDs and substance use, to obtain data on unintended results (such as changes in communication and coping skills, levels of inter-ethnic and inter-generational coping, levels of conflict in schools and home), the consultants and Global Communities staff worked closely together to develop questions to capture perceived changes in attitudes and practices resulting from HOPE. Ideally the same questions should have been asked at baseline and end-line, but given the unintended outcomes went beyond planned results, new questions had to be developed. Given there was no baseline data on the aforementioned unintended outcomes, the evaluators assessed the extensive and significant attribution of changes perceived as a result of HOPE programming at face value.

The questionnaires were developed in a participatory manner, in close consultation with HOPE program staff and the Senior Monitoring and Evaluation Specialist at Global Communities HQ. Moreover, they were pre-tested before administration to ensure they were understood by respondents and that their answers reflected the evaluation objectives.

Study Population, Sampling Framework and Process

The evaluation’s sample size was 834 respondents (682 quantitative, 152 qualitative).

Quantitative Data: The sample size for the primary target group – students in schools – was calculated using the formula below, with an adjustment of 10% to mitigate any possible design effect:
In actuality, the number of students surveyed was 420 (290 primary school students and 130 secondary school students). The evaluators surveyed an additional 262 respondents, including 137 teachers (79 trained / 58 untrained) and 125 parents (61 empowered / 64 unpowered) to reach the total of 682.

In determining the sample, Benaphil Consultants used a stratified cluster random sampling technique. First the schools were clustered by county, and then stratified into primary and secondary schools. Within the strata, schools were randomly selected. Following this, 14 primary school students and 12 secondary students were randomly selected as survey participants, using the Table of Random Numbers.

When comparing baseline to end-line data, it is important to note that the respective samples do not represent the same cohort of students; this is because a random selection of students was surveyed each time, and many of the secondary students surveyed at baseline would have graduated before the final evaluation.

Teachers from selected schools were conveniently selected based on their availability in schools at the time of interview. The parents, both trained and untrained, from the randomly selected schools were purposively invited to participate in the focus group discussions and in-depth interviews.

Qualitative Data: Purposive sampling was used to reach respondents deemed to present pertinent information, such as MoEST officials, head teachers / principals, Life Skills Education teachers and partner leaders; others included peer educators, parental facilitators, empowered parents and non-empowered parents.
### Table 2: Sample Size Distribution

<table>
<thead>
<tr>
<th>SN</th>
<th>Type of Respondent</th>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>KAP Survey</td>
<td>FGD</td>
</tr>
<tr>
<td>1.</td>
<td>Pupils/students in schools (both formal and informal)</td>
<td>420</td>
<td>60</td>
</tr>
<tr>
<td>2.</td>
<td>Peer educators</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>Parental Facilitators</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>4.</td>
<td>Teachers trained on life skills</td>
<td>79</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>Teachers not trained on life skills</td>
<td>58</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>Empowered Parents with Families Matter Package</td>
<td>61</td>
<td>8</td>
</tr>
<tr>
<td>7.</td>
<td>Empowered Parents with Tailored Package</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>8.</td>
<td>Non-empowered Parents</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>9.</td>
<td>Community leaders (Chiefs, religious leaders)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>School administrators</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>MoEST Officials at County level</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>MoEST Officials at National level</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Project staff</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Partner leaders</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>682</td>
<td>126</td>
</tr>
</tbody>
</table>

| KAP = Knowledge Attitude and Practice; FGD = Focus Group Discussion; IDI = In Depth Interview; KII = Key |

Survey data was collected by a total of 15 trained research assistants recruited by Benaphil Consultants. Their training was conducted over two days, which included the pre-testing of data collection tools.

Quantitative data analysis was undertaken using IBM Statistical Package for Social Sciences (SPSS) Version 20, and is descriptive in nature. It is, however, noteworthy that the baseline data is drawn from the baseline survey report rather than raw data, which was not available for comparative purposes. The qualitative data was used to triangulate the quantitative findings.
Sociodemographic Characteristics of Study Population

Figures 5a, 5b, 5c show primary and secondary school student distribution by sex, age group and religion:

**Figure 5a: Age Distribution of Student Respondents (n=420)**

- 15 yrs - 17 yrs: 27%
- 9 yrs - 11 yrs: 20%
- 12 yrs - 14 yrs: 46%
- 18 yrs - 20 yrs: 7%

**Figure 5b: Distribution of Student Respondents by Sex (n=420)**

- Primary School Students (n=290):
  - Female: 53%
  - Male: 47%
- Secondary School Students (n=130):
  - Female: 44%
  - Male: 56%

**Figure 5c: Religious Distribution of Student Respondents (n = 420)**

- Anglican: 15%
- Catholic: 25%
- Islam: 6%
- Other Christian: 27%
- SDA: 7%
- Other: 20%

**Figure 6: Number of Parents and Teachers Surveyed**

- Parents (125):
  - Empowered: 56
  - Non-Empowered: 58
- Teachers (137):
  - Primary School Teachers: 35
  - Secondary School Teachers: 63

- Male: 56, 58, 35, 17
- Female: 56, 58, 35, 22

Figure 6 shows the gender distribution of surveyed teachers and parents. The majority of respondents were female, due to the fact that more women than men were reached in the initial Families Matter training, and also a gender imbalance in teaching staff. Moreover, the majority of schools nominated female teachers and counselors to take part in the LSE curriculum trainings.
Methodological Limitations

The following limitations were encountered in carrying out the evaluation:

1. As stated previously, there was no baseline data collected on any of the “unintended outcomes” since those went beyond the objectives of the program. Consequently, all changes related to unintended outcomes are based on post-program perceptions of students, teachers, parents and others who participated in the HOPE Program.

   Because data was self-reported and retrospective, representing respondents’ perceptions of changes in KAP following their exposure to and/or participation in HOPE, there is a risk of bias due to the fact that respondents may not have accurately remembered things from the past, or may have responded in a manner they believed to be socially acceptable or in a way they believed was anticipated by the evaluator. To minimize this risk, the evaluators used a sizeable survey population of 834 respondents.

2. Although there were many reports of improved academic performance, and the evaluation team developed an instrument to collect trends in school test results by grade over the final three years of the project, schools were unwilling to share test results data (in line with MoEST policy);

3. Students were randomly sampled. Teachers were sampled based on their availability at the time of interview, and parents were invited to participate in the study; therefore, there is potential for some bias among these two groups of respondents.

4. The detailed raw dataset from the baseline survey was not available. Thus, the evaluators could only use summary statistics to compare results between baseline and end-line. Also, some baseline data (e.g. drug use) had been obtained from secondary data sources such as past national surveys, and may not have provided an ideal comparison with the largely urban and slum-concentrated HOPE target population;

5. Only one MoEST official was available for a KII, limiting this respondent category to a solitary perspective.
V. Evaluation Findings

This section addresses HOPE’s achieved results, both intended and unintended. Data findings are organized around the four Evaluation Objectives derived from the Key Research Questions in the SOW:

1. Establish the extent to which the HOP Program achieved its Goal and Objectives (Outcomes);
2. Assess the overall effectiveness and impact of the HOPE model in addressing the needs of at-risk youths in the urban slums of Nairobi;
3. Assess and document whether the program had unintended results (positive or negative) beyond the original HOPE goals and objectives; and
4. Examine whether there were elements of HOPE that can guide future Global Communities efforts at working with at-risk youths.

The final set of findings addresses participants’ level of satisfaction with HOPE training and services.

“A friend wanted to influence and put pressure on me to attend a bash (party) something that I don’t do and I had to say a strong no and stuck to it. I didn’t go and he respected my decisions.”—Female Student

“I have been able to practice self-control and said no to sexual advances from a boy here in school.”—Female Student

“Fellow students come to us asking us how they can stop having sex, some say they can’t do without it because they are used to it, but we see many changing their behavior.”—Peer Educator

“We were able to sensitize girls to avoid risky situations for example staying out late in the night would easily make them a prey for gang rape. Boys were equally sensitized on dangers of gang rape and that in can easily aid HIV transmission.”—Religious leader

Evaluation Objective 1: Extent to Which the HOPE Program Achieved Its Goal and Objectives (Outcomes)

The Goal of the HOPE Program was: Improved HIV/AIDS Knowledge, Attitudes and Practices through peer, school, and community-based interventions.

To achieve this Goal, HOPE documented and tracked four intended Objectives (Outcomes):

**Outcome 1:** Improve students’ Knowledge, Attitudes and Practices through Peer Education (PE) mentoring and support;

**Outcome 2:** Schools equipped with the capacity to provide HIV/AIDS related knowledge, information and support through classroom instruction and extra-curricular activities;

**Outcome 3:** Parents and community members promote healthy living through increased school involvement; and

**Outcome 4:** The Ministry of Education, Science and Technology and new County Education Officers equipped to implement the Ministry’s Revised Sector Policy on HIV and AIDS.

Key Results: Table 3 below illustrates that HOPE attained or exceeded the vast majority of its planned targets across all four program Outcomes:
### Table 3: Key Performance Indicators

<table>
<thead>
<tr>
<th>Key Performance Indicators</th>
<th>Planned Targets</th>
<th>Achieved</th>
<th>% Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td># of targeted population reached with individual and/or small group level HIV preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required. PEPFAR P8.2.D</td>
<td>64,000</td>
<td>68,933</td>
<td>108%</td>
</tr>
<tr>
<td># of peer educators trained to conduct individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required</td>
<td>2750</td>
<td>3189</td>
<td>116%</td>
</tr>
<tr>
<td># of peer educators receiving reinforcement training</td>
<td>750</td>
<td>685</td>
<td>91%</td>
</tr>
<tr>
<td># of peer group education sessions conducted through individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required</td>
<td>10,000</td>
<td>9992</td>
<td>99.9%</td>
</tr>
<tr>
<td>% targeted schools achieving at least 75% of learner outcomes</td>
<td>40%</td>
<td>47%</td>
<td>118%</td>
</tr>
<tr>
<td># teachers trained on HIV and AIDS and Life Skills Education to meet national/MoEST standards</td>
<td>1200</td>
<td>1137</td>
<td>95%</td>
</tr>
<tr>
<td># of school clubs established and/or strengthened</td>
<td>300</td>
<td>300</td>
<td>100%</td>
</tr>
<tr>
<td># of school governance structures supported/established</td>
<td>160</td>
<td>369</td>
<td>231%</td>
</tr>
<tr>
<td># of parents trained in parenting empowerment skills</td>
<td>5500</td>
<td>5907</td>
<td>107%</td>
</tr>
<tr>
<td># of MoEST personnel participating in capacity building workshops to implement MoEST sector policy on HIV and AIDS</td>
<td>700</td>
<td>719</td>
<td>103%</td>
</tr>
<tr>
<td># consultative events held on the draft HIV/AIDS policy (forums)</td>
<td>31</td>
<td>14</td>
<td>45%</td>
</tr>
</tbody>
</table>

### Key Results for Outcome 1:

**Key Results Table 4: Outcome 1: PEPFAR Indicators:** HOPE was responsible for tracking baseline to end-line changes in four PEPFAR indicators, as shown in the table below:

<table>
<thead>
<tr>
<th>PEPFAR Goal-Level Outcome Indicators</th>
<th>Baseline( A)</th>
<th>End-line (B)</th>
<th>Change( B-A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of never-married young men and women aged 15-24 who have never had sex</td>
<td>65%</td>
<td>59%</td>
<td>- 6%</td>
</tr>
<tr>
<td>Percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15*</td>
<td>45%</td>
<td>27% (&lt;14) 49% (14-16)</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of young men and women who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>Abstinence 65%</td>
<td>93%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Condoms (secondary)</td>
<td>N/A</td>
<td>57%</td>
</tr>
<tr>
<td>Percentage of population with accepting attitudes towards Persons Living With HIV/AIDS (PLWHA)</td>
<td>Remain friends with an HIV+ person 83%</td>
<td>93%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Allow HIV+ to attend school 81%</td>
<td>85%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Allow HIV+ teachers to teach students 79%</td>
<td>86%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Would live with an HIV+ person 88%</td>
<td>89%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*The indicator measures the number of individuals who, having responded ‘yes’ to the previous indicator, indicate the age of their first sexual encounter. The questionnaire combined 14-16 year-old respondents into one age group, therefore it is impossible to identify precisely which were 15 years or younger.*
PEPFAR Indicator 1: Percentage of never-married young men and women aged 15-24 who have never had sexual intercourse: This indicator was assessed only in secondary schools. As shown in Figure 7, of the students in secondary schools, at baseline 65% of students said they had never had sex, as opposed to 59% at end-line. This result suggests that the level of teen sexuality was higher at the end of HOPE – not a positive sign. However, this does not necessarily mean that a higher proportion of students had engaged in sexual activity, but rather were perhaps more willing to speak candidly following exposure to the Life Skills Education curriculum. Moreover, the differences between baseline and end-line results could merely reflect differences between the two randomly selected youth populations at two different points in time.

PEPFAR Indicator 2: Percentage of young men and women aged 15-24 who had sexual intercourse before the age of 15 (see Figure 8): Again, this question was asked only of secondary school students, and indicates the percentage of respondents who, having responded ‘yes’ to the previous indicator, reported their first sexual encounter to have occurred at a certain age. While the indicator’s threshold is 15 years and younger, the end-line questionnaire grouped respondents into age groups; therefore it is difficult to measure against this indicator precisely.

Of the secondary students who reported their first sexual encounter between 14 and 16 years of age, 64% had had sex with a boyfriend/girlfriend or peer, 15% with a neighbor, 4% with a teacher, and 4% with a relative. Twenty-two percent of those affirming within this group stated they were forced or pressured to have sex.

PEPFAR Indicator 3: Percentage of young men and women who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV. Knowledge of HIV transmission is crucial in the prevention of HIV and AIDS. Both primary- and secondary-school students were first asked whether HIV is preventable, and then asked to identify ways through which HIV could be prevented (essentially through abstinence). Compared to baseline, where only 65% of students identified abstinence as a preventative measure against HIV transmission, this number increased to 92% by end-line (Figure 9). The baseline and end-line questionnaires posed slightly different questions: at baseline, students were asked whether the risk of HIV transmission...
[was] reduced through abstinence,’ and at end-line they were asked whether ‘HIV/AIDS [was] preventable through abstinence.’

Students were also asked questions related to common misconceptions about HIV transmission. Results are shown in Figure 10, illustrating that the majority of the secondary school students rejected most major misconceptions about HIV/AIDS, both at baseline and end-line. For example, at baseline 96% of students stated that HIV cannot be transmitted through a handshake with an HIV+ person. At end-line 97% of students stated this correctly. Finally, both at baseline and end-line, 93% of surveyed students correctly stated that one can be infected with HIV after a single sexual intercourse with a person who is HIV+. The relatively high level of student knowledge of ways to prevent HIV at baseline indicates that prior to HOPE students had likely been exposed to behavioral change communication/public health messages about the disease.

**Figure 10: Student Change in Knowledge Regarding HIV/AIDS Transmission**

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Baseline (n=1791)</th>
<th>End-line (n=416-418)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV can be transmitted after one single sexual intercourse with an HIV+ individual</td>
<td>64%</td>
<td>93%</td>
</tr>
<tr>
<td>HIV cannot be prevented by taking family planning pills</td>
<td>58%</td>
<td>96%</td>
</tr>
<tr>
<td>HIV cannot be transmitted through a handshake</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>HIV cannot be transmitted through a mosquito bite</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>HIV cannot be transmitted by sharing a toilet with an HIV+ person</td>
<td>83%</td>
<td>85%</td>
</tr>
<tr>
<td>HIV cannot be transmitted through a cough or sneeze</td>
<td>66%</td>
<td>72%</td>
</tr>
</tbody>
</table>

**PEPFAR Indicator 4:** Percentage of population with accepting attitudes towards Persons Living with HIV or AIDS. To assess student attitudes towards people living with HIV and AIDS, the following questions were asked:

1. What would you do if a close friend or relative was infected with HIV and AIDS?
2. If a student is infected with HIV and AIDS should he or she be allowed to attend school?
3. If a teacher tested positive for HIV and AIDS should he or she be allowed to teach students?
4. Do you believe that people who have HIV should be left alone or isolated?
5. Would you live with a family member who has HIV & AIDS?
6. If a member of your family tested HIV positive, would you want their status to remain a secret?

The evaluation results, as shown in Figure 11, demonstrate that the majority of students had accepting attitudes towards people living with HIV and AIDS at the beginning of the program, and that these levels remained the same or had marginally increased by close-out. This indicates that there may have already been a moderate level of basic HIV knowledge and acceptance at baseline.

![Figure 11: Student (Primary & Secondary) Change in Attitudes Towards PLWHAs](image)

Despite the data indicating fairly accepting attitudes of those living with HIV, the majority of students reported that if a member of their family tested HIV-positive they would prefer their status to remain a secret (Figure 12). This finding indicates that even though students demonstrated very accepting attitudes about others with AIDS and would not be opposed to an HIV positive student or teacher remaining in their school, there is nonetheless a strong stigma relating to being HIV positive. Note that only 53% of students (primary and secondary combined) articulated this concern at baseline.

![Figure 12: % of Secondary Students Who Would Want a Family Member's HIV Status to Remain a Secret](image)

Beyond the four PEPFAR indicators, survey respondents were asked a series of other questions relating to Knowledge, Attitudes and Practices, thereby supplementing the data findings for Outcome 1.

Risk of HIV Infection: Among secondary students in particular, 58% of males and 51% of females perceived they are not at risk of HIV infection, as shown in Figure 13. As the HOPE program aimed to make all youth aware of their relative risk to HIV infection and of the need to adopt mitigating behaviors, this data merits further examination, as it is particularly important to ensure the true risk of HIV/AIDS is being properly communicated to youth through Life Skills Education and BCC Communications.

![Figure 13: % of Primary and Secondary Students Who Think They Are at Risk of Getting HIV/AIDS](image)
Figure 14 illustrates responses from those secondary school students who believed they were at risk of HIV, segregated by sex, on reasons why they felt they were at risk. The leading reason by males and females was that they did not know whether or not they were HIV positive, as they had not been tested. This is a significant finding, as the entry to HIV prevention care and treatment begins with knowledge of one’s HIV status. The result underscores the value in linking HIV prevention programs such as HOPE to HIV testing and counselling services (which may have been a missing link in the project).

Conversely, among that majority of secondary school respondents who did not believe they were at risk, the reasons for which they believed themselves to be protected from HIV/AIDS are illustrated in Figure 15. Tellingly, half of male respondents and 35% of female respondents indicated they were not at risk because they knew their HIV status. This corroborates the above statement that knowledge of HIV status is critical for students to protect themselves and their partners from HIV transmission.
Knowledge of HIV/AIDS, STDs/STIs: Students were asked at both baseline and end-line if they (1) had heard of a disease that spreads through sexual intercourse; and if so (2) what diseases they had heard about. As shown in Figure 16, awareness of six STDs (including HIV) increased significantly following HOPE programming.

Drug and Substance Abuse: Drug and substance abuse is a risk factor in HIV infection, as such abuse is associated with a myriad of negative consequences including injury and risky sexual behavior\(^1\). This occurs even among young people who have knowledge of safe health practices. Such abuse among youth in Kenya has been on the rise in recent years, posing increased danger to youth health and well-being.

At baseline 19% of secondary school students claimed they had tried drugs other than those prescribed by a doctor, with 42% of claimants stating they took these drugs at least once a week. At end-line (Figures 17a and 17b), 24% of secondary school students surveyed said they take drugs, with 38% of claimants stating they took these drugs at least once a week – thus a slight decrease in prevalence. Among primary students, who were not asked this line of questioning at baseline, 6% of respondents claimed to use non-prescribed drugs, with 11% of claimants stating they did so at least once a week. It is impossible to know whether “drugs not prescribed by a doctor” were interpreted by students to include over-the-counter drugs such as aspirin, as opposed to recreational drugs. It is nevertheless possible that the data corroborates the above statement of rising drug and alcohol abuse in Kenya.

Interestingly, students were also asked if they’d observed a change in classmates’ drug use following HOPE. As shown in Figure 18, 31% of primary and 42% of secondary students said drug use had decreased, while 50% and 29%, respectively, were unsure.

Figure 18: Student Perceived Change in Drug Use Following HOPE

<table>
<thead>
<tr>
<th>Percent of Students</th>
<th>Primary Students (n=290)</th>
<th>Secondary Students (n=130)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Higher / Higher</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Much Lower / Lower</td>
<td>31%</td>
<td>42%</td>
</tr>
<tr>
<td>No Change</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>50%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Key Results for Outcomes 2-4:

Outcome 2: Schools equipped with the capacity to provide HIV and AIDS related knowledge, information and support through classroom instruction and extra-curricular activities

- Program support to new or established school clubs and governance structures met or exceeded targets, and Life Skills Education training reached 95% of its intended targets.

Outcome 3: Parents and community members promote healthy living through increased school involvement

- HOPE programming reached 107% of its intended target of parents/caregivers trained in empowerment.

Outcome 4: Ministry of Education, Science and Technology and new County Education Officers equipped to implement the Ministry’s Revised Sector Policy on HIV and AIDS.
The HOPE Program supported MoEST in holding fora, reviewing and disseminating its Education Sector Policy on HIV and AIDS (Second edition, 2013) nationally to each of Kenya’s 47 counties, training 719 MoEST employees in the process (exceeding its target of 700).

Note the policy framework provided an enabling environment for implementing HIV and AIDS programs in schools. The policy objectives are to: “a) review the Life Skills Education curriculum and other subjects to enhance provision of age appropriate Comprehensive Sexuality Education (CSE) and reinforce the capacity to implement, monitor and evaluate the same; b) strengthen coordination of all education related HIV and AIDS programs within the sector; c) ensure HIV and AIDS education is mainstreamed at all levels including alternative, adult and continuing education; and d) regularly monitor and evaluate the status of implementation of the Education Sector Policy on HIV and AIDS, 2013”. Country level dissemination of the policy was considered an important milestone as it included clauses on reducing the age of consent for HIV testing to 15 years, and also proposed that Comprehensive Sexuality Education be introduced in schools in a bid to scale up HIV prevention efforts.

**Evaluation Objective 2: Assess the program’s overall effectiveness and impact in addressing the needs of at-risk youths in the urban slums of Nairobi**

The HOPE Program used an integrated, hybrid approach (PE, LSE curriculum and parental empowerment) in working directly with students, teachers and parents/caregivers, as well as outside community and religious leaders. This allowed HOPE to influence the relationships between youth and the adults in their lives, reach beyond schools in reinforcing school-based activities and messages, and increase ownership of the interventions. HOPE trained PEs to reach fellow youth with HIV/AIDS and STI/STD prevention information, built the capacity of teachers and head teachers to deliver Life Skills Education through classroom instruction and supporting the needs of learners living with HIV; and engaged out-of-school Youth Living with HIV (YLHIV) to connect with in-school youth in a stigma reduction effort. HOPE also helped parents and caregivers increase their skills and comfort in communicating with their children on Sexual and Reproductive Health (SRH) issues, as well as engaging in and supporting their children’s schooling.

This model was found to be effective, as evidenced by both quantitative and qualitative data showing positive changes in HIV/AIDS and STIs KAP among students and empowered parents, and as illustrated by the unintended outcomes documented below (coping with life challenges, communicating effectively, peacefully resolving conflicts, making better decisions and avoiding high-risk behavior).

**Prospects for Sustainability:** HOPE has proven to be a fairly low-cost approach, having trained 79,166 students, teachers and parents for a cost of $58 per direct beneficiary or $19 per year. One hundred sixty-one School Health Committees (SHCs) were created and/or strengthened to support program activities, and in a way that was consistent
with MoEST policy. Further, the program initiated and supported a Program Advisory Committee (PAC) at the national and county levels, bringing together various stakeholders including MoEST, the Ministry of Health, the Teachers Service Commission (TSC), Kenya Institute of Curriculum Development (KICD), parents, teachers and students. KICD was instrumental in developing the LSE curriculum used by MoEST, and TSC was instrumental in rallying teachers to attend trainings and also in monitoring completion output in learning lessons for use in the upcoming curriculum reform process. HOPE and MoEST jointly encouraged TSC to recognize the LSE certificate of training completion as part of continuing education for teachers and also as an incentive for teachers to access the training. Overall, without such widespread buy-in, HOPE would have less easily been able to access schools and teachers.

While the program was not costly, and participants in the Life Skills Education trainings will hopefully retain much of what they have learned, similar programs will nonetheless require continuous MoEST commitment (possibly with outside donor resources) to successfully instill the Life Skills curriculum in additional schools (training for new teachers, parents and peer educators, and follow-up support and mentoring). It should be noted that lack of funding and support at the school and community level means that with HOPE’s conclusion there is currently no continuous training available to individual PEs, who continuously graduate, or new cohorts of parents. This is particularly unfortunate as parents, students and teachers were quite vocal during workshops that there was strong, unmet demand from other schools and communities eager to access HOPE’s services. The teacher-led Life Skills education will continue so long as trained teachers remain in schools where the curriculum is being implemented. However additional resources will be needed to bring Life Skills education to new schools.

Evaluation Objective 3: Assess and document whether the program had unintended results (positive or negative) beyond the original HOPE goals and objectives

There were significant, positive unintended outcomes of the program, as indicated by perception data on perceived changes as a result of HOPE programming, and illustrated in the figures below. These included perceived changes in:

- New Role of Schools Beyond Academics
- Enhanced Role of Peer Educators
- Improved Academic Performance
- Reduced High Risk Behavior

“Open discussions on sexuality between parents and children has had a good effect and parents have begun to engage with their children.” —Religious leader

“They said that the training brought parent child reconciliation, clear communication between parents and their children and they are now able to monitor their children better. Before the training, only 8% of parents had talked to their children on sexuality but this escalated to 80%.” —Partner

“[I] never used to read and revise but after reading a book on life skills I started reading and revising, this has improved my grades.” —Primary school student

“There are friends who will call you to study with them if they think that you are idle or they will call you so that you may help each other finish your homework.”

—Primary school student
• More Effective Communication and Conflict Resolution Skills of Students, Parents and Teacher

• Increased Willingness of Parents to Discuss High-Risk Behaviors with their Children

• Increased Parental Engagement With their Children

• Changes in How Parents Discipline Children

**New Role of Schools:** During interviews and FGDs, some teachers communicated that schools had become a ‘safe haven’ where children were viewed holistically, with issues they faced outside the classroom no longer ignored.

**Enhanced Role for Peer Educators:** PEs became more recognized in their schools, and were able to assume more leadership positions.

**Improved academic performance:** The end-line evaluation attempted to measure whether HOPE programming had resulted in changes in students’ academic performance. Both quantitative and qualitative data indicated that students, teachers and parents believed academic performance had improved as a result of HOPE, though unfortunately the evaluators were not able to corroborate these findings with school testing data, given MoEST policy restrictions on sharing test results.

Nevertheless, survey data (Figures 19 and 20) showed that 86% and 77% of primary school males and females, respectively, as well as 62% and 81% of secondary males and females, respectively, perceived a noted improvement in their academic performance correlated to the Life Skills curriculum, delivered through PE and teacher-led sessions. Both parents and teachers noted significant improvements in students’ performance (87% and 76% of surveyed parents and teachers, respectively).

---

“As teachers, we barely understood the impact of our role in influencing students’ behavior and attitudes until we were taken through Life Skills Education training by Global Communities in the HOPE Program. It was an eye-opener and for once, my role as a teacher was re-defined. We encouraged other teachers to enroll. Teaching life skills has greatly encouraged our students to seek more support and tips on how to handle problems, it has also created safe spaces for students to open up and share issues affecting them, they are confident that they can find help. As teachers, we have taken up parental roles as we link up with the surrounding community to support and protect our students. As much as grades are important to take them to the next level, we realize that the life skills sessions double up in ensuring students are focused and this results in better grades unlike before. Everyone needs skills in life to cope with difficult situations, especially in slums.”

—Deputy Head Teacher at participating secondary school

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**Figure 19: Student Perception of Change in Academic Performance by Gender**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>86%</td>
<td>77%</td>
</tr>
<tr>
<td>No Change</td>
<td>62%</td>
<td>81%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>18%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Figure 20: Parent and Teacher Perception in Academic Performance of Students**

<table>
<thead>
<tr>
<th></th>
<th>Parents (n=123)</th>
<th>Teachers (n=136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>82%</td>
<td>76%</td>
</tr>
<tr>
<td>No Change</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>11%</td>
<td>17%</td>
</tr>
</tbody>
</table>
More effective communication, conflict resolution and decision-making skills (students and parents): Surveyed students and empowered parents stated overwhelmingly that HOPE training had significantly improved communication, conflict resolution, coping and decision-making skills at school, at home and in the larger community (Figure 21). At school, students observed decreased inter-religious tensions, with reports of more communal participation in activities such as sports and debates. Students were also reported to have opened up more to their teachers and parents, and to have become more assertive. Additionally, during interviews some students noted improved communication between Christian and Muslim students as a result of HOPE.

![Figure 21: % of Trained Parents and Students that Perceive Improved Communication Skills Among Youth](image)

Reduced High-Risk Activity: Students and empowered parents (Figure 22) stated that following HOPE there was less conflict in schools, more awareness of gender-based violence, and a greater awareness among students over how to protect themselves from HIV, STIs, drug abuse, violence and other problems common to Nairobi’s urban slums.

![Figure 22: % of Students’ and Empowered Parents’ Perception of Changes in High-Risk Activity](image)
Additionally, across a number of high-risk behaviors over fifty percent of surveyed primary and secondary school students (Figure 23) noted positive behavior improvements (e.g. reduction in school absenteeism and an increase in open HIV/AIDS discussion, and among secondary school students decreases in drug and alcohol use, and perpetrating crimes).

**Figure 23: Students’ Perception of Changes in Individual High-Risk Behavior**

- **Missing School**: 60% (Primary), 59% (Secondary)
- **Engaging in Sexual Relations**: 50% (Primary), 54% (Secondary)
- **Talking About HIV, STIs and…**: 46% (Primary), 58% (Secondary)
- **Using Drugs**: 38% (Primary), 45% (Secondary)
- **Using Alcohol**: 45% (Primary), 57% (Secondary)
- **Piercing or Tattooing Body…**: 45% (Primary), 45% (Secondary)
- **Joining Gangs**: 48% (Primary), 51% (Secondary)
- **Engaging in Crime**: 50% (Primary), 60% (Secondary)
- **Fighting**: 46% (Primary), 60% (Secondary)

![Primary (n=290) Secondary (n=130)]

“In the old days, drugs were the order of the day but after peer education it has changed.”

—Secondary school student

“My peers try to influence me to attend “bash”, meaning parties. In most of the bashes there is alcohol, dance and at times when you attend “ukifika unawekewa mchele” meaning they spike your drink with drugs. Drugs that hypnotize and people can have sex with you without you willing or even knowing what is happening.”

—Secondary school student

“I deal with this challenge by being assertive “nikusema siendinasiendi” meaning I make active and firm decision not to attend the parties, I mean what I say and do what I say period. However, when I attend the “bash” meaning party, for me “nikujitoamapema” meaning I leave the party early before things get worse.”

—Secondary school student

**Improved Parenting and Household Communication Skills for Trained Parents:** Survey and FGD data indicated that empowered parents experienced significant attitudinal transformations (Figure 24). Of the 61 surveyed parents who had participated in the empowerment training, 100% stated they could communicate more effectively with their children; 98% stated they could positively reinforce desired behaviors of their children; and 98% could better manage conflicts in their families. At the household level there were improved relationships between spouses (husband and wife) where one had attended the parental empowerment training. These findings show that parental empowerment sessions offered a good platform for exploring ways of improving communication and creating a conducive home atmosphere for initial and sustained dialogue on reproductive health issues, not just with adolescents but also with spouses.
Corroborating the above (Figure 25), of the 27% of surveyed primary school students who stated their parents had participated in the HOPE parental empowerment trainings, over fifty percent reported significant changes in their parents’ behavior in all areas questioned, with 84% of respondents stating their parents spent more time focused on what they did in school, and 79% of respondents stating they spent more talking with them about life decisions.

**Figure 24: Empowered Parent Perceptions of Improved Skills Following Empowerment Training (n=61)**

- Positively reinforce behavior in my children: 98%
- Manage conflicts outside my family: 93%
- Manage conflicts in my family: 98%
- Listen effectively to my children: 100%
- Make good decisions: 98%
- Talk about personal issues with my children: 95%
- Talk about HIV, STDs and sexuality: 98%
- Communicate effectively with my children: 100%

**Figure 25: Students' Perception of Improvement of Parental Involvement Following Training (n=77)**

- Talking about life decisions: 79%
- Talking about alcohol and drugs: 72%
- Talking about sex: 64%
- Talking about life outside school: 65%
- Focused on what I do at school: 84%

**Improved Communications with Members of Community**: In the community at large, empowered parents reported improved relationships with neighbors from different ethnic groups, and some took it upon themselves to share lessons learned with others, gathering children from different households to discuss lifestyle issues, particularly concerning sexuality and drug abuse.
Evaluation Objective 4: Examine whether there were elements of HOPE that can guide future Global Communities efforts at working with at-risk youth

Data in this study indicates that the HOPE hybrid model of working with peer-empowered youth, trained teachers, empowered parents and other participants, through their schools and home environments, represents a low-cost and effective approach for not only improving HIV, STI and substance abuse KAP and providing risk-prevention support, but also for addressing many of the other coping, communication, decision-making and conflict resolution skills needed by all youth, particularly those living in high-density, conflict-prone, impoverished urban settlements.

The HOPE model is ideal within a school-based system, as youth of various ethnic, religious and tribal backgrounds spend so much time together, and the setting naturally provides access to parents and families. Nonetheless, while the school setting and the lens of HIV, STDs/STIs and substance abuse provide an effective entrée into the lives of at-risk youth, the HOPE model, curriculum and training materials could be applied in other settings and focus on other issues affecting youth.

Further, HOPE seems well-suited for urban areas, where the social-ecological environment does not consistently support healthy behaviors and decision-making. External influences such as drugs, sexual promiscuity, gang activity, crime and violence are common, and family structures are often devoid of an extended support system. Given the increasingly diverse nature of such urban centers as found in and around Nairobi, HOPE represents a model for bringing young people and the adults in their lives together, and facilitating programming across religion, tribe, ethnic group, and country of origin.

Although Global Communities and other NGOs cannot on their own replicate the full HOPE model – as it is school based and must operate in conjunction with national ministries of education – there are nonetheless key replicable features of the program. For example, the hybrid approach of working with youth, parents and community and religious leaders could be applied in less formal urban/rural settings and used to address a number of problems confronting at-risk youth. In addition to HIV/AIDS and STIs, these might include gang activity, crime and violence, substance abuse, religious extremism, and dropping out of school.

...there are key replicable aspects of the program…. the hybrid approach of working with youth, parents and community and religious leaders could be applied in less formal urban/rural settings (urban/ rural) and used to address a number of problems confronting at-risk youth. In addition to HIV/AIDS and STIs, these might include gang activity, crime and violence, substance abuse, religious extremism, and dropping out of school.

“The HOPE life skills program has been able to equip students to deal with the day to day challenges of life. They are now able to fit in the school environment as well as outside school. To me it has promoted the morals for the students and like I said, life skills are also tested in other teaching subjects such as Kiswahili, CRE, English and many others. To me it’s like life skills complements all of these subjects.”

—Life Skills Teacher

“We have seen at least most of the (students) have understood themselves better, they are able to stand firm and say no to things that are not good….some have gotten serious with life. Yes some issues could not have been tackled without the program. For example, Muslims and Christians discriminating each other but through games and other activities they tend to open up. We have seen change in the boys’ attitudes, behavior and even the studying habits which have led to an improvement in performance.”

—Life Skills Education Teacher

“I am more empowered and I try to use any free time that I get to share with different people, this has made people in my neighborhood to see me as a resource person and they always refer their children to my house for advice or even couples that want to break up come to seek for my counsel.”

—Empowered Parent

“My facilitation skills have been sharpened and I have been invited to facilitate parental empowerment programs even in church. I and my partner are now even training other institutions on the same.”

—Parental Facilitator
Effectiveness of and Satisfaction with Training

During the evaluation Focus Group Discussions and interviews, and through several of the survey questions, teachers, parents and students (including PEs) were asked about their satisfaction with the training provided, including the quality of instruction and curriculum, usefulness of new knowledge, follow-up, etc.

Despite general satisfaction with the skills learned and the transformative effects of HOPE, there were concerns raised about an inadequate amount of time provided for training and follow-up, as well as the lack of an adequate referral system for HIV+ youth. It is likely that the reduction in HOPE’s budget and project life contributed to these problems.

Additional key concerns:
1. Some felt that that the time for training was inadequate, and that the training content was covered hurriedly and in too short of a time – in some cases, only one day of orientation or only 40 hours total. Similarly, many PEs, teachers and parental facilitators felt there should have been more follow-up;
2. Referral systems and tools were initiated only towards the end of the program, although these needs were expressed much earlier;
3. PEs identified topics they often received questioning from their peers about, yet were not covered by trainings. These included sexual orientation, stress management, depression and anger management;
4. The staggered approach to bringing schools into the program meant that for those implementing in Year 3, PEs did not receive adequate mentoring to enable them to function effectively and continue their work beyond close-out;
5. There were reports of inadequate project branding inside the schools. This led to some schools not knowing the program implementing partners; and
6. Different honorarium rates were used by implementing partners leading to discontent from some stakeholders participating in activities implemented by those granting lower rates. This was particularly problematic when more than one implementing partner was operating in a school.

Life Skills Training: As illustrated in Figure 26 on the next page, from the quantitative data collected from 137 teachers and 61 empowered parents, their satisfaction with training was mixed. The majority of teachers felt the trainings and follow-up were inadequate; 39% of teachers were dissatisfied or very dissatisfied with the reference materials, and 41% were dissatisfied or very dissatisfied with the after-training support and follow-up.

“This if we can get more training on anger and stress management and how to relate well with our parents and how to deal with family conflicts because currently in school we have people who are like he said depressed and have issues as peer educators we lack sufficient training on how to handle.”
—Peer Educator

“After the training, there was no support provided by the program leaders. HOPE just sent someone to pick reports once a month, but this person never had time to debrief with me. There was no good follow up and monitoring by HOPE program staff.”
—Life Skills Teacher

“One of our challenges is follow-up of those we trained. We are not facilitated to do so. We however, do trainings in our churches to share the information with others.”
—Parental Facilitator

“The training was not adequate mainly because of time. The days were so few hence little time was allocated to cover each topic. Some topics like drugs and substance abuse are quite wide and need thorough knowledge to teach yet, there was so much to be covered in a small span of time.”
—Parental Facilitator
Empowered parents were happy with the training and performance of facilitators, expressing during FGDs that the trainings should be extended to other parents who had not received it. The facilitators themselves felt the parents needed more time to learn, and similar to the teachers some reported that trainings were inadequate in terms of content and allocated time.

VI. Summary of Key Findings and Recommendations

The HOPE model is ideal for working in a school-based system, as youth of various ethnic, religious and tribal backgrounds spend much of their time together in school, and the setting naturally provides access to parents and families. While the school setting and lens of HIV/AIDS, STIs and substance abuse provided an effective entrée into the lives of at-risk youth, the HOPE approach, and curriculum and training materials could be applied in other settings. The model seems particularly well suited for urban areas, where the social-ecological environment does not consistently support healthy behaviors and decision-making; external influences, such as drugs, sexual promiscuity, gang activity, crime and violence are common; and family structures are often void of an extended support system. Given the increasingly diverse nature of such urban centers as found in and around Nairobi, HOPE represents a model for bringing young people and the adults in their lives together and facilitating programming across religions, tribes, ethnic groups and countries of origin.

A summary of key program strengths and challenges (some of which are identified throughout this report) include:

**Program Strengths**

1. HOPE represents a low-cost and effective approach for addressing many of the issues confronting youth, including HIV, STI and substance abuse KAP. Moreover, the hybrid model of supporting youth through their schools and families could be used to address many youth-related problems.
2. The Kenya Life Schools curriculum for schools, as well as the complementary Life Skills Education used in and/or modified by HOPE, proved effective in helping youth develop skills related to coping, communication, decision making, conflict resolution, etc. These skills are needed by all youth, particularly by those living in high-density, conflict-prone, impoverished, urban settlements.

3. Participation of young people in decision-making forums enhanced ownership and innovation. For example, involvement of students in the PAC and implementation committees provided them with innovative strategies to reach their peers with HIV prevention messages using a language with which the youth identified.

4. The HOPE Program combined several evidence-based curricula to ensure the trainings met the needs and constraints of parents living in informal settlements.

5. Using schools as platforms for mobilization along with the adoption of a tailored content resulted in high turnout of parents for trainings.

6. The HOPE Program worked through existing government structures, which increased its effectiveness in working with schools as well as the model’s prospects for institutional sustainability.

7. Data shows that the HOPE Program yielded numerous, positive unintended outcomes, including perceived improvement in academic performance, improved general discipline among students and leadership development. In survey responses, 86% and 77% of primary school males and females, respectively, as well as 62% and 81% of secondary school males and females, respectively, perceived this positive change; among teachers and parents, 76% and 87% respectively reported this change. However, this perception data could not be corroborated with actual academic records due to prohibitions by MoEST in sharing academic performance data. At the household level, most empowered parents stated that they were more engaged in their children’s lives and had developed better communication skills. Some empowered parents even stated their marriages had improved.

8. The evaluators found the implementation structure and process to be effective, as they followed existing government structures and ensured all those involved had clear roles and responsibilities, and that relevant stakeholders participated in "We were trained in 2013 but we have been continuing till now even though we have never met those who trained us since the last day of the training. We have to continue since now it has become our intellectual property." —Empowered Parent

“We men need to be desensitized from the thought that it’s the mother who needs to talk to the children on issues of sexuality and their growth as a whole. They should be told that it’s a collective responsibility and be helped to change their attitudes.” —Unknown

“We selected individuals with a minimum of certificate in counseling to be the parental facilitators but realized that its only individuals who have a passion for this that can make it continue.” —Partner

“Enhance more engagement with religious leaders who have huge constituents both parents and youth that they can reach with relevant messages.” —Unknown

“Have closer consultations with the youth on how to better target them e.g. through tournaments, music etc.” —Unknown
decision-making at different levels. This included the target population (students in primary and secondary schools), their parents, implementing partners, MoEST at both the national and county level, the TSC, head teachers/principals and teachers.

9. HOPE continuously provided MoEST with meaningful program updates, thus strengthening the critical partnership.

10. Although the absence of a Life Skills training and certification process in schools is an obstacle to the institutionalization of Life Skills Education, HOPE training motivated teachers to use the curriculum in their classrooms. Training head teachers and school administrators in utilizing the LSE curriculum also helped to ensure it was a priority of school management and received support and monitoring at the individual school level. Prior to HOPE, most schools and teachers did not know how to teach Life Skills in their classrooms.

11. The program was strengthened by engaging YLHIV to share their experiences and challenges with students in schools. This was intended to help minimize HIV-related stigma and discrimination.

12. The Peer Education component seemed appropriately tailored to the needs of primary and secondary schools. For the primary schools, there was more teacher involvement and each PE was attached to a teacher so there was always a teacher or trainer in the sessions to help reinforce the message being provided. In secondary schools, PEs assumed more leadership in independently managing sessions.

13. As PEs assumed increased responsibility within their schools, many administrators gave them increased leadership roles.

Program Challenges

1. Although teachers in Kenya are expected to impart the LSE curriculum, many do not because they have not been trained. Life Skills Education is not currently an examinable subject, thus the LSE curriculum is not effectively included among MoEST’s monitoring tools to ensure it is delivered in schools.

2. PEs identified topics for which they often received questions from their peers, yet were not covered by trainings. These included sexual orientation, stress management, depression and anger management;

3. As Peer Educators are continuously graduating, the PE model cannot continue beyond the life of HOPE unless schools and/or a donor assumes responsibility for rebuilding and training new PE cohorts; parental empowerment programs will face the same challenge. These issues affect the potential sustainability of the Life Skills services provided by the HOPE Program.

4. Concerns were raised, particularly by parents and PEs, that there was not adequate time allocated to training and follow-up. PEs also identified topics not covered in the training, including sexual orientation, depression and anger management, for which they often received questions from students.

5. Despite a high HIV prevalence rate among youth in Kenya, the vast majority of secondary school students did not consider themselves at risk of HIV infection primarily due to lack of knowledge about their HIV status.

6. Although HOPE made efforts to facilitate referrals for students with HIV, the evaluators found weak linkages between schools and health service providers. Referral systems and tools were initiated only towards the end of the program, although these needs were expressed much earlier. Thus, only two young people were referred for HIV-related services, despite the fact that Nairobi County has high HIV rates among youth (and throughout Kenya 16% of all people living with HIV and 29% of all new infections are among adolescents and youth). These weak links were attributed to the fact that the HOPE design did not focus on monitoring the HIV status of students, and the program team could only rely on information from students who came forward to disclose their status. Additionally, not all 300 schools reached by HOPE benefited from the school health program that included
the HIV referral component. Unfortunately, efforts to strengthen linkages, including production of referral systems and tools, were developed late in the program and couldn’t be further supported when USAID funding was reduced.

**Key Recommendations**

1. Given the positive results shown in this evaluation using end-of-project perception data, the evaluation team suggests that further and rigorous research of Life Skills education should be carried out (perhaps by the Government of Kenya), preferably in a manner that tracks beneficiaries against a control population over the Life of a Program. Ideally, such research would try to measure changes in academic performance; coping, communication and conflict resolution skills; prevalence of high-risk behaviors; and other variables for which positive outcomes were reported in this HOPE assessment.

2. In similar, future programs, consider offering formal linkages and referral systems to ensure young people receive SRH services, including HIV treatment, care and support and counseling – all of which the program did not offer directly. These types of services are critical for HIV prevention, particularly as knowledge of one’s HIV status students is critical to protect themselves and their partners from HIV transmission.

3. The PE model should be expanded to reach youth as young as 6 years and between the ages of 19 to 24.

4. PE services should be expanded to engage young people during school holidays and breaks to ensure continuous support.

5. Efforts should be made to institute a school-based care and support system for YLHIV through training of teachers on adherence counselling, nutrition for YLHIV and linking a health worker to schools to facilitate access to Anti-Retro Viral Drugs (ARVs).

6. Future programs should explore the use of technology and social media (i.e. Facebook, WhatsApp, and Instagram) to reach young people with HIV prevention messages. Some parents also suggested future programs use Entertainment-education, or ‘edutainment’ to reach more young people. ‘Edutainment’ entails the “process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience members’ knowledge about an educational issue, create favorable attitudes, shift social norms, and change overt behavior”

7. More effort should be made to strengthen the capacity of the MoEST to provide and coordinate PE activities in schools, as expected in the Education Sector Policy for HIV and AIDS.

8. In future programs, consider harmonizing honorarium rates across partners working in the same project to avoid discontentment voiced by some stakeholders.

**Donor:** Consider continued funding of Life Skills Education programs in urban settlements to educate and empower young people, as the evaluation found that this approach of working with youth and the adults in their lives is an effective

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2 Singhal et al., 2004
model for empowering youth and equipping them to make better life decisions.

**Ministry of Education, Science and Technology:** MoEST should consider including the LSE curriculum as part of its monitoring and evaluation tools to encourage school administrators to ensure it is taught. Additionally, MoEST should consider expanding the HOPE model to additional schools, including provision of training for parents and PEs, the two components of the program unlikely to be sustained without outside support (it is assumed that teachers who have been trained will continue teaching Life Skills, though this will only benefit the schools where trained teachers work).

**Global Communities and its Partners:** Global Communities on its own likely cannot replicate the full HOPE model, as it is school based. However, there are key aspects of the program – particularly work centered on youth, parents and community leaders – that could be applied in many urban/rural settings and used to address a number of problems confronting at-risk youth. In addition to HIV/AIDS and STIs/STDs, these might include gangs, violence, substance abuse, religious extremism, and dropping out of school.
VII. ANNEXES

Annex I: SOW

BACKGROUND ON PROJECT

Nairobi County has one of the highest HIV prevalence rates in Kenya. This rate is more acute in the in informal settlements, where half of Nairobi’s population lives. The informal settlements are characterized by high poverty, insecurity, poor health outcomes, substance abuse and low levels of education. This environment makes young people, particularly girls, vulnerable to HIV infection, sexual and gender-based violence, and early education dropout. It is within this context, that Global Communities/CHF and its local implementing partners have implemented the USAID/PEPFAR funded HOPE Program. The goal of the Program is to prevent HIV and promote healthy outcomes among students and their families.

For the last three years, with USAID support, the HOPE Program has implemented a number of activities to improve the students’ HIV and AIDS KAP in primary and secondary schools in Nairobi and Kiambu Counties, with a particular focus on informal urban settlements. The Program has reached over 64,000 across 300 formal and non-formal primary and secondary schools through peer education. In addition, the program has trained 1,200 primary and secondary school teachers to integrate life skills and HIV prevention education into the classroom, and reached over 5,500 parents with parental empowerment trainings aimed at encouraging greater involvement of parents and community members in the schooling of their children. The program has undertaken other activities to ensure a more supportive enabling environment.

Program Objectives and key activities supported include:

Objective 1: Students’ HIV and AIDS Knowledge, Attitudes and Practices improved through Peer-To-Peer support and mentoring

- Peer Education Training provided and events supported in Schools
- Support provided to Peer Educators, Teachers, and Youth Living with HIV/AIDS

Objective 2: Schools equipped with the capacity to provide HIV and AIDS related knowledge, information and support through classroom instruction and extra-curricular activities

- Life Skills Education Training Provided to Teachers
- School Clubs Established or Strengthened
- Youth Awards Given for Outstanding Performance
- Students sponsored for participation in national events and conferences

Objective 3: Parents and community members promote healthy living through increased school involvement

- Comprehensive School Health Program Training
- School Health Committees
- School Capacity Building Plans
- Parental Empowerment through Family Matters Program
Healthy Outcomes through Prevention Education (HOPE) Program: Final Evaluation Report

Objective 4: The Ministry of Education, Science and Technology (MoEST) and new County Education Offices equipped to implement the Ministry of Education’s Revised Sector Policy on HIV and AIDS.

- Policy launch, dissemination and associated training

Although HOPE was designed to “enhance students’ Knowledge, Attitudes and Practices (KAP) related to HIV and AIDs,” as well as Sexually Transmitted Infections (STIs) and Substance Abuse” those involved with the HOPE program (based on stories and testimonies of HOPE beneficiaries and partners) think, in reality, that the HOPE program may have accomplished much more than its stated objectives. Rather, they believe the HOPE Program may serve as effective model for working with youth, in a manner that allows them to have a voice, and in a manner that addresses cross-cultural and inter-generational conflicts, provides psychosocial support, and equips parents and teachers with a deeper understanding of child development and the needs of youth (particularly adolescents and pre-adolescents). Thus, a key goal of this evaluation is to test this hypothesis and see if data can be gather to document the effectiveness of the HOPE model for working with at-risk youth.

Objectives of Program Impact Assessment

The objectives of this impact assessment are to:

1. Establish the extent to which the HOPE Program achieved its goals and objectives, particularly relating to reducing the risks, increasing knowledge, and enhancing positive behaviors among primary and secondary school boys and girls regarding HIV and AIDS from the initial baseline data that was collected in June 2012.
2. Assess the overall effectiveness and impact of the HOPE model in addressing the needs of at-risk youth in the urban slums of Nairobi.
3. Assess and document whether the program had unintended results (positive or negative) beyond the original HOPE goals and objectives.
4. Examine whether there are elements of HOPE that can guide future Global Communities/CHF efforts at working with at-risk youth, within the structure of their schools, communities and families.

The assessment will focus on the first three objectives of the HOPE Program. The target population is primary and secondary school students, teachers, counselors, school administration, parents/caregivers residing in Nairobi and Kiambu Counties with a focus on the informal settlements.

Using the list of Key Research Questions as a Guide, and to achieve the Evaluation Objectives outlined above, the evaluator will be expected to:

a. Determine the extent to which the program achieved its intended goal, objectives, outputs/targets and outcomes.
b. Evaluate program achievement regarding improved KAP and positive behavior change among students via a baseline assessment. The following USAID PEPFAR indicators will be assessed:
   - % of never-married young men and women aged 15-24 who have never had sex;
   - % of young men and women aged 15-24 who have had sexual intercourse before the age of 15;
   - % of young men and women who both correctly identify ways of prevention the sexual transmission of HIV and who reject major misconceptions about HIV
   - % of population with accepting attitudes towards Persons Living with HIV or AIDS (PLWHA)
c. Assess whether the HOPE model (or components of the model) should be expanded or replicated,
d. Assess the appropriateness and effectiveness of the program approach and activities in achieving the objectives
e. Identify and document lessons learnt and best practices; and
f. Make recommendations on ways to sustain what was accomplished by HOPE and for future programming of this
Key Research Questions

This list of research questions should guide development of the research plan and all related survey instruments and protocol. Additional research questions may be proposed by offerer.

1. Can we document whether there was a change in high-risk behaviors among youth who participated in HOPE programming? If so, what were the changes and can they be correlated with HOPE interventions? (Particular focus should relate to HIV, STDs and substance abuse, though other high-risk behaviors should be examined).

2. Can we document any type of psychological transformation/shift of attitudes among those who participated in the HOPE program, including students, parents, teachers, counselors and school administrators? If so, what changes are there?

3. If psychological transformations/shift of attitudes can be documented, are there aspects of the training, curriculum or other inputs that resulted in these changes?

4. How, if at all, did HOPE alter the way targeted schools in urban slums in Nairobi address the needs of youth?

5. How, if at all, did HOPE alter the way parents in targeted urban slums in Nairobi address the needs of their children, particularly adolescents and pre-adolescents?

6. Is there any evidence that HOPE improved student performance in targeted schools?

7. Is there any evidence that HOPE improved cross-cultural, inter-ethnic and inter-generational communications within the school, home and/or larger community settings? If so, why and how?

8. Is there evidence that the program resulted in a reduction of or changed attitudes towards gender based violence?

9. What commitment and capacity is demonstrated by the Ministry of Education, Science and Technology (MoEST), individual schools or other providers to sustain the services that have been provided by HOPE? What elements of HOPE is MoEST most likely to adopt or encourage others to apply?

10. Has HOPE influenced the MoEST’s approach to Life Skills Education and the training needed to support it?

Scope of Work

The final evaluation will be a participatory, inclusive process working jointly with the Global Communities/CHF HOPE Program team, its implementing partner(s) and other stakeholders in the targeted communities.

The consultant, in consultation with Global Communities/CHF, will be responsible for carrying out the following activities:

a) Develop scientifically sound research tools, instruments and sampling methodologies that would help measure the effects of the program’s interventions covering all components highlighted under the Objectives of the assessment, described above.

b) Understand the scope, orientation, structure, inputs, outputs and results of the program and obtain secondary data by conducting a desk review of documents provided by Global Communities/CHF including but not limited to:

   i. Program proposal;

   ii. National guidelines, tools and curricula among others;

   iii. Program baseline data and report; and

   iv. Program reports.

   c) Develop a detailed work plan for the final evaluation in consultation with Global Communities/CHF.
d) Under close guidance from Global Communities/CHF, develop qualitative and quantitative assessment instruments.

e) Pilot and revise the assessment tools as necessary.

f) Participate in validation meetings of the assessment tools.

g) Train the enumerators on the tools administration.

h) Collect primary data through surveys, key informant interviews and focus group discussions with students, teachers/counselors, parents and other key stakeholders working and/or living in the target communities and capture data.

i) Clean and analyze all data.

j) As relevant, disaggregate data by gender, ethnicity and age.

k) Analyze quantitative and qualitative findings along the parameters set in the Objective section while highlighting effectiveness and impact of interventions/strategies, paying particular attention to issues of adolescent girls.

m) Draft two copies of assessment report. Reports should include:

   - Contact details of persons interviewed;
   - Visual presentations (e.g. charts, graphs and/or tables) to most appropriately display key findings;
   - Analysis of key findings;
   - Executive Summary;
   - List of Key Findings and Recommendations;

n) Participate in debriefings on the assessment report, which will be arranged by Global Communities/CHF.

o) Revise report to incorporate feedback of Global Communities/CHF and key stakeholders.

p) Update HOPE Program Director and Global Communities/CHF Kenya Monitoring and Evaluation Manager on the progress of the scope of work on a weekly basis.

**Proposal Preparation and Submission**

Interested and qualified consultants should submit a proposal no more than 15 pages (in MS Word documents using 12 point font) outlining the following:

a) Proposed approach/methodology/design, activities and method of analysis. The proposal should demonstrate understanding of the terms of this call for proposals.

b) Proposed work plan with timeline.

c) Realistic and detailed budget for the assessment including a narrative describing and justifying expenses such as daily rates for proposed team members, number of days, supplies and other direct costs. (Note budget will not contribute to the 15 page limit for the proposal).

d) Summary details of qualifications and experience of the consultant(s) including relevant sample(s) of work demonstrating competence and understanding of health and education sector policies and have a demonstrated experience in conducting impact assessments of youth and health projects at national or sub national levels, particularly those working within schools, families and/or communities. (Note samples of relevant work will not contribute to 15 page limit).

e) Curriculum vitae (CVs) of proposed key consultant(s) of up to two pages each. (Note CVs will not contribute to the 10 page limit for the proposal).

The proposal and all correspondence and documents relating to the proposal shall be in English and all prices shall be quoted in Kenyan Shillings (KES.)
Contractor Tasks and Responsibilities

Under the overall guidance of Global Communities/CHF, the Contractor will:

1. Carry out desk review of relevant documents (Project documents which include proposal, reports, project proposal, and Performance Monitoring Plan (PMP), including consultation with the program partner(s) etc.

2. Develop a detailed work plan for the overall assessment in consultation with and to be approved by Global Communities/CHF.

3. Employ sound research methods to gather needed primary and secondary data. Will likely include surveys, interviews and focus group discussions (FGDs) with selected students, parents, teachers/ counselors, and other community members and key stakeholders. Key Informant Interviews will be carried out with relevant government officials, community leaders and other key stakeholders. Where relevant, end-of-project results will be compared to baseline and other collected data.

4. Where relevant, employ mixed methods of gathering data, particularly for purposes of triangulation.

5. Develop, in English, quantitative and qualitative survey tools, key informant interview protocol and observation checklists, and share with Global Communities/CHF (field and HQ) for review and input prior to use.

6. Identify, engage and train enumerators on using the tools and pretest any survey instruments prior to use.

7. Gather data through identified research methods, ensuring data quality control. Primary data sources likely to include, surveys, interviews and focus groups of key individuals, program partners and organizations involved in HIV prevention among youth in urban informal settlements as well as project staff and key stakeholders. Host government policy stakeholders should also be included if deemed relevant to the HOPE program implementation.

8. Prepare an annex with all contacts, their coordinates, organized under beneficiary headings.

9. Conduct all data entry, cleaning and analysis.

10. Present preliminary findings and data in draft report to the HOPE Chief of Party (hard and electronic copies) within the agreed upon time. The report shall:

   a) Identify all methodological issues and approaches,

   b) Provide quantitative and qualitative analyses of the data

   c) Provide general observations, conclusions and recommendations

Responsibilities of Global Communities/CHF

Global Communities/CHF will be responsible for the following:

a) Provide relevant contacts in schools, Ministry of Education, Science and Technology (MoEST) and communities.

b) Secure required approvals from MoEST to collect data from students.

c) Review and provide guidance on proposed approach, work plans and tools.

d) Assist with contacting and bringing together HOPE project implementing partners and stakeholders during the assessment process.

e) Review and provide feedback on draft reports before production of the final documents.

f) Manage logistics for the assessment and dissemination of final report, including sending out invitation letters to partners, managing communications, printing and binding the final report.

Deliverables

The final products of this assessment will include:
a) Detailed work plan for the assessment.

b) Inception report

c) Final data collection tools (Hard and electronic copies – MS Word).

d) Draft and Final assessment reports to be delivered to Global Communities/CHF based on the schedule in the table below.

c) Assessment data files in commonly readable format (e.g. SPSS, STATA, CSV or Excel).

**Level of Effort and Time Frame**

The assignment is scheduled to commence on April 30, 2015 so as to be completed by July 3, 2015. The estimated Level of effort is 25 man days to be guided by the following schedule.

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Responsible</th>
<th>Proposed Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize / sign the Contract</td>
<td>GlobalCommunities/CHF &amp; Contractor</td>
<td>April 30, 2015 (estimated)</td>
</tr>
<tr>
<td>Launch meeting with Global Communities/CHF KENYA</td>
<td>GlobalCommunities/CHF &amp; Contractor</td>
<td>May 4, 2015</td>
</tr>
<tr>
<td>Review of project documents and hold consultations with staff and partners</td>
<td>Contractor</td>
<td>May 6-11, 2015</td>
</tr>
<tr>
<td>Develop work plan, draft survey instruments and interview/FGD protocol with Global Communities/CHF for review and approval</td>
<td>Contractor</td>
<td>May 6-11, 2015</td>
</tr>
<tr>
<td>Sharing of work plan and all draft Survey instruments and interview/FGD protocol with Global Communities/CHF for review and approval</td>
<td>Contractor</td>
<td>May 16, 2015</td>
</tr>
<tr>
<td>Final Global Communities/CHF reviews and approvals provided in collaboration with MoEST</td>
<td>Global Communities/CHF</td>
<td>May 18/19, 2015</td>
</tr>
<tr>
<td>Pilot testing/finalization of survey instruments by contractor</td>
<td>Contractor</td>
<td>May 20-21, 2015</td>
</tr>
<tr>
<td>Surveys, interviews and/or focus groups of students and peer educators</td>
<td>Contractor</td>
<td>May 25-29, 2015</td>
</tr>
<tr>
<td>Conduct surveys, interviews and/or focus groups with teachers, counselors and school administrators</td>
<td>Contractor</td>
<td>June 2-6, 2015</td>
</tr>
<tr>
<td>Surveys, interviews and/or focus groups of parents and community leaders</td>
<td>Contractor</td>
<td>June 8-12, 2015</td>
</tr>
<tr>
<td>Data cleaning and analysis</td>
<td>Contractor</td>
<td>June 15-19, 2015</td>
</tr>
<tr>
<td>Draft Report submitted to Global Communities/CHF</td>
<td>Contractor</td>
<td>June 22, 2015</td>
</tr>
<tr>
<td>Final Global Communities/CHF comments and input on report</td>
<td>Global Communities/CHF</td>
<td>June 25, 2015</td>
</tr>
<tr>
<td>Final Report, including all Tools and Appendices submitted to Global Communities/CHF and USAID</td>
<td>Contractor</td>
<td>July 3, 2015</td>
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</tbody>
</table>

**Qualifications and Experience**

a) Demonstrated experience in carrying out social science research, particularly related to public health, HIV/AIDS, at-risk youth and/or education for the last 5 to 10 years. Experience working in schools and with youth a plus

b) Demonstrated experience using a variety of research methods, including KAP surveys, interviewing, and focus groups
c) Experience conducting assessments in informal settlements preferably in Nairobi

d) Possess postgraduate training in public health, social sciences or related disciplines

**Reporting**

Contractor shall submit a final report in English at the end of the assessment to Global Communities/CHF via electronic copy. The report must not be longer than 50 pages, excluding an executive summary of no more than 5 pages, a list of key findings and recommendations of no more than 5 pages, and appendices.

Appendices should include:

- Copies of all surveys, interview guidelines, protocol and other instruments used
- List of all individuals, firms and organizations interviewed
- List of reference documents cited
- Dataset and related tools as described above

Before finalizing the report, Contractor shall submit a draft report to Global Communities/CHF for feedback as described under Section VIII TIME FRAME above.
Additional Annexes

Healthy Outcomes through Prevention Education (HOPE) Program: Final Evaluation Report

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