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AIDSFree Strengthening High Impact Interventions for an AIDS-free Generation

IMPROVING HEALTH AND SOCIAL OUTCOMES FOR PREGNANT ADOLESCENTS, ADOLESCENT MOTHERS AND THEIR INFANTS IN KENYA

JIELIMISHE UZAZI NA AFYA (JUA) PROGRAM FINAL REPORT

SEPTEMBER 2019

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AIDSFree

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As of February 2019, the International HIV/AIDS Alliance is Frontline AIDS.

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We dedicate this report to the memory of AIDSFree JUA staff member Carren Amolo.

ACRONYMS

ANC	antenatal care
ART	antiretroviral therapy
CBO	community-based organization
CHV	community health volunteer
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant HIV diagnosis
GBV	gender-based violence
HCW	health care worker
HEI	HIV-exposed infant
HVT	home visiting team
JUA	*Jielimishe Uzazi na Afya*
LTFU	lost to follow-up
MBP	mother-baby pair
MCH	maternal and child health
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
PPD	postpartum depression
SOP	standard operating procedure
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Jielimishe Uzazi na Afya

In Kiswahili, this phrase means "take pride in parenthood and health." It encourages the pregnant adolescent to be confident and have self-worth during pregnancy and to seek health services as appropriate.

Globally, pregnant adolescents and young women are highly vulnerable to HIV, with poor HIV testing coverage and high rates of HIV-related mortality and mother-to-child transmission of HIV. Kenya, with a high rate of adolescent pregnancy, also has high HIV prevalence among female adolescents. This creates parallel risks of unplanned pregnancy and HIV for young women, and of vertical HIV transmission to their infants. Home and community visiting programs present a crucial opportunity to identify young HIV-positive pregnant adolescents and those at risk of HIV infection, and to link them to services, including: antenatal care (ANC); HIV prevention services and care; prevention of mother-to-child HIV transmission services; postnatal care (PNC); early childhood development, and other types of health and social services.

The *Jielimishe Uzazi na Afya* (JUA) program (2017–2019) is an innovative home visiting, case-management intervention to improve health and social outcomes for pregnant adolescents and adolescent mothers (10–19 years) and their infants (0–2 years). The JUA program was implemented by AIDSFree, a five-year project funded by the United States Agency for International Development and the U.S. President's Emergency Plan for AIDS Relief. It is managed by JSI Research & Training Institute, Inc. and the Elizabeth Glaser Pediatric AIDS Foundation, alongside Kenyan community-based organizations Make Me Smile, Kagwa, Adventist Centre for Care and Support, and St. John Community Centre. The JUA program was implemented by AIDSFree in rural and urban communities in three counties: Homa Bay (two wards), Kisumu (three wards), and Nairobi (four wards).

JUA was designed to address the barriers adolescent girls face when accessing and using health and social services—utilizing carefully designed curricula, tools, and job aids developed via a consultative process with stakeholders and building on global evidence on what works for adolescent populations.

While most home visiting programs use peer mentors to talk to adolescents, AIDSFree created a home visiting team (HVT) model that uses peer mentors as well as adult household communication facilitators—both male and female—who work with caregivers and other family and community members in the client's life. The cadre of community-led HVTs focus on three goals: ensuring the adolescents receive antenatal and postnatal care and/or HIV treatment, care, and prevention services; ensuring that babies receive health and development services; and empowering adolescents and building their resilience—their ability to recover from and cope with the stigma, rejection, and emotional stress associated with adolescent pregnancy.

The HVTs consisted of:

1. **Mentors** who offered peer support for pregnant and adolescent mothers to access and remain in ANC and PNC services, including HIV services. Mentors also helped their clients to access social services, including livelihood support, gender-based violence programs, and school retention or re-entry opportunities.
2. **Female and male household facilitators** who worked with household members to address structural barriers to care, decrease HIV- and pregnancy-related stigma/discrimination, support family conflict resolution, and mobilize support.
3. **Supervisors** who ensured HVTs were performing well as teams, assisted with challenging cases, and ensured adherence to quality standards.

Intensive training helped ensure HVTs were well-prepared for the challenging and rewarding work of engaging with adolescents and households and working as a team. Partnerships with community, facility, and school stakeholders fostered a welcoming and supportive environment for each adolescent and her child. AIDSFree trained 167 individuals to serve as JUA HVTs. These mentors, household facilitators, and supervisors identified and engaged with 960 pregnant adolescents and adolescent mothers, enrolling 384 of them in the JUA program. HVTs conducted 7,344 home visits with adolescents to complete individual service plans.

The JUA program helped achieve elimination of mother-to-child transmission of HIV among program beneficiaries, having ensured that 100 percent of beneficiary adolescents living with HIV were initiated on antiretroviral therapy (ART); 94 percent of beneficiaries achieved viral suppression. The HVTs provided support during pregnancy and after delivery: 94 percent of beneficiaries who gave birth delivered their babies with the support of a skilled birth attendant—a rate significantly higher than the Kenyan national average of 61 percent. One hundred percent (18/18) of eligible infants received HIV prophylaxis to help them stay HIV-negative, and 100 percent of postnatal clients with infants below six months of age were mentored on exclusive breastfeeding.

Other key results included:

- Family planning uptake increased from 39 percent to 64 percent.
- JUA enabled school re-entry for 69 postnatal adolescents, and helped 10 at-risk girls be retained in school.
- The program saw an increase in household supportiveness—assessed as willingness to have the adolescent girl enrolled in the project, willingness to have her stay in the household during the pregnancy and/or afterward, willingness to support her to attend to ANC and other health services, and willingness to support the girl's school readmission. Initially, 56 households were not supportive; by end of project, these households were either partially or fully supportive of their adolescents through HVT efforts. The proportion of households that were fully supportive rose from 57 percent to 79 percent.

Overall, the achievements of AIDSFree's JUA program demonstrate how important it is to consider a girls' entire environment—peers, family, school, health care, and community—when supporting her through her pregnancy, delivery, and successful early motherhood.

There were a number of fundamental elements/factors critical to the program's success:

1. Working not only with the adolescent but with the "gatekeepers" around her (including her partner and those in her household, in her school setting, and at her local health facility).
2. Offering a needs-based, case management approach.
3. Involving men as part of the core intervention team as household facilitators.
4. Ensuring a strong network of supervisory support across all levels of the program, which also provided "care for the caregivers" who worked to support the adolescents.
5. Working with community stakeholders, including government officials, to sensitize them to the needs of these adolescents and to foster support.
6. Engaging schools and school leadership, particularly in pregnancy mapping and identification of prenatal and postnatal adolescents. This intervention facilitated early ANC visits and the retention/re-entry of adolescents in school.
7. Using "Mama Packs," which provided a morale boost and motivation (as a non-monetary incentive).
8. Responsive health facilities that were open to listening to the JUA team and adapting improved attitudes around adolescent pregnancy. This spirit of cooperation included offering quality services and doing an excellent job in documenting completed referrals.
9. Intensive training that included a strong focus on role-playing, listening, and motivational interviewing.
10. The hard work of a highly committed and dedicated team, which consisted of both the compensated HVTs as well as the core AIDSFree staff who were passionate advocates and tireless champions in supporting adolescents and paving the way for them to have access to key services.

To achieve an AIDS-free generation, adolescent girls must have the support of their families to use HIV testing and treatment services during and after their pregnancy. The inherent design of JUA—working with not only the adolescent herself, but her parents, caregivers, community members, and men—sought to address critical sociocultural and behavioral barriers in accessing and using health services. HVTs were instrumental in reducing stigma directed at pregnant adolescents and adolescent mothers in their communities, including at schools and health facilities.

Issues and challenges that should be addressed in the next design phase include incorporating a Cash + Care (cash transfer component) and/or similar solution to support adolescent mothers by covering child care costs (to support the adolescents' return to school or work), and increased support for postpartum depression/psychosocial support for pregnant adolescents and young mothers.

BACKGROUND

Adolescents differ from adults in many ways. Their behavior and decisions are heavily influenced by their physical and psychological development and by the social and physical environment they live in. Despite being thought of as "young and healthy," adolescents are at increased risk for many health outcomes that can impact them as adults as well as affect the health of their future children. Adolescent girls are particularly at risk for HIV, sexually transmitted infections, and unintended pregnancy. Programs and policies need to consider the unique experience of adolescents in order to be effective at improving health outcomes in this population.

The parallel risks of pregnancy and HIV for young women, and of vertical HIV transmission for their infants, makes girls and adolescents aged 10–19 years a critically important group. Nearly two million adolescents 10–19 years of age are living with HIV in sub-Saharan Africa (UNICEF 2016) and the number of new HIV infections among adolescents is expected to increase by 2030. In east and southern Africa, adolescent girls 15-19 years of age make up 78 percent of new HIV infections and 25 percent will give birth by age 18 (Kharsany & Karim 2016; Loaiza & Liang 2013; UNAIDS 2016). One in five adolescent girls and young women in sub-Saharan Africa become pregnant by age 18—a rate that will result in an estimated 16.4 million adolescent mothers by 2030 (Santhya 2015).

Box 1. HIV, Pregnancy, and Adolescents in Kenya

More than half (51 percent) of all new HIV infections in Kenya in 2015 occurred among adolescents and young people (aged 15–24 years), a rapid rise from 29 percent in 2013 (UNICEF 2016). Teen pregnancy and motherhood rates in Kenya are also high: about one in every five adolescent girls either has had a live birth, or is pregnant with her first child.

Studies in sub-Saharan Africa have reported that adolescent girls, in comparison to older women, are less aware of their HIV status, have lower antiretroviral therapy (ART) uptake, higher loss to follow-up from prevention of mother-to-child HIV transmission (PMTCT) programs, reduced uptake of early infant diagnosis and increased rates of mother-to-child transmission of HIV (Fatti, Shaikh, Eley, Jackson, & Grimwood 2014; Ronen et al. 2017). Young maternal age also increases the risk for adverse pregnancy outcomes, including maternal mortality and stillbirth (World Health Organization 2018). There are also concerns about the neurodevelopment of HIV-exposed uninfected and HIV-positive infants who experience delays in cognitive, language, and motor functions—indicating a great need for early intervention (Annelies Van Rie, Dow, & Robertson 2007; Whitehead, Potterton 2014). Gender

inequalities create barriers to access health services, particularly for adolescent girls who are constricted by parental consent laws from accessing care (UNAIDS 2016).

Photo: AIDSFree/Marcy Levy.

Client Doreen Kageha Asirigwa, 17, lives with both her parents. Her baby boy was 5 months when they enrolled in JUA.

Improving health and social outcomes for pregnant adolescents, adolescent mothers and their infants requires an increased focus on pregnancy, birth, and the postnatal period. The focus include improving facility-based care and implementing appropriate models of sustainable community-based care to reach the poorest families, especially the peri-urban and rural poor (Global Fund 2017). Home visiting programs to support access to and use of health services by mothers and infants have been advocated for globally for over a decade. The Lancet Neonatal Survival series in 2005 pointed to the potential role of universal outreach and family-community care during the prepartum, peri-partum, and postpartum periods to promote uptake of evidence-based newborn practices including early and exclusive breastfeeding, thermal care, and clean cord care to prevent neonatal deaths (Horton 2005). Programs such as the Philani Plus (+) Intervention Program and the original Philani community health worker home visiting intervention program offer promising examples of scalable programs. In recent years, home visiting models have been adapted to support pregnant and postpartum women and their infants to access and use HIV services. However, implementation varies widely, making it difficult to demonstrate programmatic benefits, especially through the entire PMTCT cascade (Global Fund 2017).

Increased global resources for HIV prevention, care, and treatment for adolescents include the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women (DREAMS) initiative, a public-private partnership launched in 2014 by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to reduce new HIV infections among adolescent girls and young women in 10 sub-Saharan African countries. Similarly, in July 2014 the Joint United Nations Program on HIV/AIDS (UNAIDS) and UNICEF launched the "All In" initiative, which prioritized including adolescents infected and affected by HIV in the global HIV response. Despite this renewed attention, a gap remains related to the specific needs of pregnant and postpartum adolescents and their infants who need PMTCT and other services (Callahan, Modi, Swanson, Ng'eno, & Broyles 2017).

PROGRAM DESIGN

Home Visiting Team Model and Case Management Approach

The *Jielimishe Uzazi na Afya* (JUA) program (2017–2019) program was implemented by AIDSFree, a five-year project funded by USAID and PEPFAR and managed by JSI Research & Training Institute, Inc. and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), alongside Kenyan community-based organizations (CBOs) Make Me Smile in Kisumu (three wards: Kajulu, Kolwa East, and Miwani), Kagwa in Homa Bay (two wards: Kendu Bay Town and Wangchieng), Adventist Centre for Care and Support in Nairobi (two wards: Kabiru and Gatina), and St. John Community Centre also in Nairobi (two wards: Karura and Kangemi).

Photo: EGPAF.

JUA was designed to address the barriers adolescent girls face when using and accessing health and social services. Most home visiting programs use a peer mentor to talk to target clients (i.e., in programs for pregnant women generally). AIDSFree created a home visiting team (HVT) model that uses peer mentors as well as adults—*both male and female*—who work with caregivers, partners and other family and community members in the client's life. This design was intentional, intended to address the barriers adolescent girls face when using and accessing health and social services.

At the core of the JUA model (figures 1 and 2), were a cadre of community-led HVTs who focused on three goals: ensuring that adolescents receive antenatal (ANC), postnatal (PNC) and/or HIV treatment, care, and prevention services; ensuring that babies receive health and development services; and empowering adolescents and building their resilience, their ability to recover/cope with the stigma, rejection, and emotional stress associated with adolescent pregnancy. The HVTs consisted of:

1. **Mentors** who offered peer support for pregnant and adolescent mothers to access and remain in ANC and PNC services, including HIV services. Mentors also helped their clients to

access social services including livelihood support, gender-based violence (GBV) programs, and school retention or re-entry opportunities.

2. **Female and male household facilitators** who worked with household members to address structural barriers to care, decrease HIV- and pregnancy-related stigma and discrimination, support family conflict resolution, and mobilize support.
3. **Supervisors** who ensured HVTs were performing well as teams; assisted with challenging cases; and ensured adherence to quality standards.

Figure 1. HVTs and the Case Management Model

Each **HVT** has 5–8 adolescent clients depending on the catchment area.

2 Household Facilitators, one female and one male, largely pulled from existing community health volunteer (CHV) cadres (aged ~31–45).

Mentor (case manager), sensitive to the issues of pregnant adolescents/adolescent mothers and their infants (aged ~19–30).

Supervisor (2 per ward), at least 3–4 years of work experience in relevant community work.

Intensive training helped ensure HVTs were well-prepared for the challenging and rewarding work of engaging with adolescents and households and worked as a team. Partnerships with community, facility, and school stakeholders fostered a welcoming and supportive environment for each adolescent and her child.

Community and Government Engagement

AIDSFree ensured early and continuous engagement with county leadership, via county health management teams as well as the subcounty health management teams, throughout the design, implementation, and monitoring of the intervention with full buy-in and leadership from these government bodies.

The activity had the full support and buy-in of community leadership, with ongoing communication of successes and challenges through community meetings. Regular communication processes between the adolescent and her household, the HVTs and their supervisor, the CBOs, the JUA in-country management team, and the AIDSFree management team played an important role in smooth implementation.

The AIDSFree team designed the JUA program with active engagement of target youth themselves, as well as the broader community, including traditional leaders. This engagement

helped ensure the JUA program design reflected the needs and concerns facing adolescents as well as community members more broadly.

Overall, the JUA design built on existing community structures, using previously trained community health workers/cadres who are familiar with the health and social systems, infrastructure that is available in most community settings. The JUA design also incorporated tools and processes to ensure enrollment of the most vulnerable adolescents in a feasible and efficient manner through the use of a Vulnerability Screening Tool.

Figure 2. Home Visiting Team Roles and Responsibilities

Mentors

- Enroll adolescents and infants into the program and enroll their partners, whenever possible, upon consent.
- Support the enrollment of adolescents and their households.
- Visit households a minimum number of times, provide household-level and facility-level support/visits for the adolescent.
- Provide navigation assistance and emotional support for the adolescent to help her navigate community and clinical health services.
- Provide basic information on HIV/reproductive health (prevention, ANC, PTMCT) services, healthy relationships, child development.
- Help build understanding and trust between adolescent girls and health system/health providers.
- Support re-entry in school and/or other economic strengthening interventions.
- Compile and submit periodic reports according to reporting schedules.

Household Facilitators

- Introduce activity to community and maintain continuous engagement with community.
- Support identification of pregnant adolescents and infants in collaboration with mentors.
- Support the enrollment of adolescents and their households.
- Work with gatekeepers (especially guardians, parents and partners) and mobilize household support.
- Collaborate closely with and provide support for mentor (and adolescent) as needed, particularly support for ensuring referral and linkages.
- Compile and submit periodic reports according to reporting schedules.

Supervisors

- Provide functional supervisory support for household facilitator and mentor.
- Support the sensitization of community structures and resources.
- Focus on quality assurance and monitoring and evaluation, ensuring referral and linkages with health and social services are functioning.
- Ensure availability to support difficult cases.
- Facilitate monthly meetings with core team, using regular reporting tools.
- Facilitate feedback by the adolescent pregnant girls/mothers, household members, health facilities, and community.
- Compile and submit periodic reports according to reporting schedules.

Box 2. Development of Tools and Processes

To inform JUA program design, the AIDSFree team conducted an extensive review of existing peer-reviewed and gray literature and a review of existing home-visiting programs for pregnant adolescents and pregnant women generally. The team further reviewed a range of curriculum and training materials designed to support home-visiting programs for pregnant and new mothers, noting that very few programs were specifically designed for adolescents. A technical review team determined the key topics to include and determined priority topics for inclusion that are most relevant and useful to the lives of the JUA program's adolescent clients. This review informed the following suite of materials:

- **Facilitator's Training Guide** provides detailed information and resources for training HVT members. This training is ten days in length and is intended for all members of the HVT.
- **SOP 1: Ethical Procedures & Code of Conduct** is an overview of the program's key principles as well as procedures for informed consent/assent. It also covers procedures for reporting child abuse and GBV violations.
- **SOP 2: Case Management** provides clear guidance around the case management approach, the steps for each household visited, and implementing the program's key steps (intake, needs assessment, service planning). This SOP also contains information about the program's data flow and tools, forms, and resources.
- **SOP 3: Supportive Supervision** reviews the supervisory principles for the program.
- **SOP 4: Program Monitoring** reviews the program data flow and M&E procedures.
- **Counseling Cards and Job Aids** offer a series of easy-to-use cards that HVTs can use as easy reference for delivering key health information. These counseling cards are also used extensively in the training. This resource also contains skill sheets to help build the skills of the HVT.

This suite of materials can be used in any setting, but requires review and update to be in line with local laws, policies, and context.

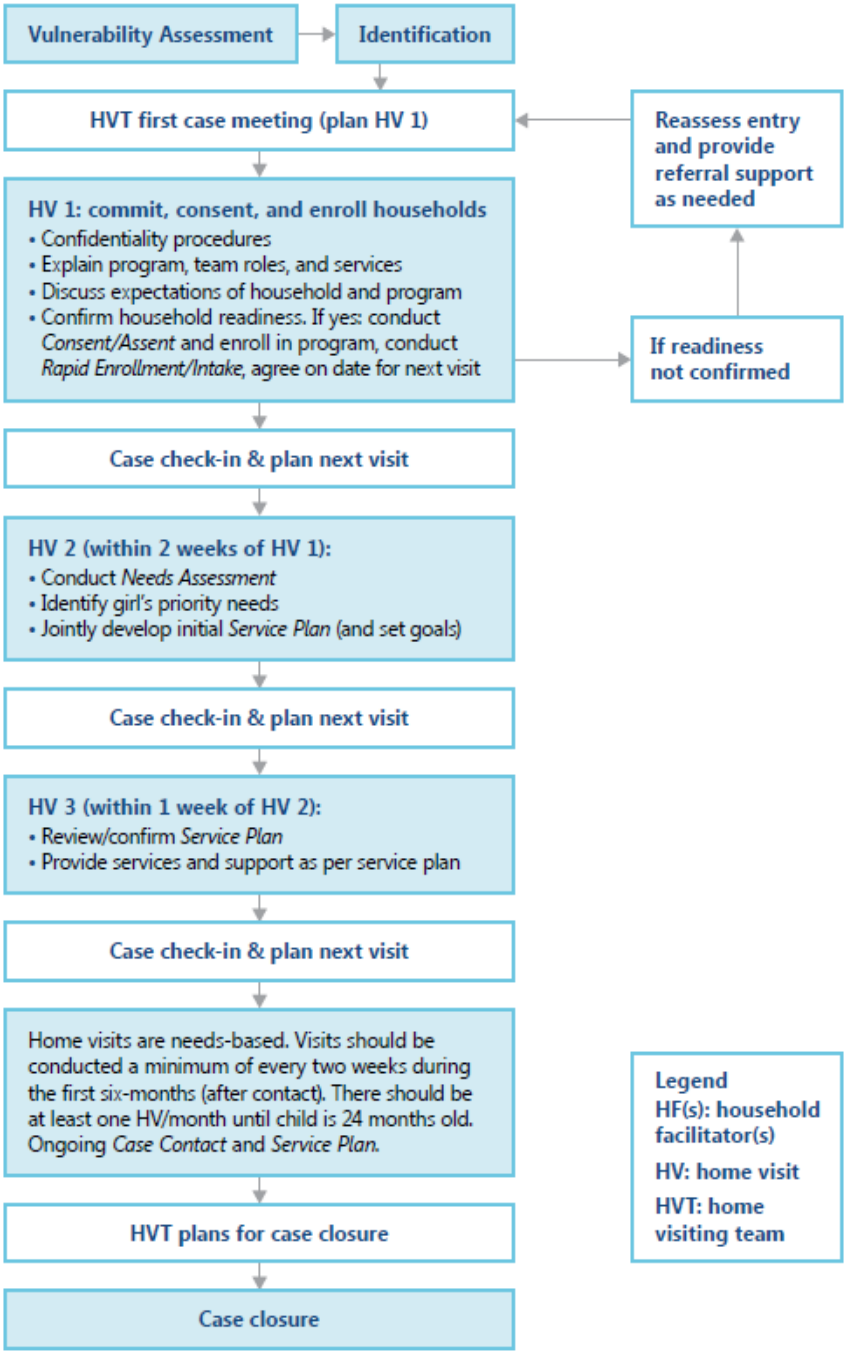
IMPLEMENTATION

The AIDSFree JUA program was guided by a case management approach (see Figure 3). The main goals of case management by the HVT were to:

- Empower individual pregnant adolescents and adolescent mothers and their infants in order to improve their health and social outcomes.
- Empower the target population to overcome barriers to seeking early uptake of ANC and PMTCT for clients who need these services; support adherence to ART; and retain mother-baby pairs in care until the infant is 24 months.

Case management generally follows a cycle of steps to identify and respond to the needs of vulnerable clients. While not always the same for every situation, the case management process for the AIDSFree JUA program moved through the phases described below:

- Identification.
- Assessment (initial and comprehensive levels of assessment).
- Service planning.
- Implementation of the service plan.
- Follow-up and review.
- Case closure.



Home Visiting Team Recruitment and Training

The HVTs were recruited through a comprehensive and competitive process that identified individuals with the skills and previous community-level training to support vulnerable adolescent clients. Recruitment was led by each respective CBO. This process included recruitment for the two household facilitators (one male, one female) to work closely with all household members), pulled largely from existing community health volunteer cadres. Mentors were recruited based on a number of factors including their demonstrated maturity and potential ability to work with adolescents in a sensitive manner. Supervisors were required to have at least 3–4 years of work experience in relevant community work.

Household facilitators and mentors were offered a monthly stipend of Ksh 10,000 (US$98) and transport and airtime allowance of Ksh 2000 (US$19.50). Supervisors received a monthly stipend of Ksh 20,000 (US$195.50) and transport and airtime allowance of Ksh 4000 (U$39).

In January 2018, AIDSFree trained 80 individuals from Homa Bay and Kisumu counties in western Kenya to serve as JUA HVTs; in June 2018, AIDSFree trained 87 from Nairobi. The intensive 10-day, eight-module HVT training included role plays and building motivational interviewing skills (using JUA curricula, tools, and job aids) and capacity building on topics including PMTCT, HIV testing services, antiretroviral adherence and viral suppression; pre-exposure prophylaxis; partner disclosure; screening/referring for postpartum depression; early childhood development; and addressing GBV. Training also highlighted resources to assist the HVTs with their work. These resources include job aids, such as *Attitudes: Building Blocks of Supportive Interactions with Pregnant Adolescents/Adolescent Mothers and Their Households, Building Rapport with Adolescent Girls and Their Households, Basic Information about Active Listening*, and *Skills for Motivational Interviewing* (available as part of the training package).

Box 3. HVT Training Modules

- **Module 1.** Context of and Need for this Program
- **Module 2.** Communicating with Adolescents and Adults in Households
- **Module 3.** Empowering Adolescents to Achieve Zero New Infections
- **Module 4.** ANC & PMTCT Services: Supporting Retention and Adherence of Pregnant Adolescents/Adolescent Mothers and their Infants
- **Module 5.** Postpartum Care and Caring for Infants/Toddlers
- **Module 6.** Supporting Adolescent Mothers with Child Development Knowledge and Skills
- **Module 7.** Supporting Adolescents in Developing Life Skills
- **Module 8.** Program Monitoring and Evaluation

Identification of Clients

AIDSFree aimed to enroll 384 adolescents across all four sites (eight clients total per HVT, 96 clients total per CBO). As a first step, the HVTs used JUA mapping tools to identify pregnant adolescents and adolescent mothers in their respective areas of coverage. This process included reviewing existing Ministry of Health household mapping registers, holding sensitization sessions at meetings of women's groups, churches, and other social settings, as well as identifying potential clients through referrals from community health volunteers and other key informants, such as facility-based midwives, traditional birth attendants, other pregnant women, teachers, and school administrators.

Photo: AIDSFree/Marcy Levy.

AIDSFree JUA staff member Samuel Odoung discussing the role of data collection and monitoring during HVT training, January 2018.

Once HVTs compiled a list of potential clients, they obtained informed consent from the adolescent and her household, as guided by the JUA Program's Standard Operating Procedure (SOP) 1: Ethical Procedures & Code of Conduct, which includes clear procedures for informed consent/assent. In total, HVTs screened 960 pregnant or adolescent mothers for eligibility across all sites.

Out of the 960 pregnant or adolescent mothers screened, 384 were enrolled across all sites. Each screened client (even those who were not subsequently enrolled) received one session on feedback and support for referrals from the HVT. Enrolled clients were offered another household consent process, and those who agreed to enroll in JUA were provided with a unique tracking code. Those not enrolled were not categorized as "most vulnerable/at-risk" based on eligibility criteria, and enrollment was limited to eight adolescent girls per HVT.

Household Visits

Once a client was enrolled, the HVT undertook a detailed needs assessment process, typically led by the mentor with the support of the household facilitators. The *Needs Assessment* captured key data about the adolescent, her pregnancy and/or child, and other information (living status, health needs including HIV status). This participatory process served a number of purposes: It was the initial activity to identify an adolescent's needs (to inform her service plan*)*; provided an opportunity for the HVT to better understand how to tailor health education messages (and start to provide these during the *Needs Assessment* if necessary); and provided a context for building rapport and trust between the Mentor and the adolescent. Importantly, this process helped identify immediate referral needs, such as if the adolescent was pregnant and had not yet accessed ANC; did not know her HIV status; demonstrated any pregnancy danger signs; showed signs of postpartum depression; and/or showed signs of child abuse/GBV. The needs assessment activity led directly into action planning, whereby the adolescent client, her household (if appropriate), and the HVT developed a personal, detailed service plan laying out goals and milestones to be achieved. This service plan was then revisited monthly and adjusted over time.

While home visits were generally needs-based (per the needs identified in the service plan), home visits by the HVT were conducted a minimum of every two weeks during the first six months after contact, and included at least one household visit per month until the child was 24 months old. Each home visit was guided by a set of principles outlined in SOP 2: Case Management, which included being respectful, making friendly conversation, showing concern, giving the required messages, answering questions correctly, and not hesitating to say "I don't know the answer" (and asking permission to share the answer later once the HVT member has investigated further or consulted with other HVT members and/or their supervisor). JUA also developed detailed counseling cards and job aids for use among HVTs to easily reference and deliver key health information to adolescent clients and their households.

Box 4. Reaching the Most Vulnerable: JUA's Vulnerability Screening Tool

To determine eligibility, reduce bias in the selection process, and ensure JUA prioritized the most vulnerable adolescents and households, the HVTs used a Vulnerability Screening Tool. This tool provided an assessment of a potential client's vulnerability, looking at HIV status and other factors, including school status of the adolescent, mental challenges, physical disabilities, living in a child-headed household, and age (with those between 10–12 years of age being flagged as the most vulnerable). This process helped narrow down the list of clients from the 960 identified to the 384 enrolled.

During these home visits, HVTs worked directly with the adolescent, spoke to caregivers about feelings of discomfort with their daughter's pregnancy, and tried to shift caregivers' attitude and help them find positive ways they could support the adolescent and her child. The HVT and family would work together to address support needed for adolescent postpartum depression (more common in adolescents than adults), to attend clinic appointments for adolescents and their children, ensure birthing plans were in place for a skilled delivery, and work with the adolescent to find child care so she could resume school and/or employment post-delivery.

Photo: AIDSFree/Marcy Levy.

A newly formed HVT team practices role-playing meeting with the adolescent and caregiver during HVT training, January 2018.

Typically, the male HVT member worked especially closely with men and boys in the adolescents' life to foster their support for the adolescent and baby. The HVTs also worked with other stakeholders, including local school administrators, to allow the adolescent to continue or resume her education; health facility management to ensure they were prepared to accept young clients; and with other community groups to build a culture of support and to identify services that would accept referrals.

Feedback from the adolescent and the household was used to improve and inform subsequent visits. Case contact forms were completed by the HVTs after each visit, summarizing the priority needs identified for the next visit. The JUA team also distributed Mama Packs to ensure the new young mothers had essential items to care for themselves and their baby; these included a bar of soap, baby shawls, sanitary napkins, baby linens, a wash basin, and petroleum jelly.

Supportive Supervision

Day-to-day support for the activities of the household facilitator and mentor came from the supervisors. These staff played a critical role in ensuring quality assurance processes and tools were implemented, and supported the HVTs to problem-solve and manage their cases effectively. This relationship was especially important as the HVTs were often dealing with highly complex and complicated issues, including suicidality and abuse (physical, substance, etc.) among adolescents. The supervisors were also responsible for receiving weekly reports from HVTs, which were then compiled and shared with the CBOs. The supervisors also provided debriefing to their teams, as care for the caregiver became highly important to ensuring that the JUA team remained mentally healthy and able to navigate their complex roles.

Photo: AIDSFree/Marcy Levy.

Client Imelda with her husband, baby, and JUA program home visiting team. Imelda and her husband Bernard joined JUA after the birth of their baby. All three family members are HIV-positive. The HVT's Male Facilitator spent time with Bernard, talking to him about the importance of supporting his wife and child's treatment plans. The HVT linked the family to the Rabuor Health Centre and helped the couple navigate a plan for monthly HIV medication adherence assessment and counselling. With JUA's support, the couple adhered to their treatment plan. Follow-up test results for Imelda and her child showed they both achieved viral suppression. The couple was also adhering to the family plan that they developed with the JUA team.

The AIDSFree team also provided supportive supervision to CBOs for implementation. For day-to-day management, AIDSFree ensured that the CBO partners were actively engaged with recruitment, supervision, and management of the HVTs. Monthly management meetings between the AIDSFree team and the CBOs were held to discuss details around program implementation and troubleshoot challenges.

Health Facility and School Engagement

Collaboration with and active engagement of health facilities played a large part in the AIDSFree JUA program design and implementation. The AIDSFree JUA staff and HVTs worked closely with community health facilities to ensure these facilities and staff were ready to accept pregnant adolescent clients and new young mothers without stigma, and to ensure functioning bi-directional referrals. The county health management teams were consulted on the design and

subsequently sensitized on the model for buy-in and ownership. This process resulted in health facility staff embracing the intervention and supporting the implementation at that level.

JUA adolescent client with her infant.

Photo: EGPAF/Kenya.

The AIDSFree JUA team also worked with public primary and secondary schools to sensitize them on pregnancy mapping and need to prevent adolescent clients from dropping out of school when pregnant, and worked to facilitate their re-entry after delivery. The team drew on the *Kenya School Health and the School Re-admission Policies* as an advocacy tool, to sensitize local school administrators and teachers to implement the provisions. In some cases, the program helped the schools secure support from other partners to sustain retention in school.

Referral and Linkages

Offering and supporting referrals and linkages to health and social services was an essential component of the JUA program. Early on, the AIDSFree JUA program fostered key relationships with other U.S. Government implementing partners, other donor-funded projects, and other local health and social services. Key reference services included the Kenya Department of Children Services, local administration, GBV services, health facilities, and other PEPFAR implementing partners for DREAMS, OVC, and HIV testing services. Networks for referrals and linkages were also important for providing resources, such as support groups and social activities, to help pregnant adolescents/adolescent mothers and their households cope with the isolation, social stigma, and emotional stressors that they often face. The relationships built with these partners helped facilitate AIDSFree JUA's clients to be absorbed into existing services when the program ended.

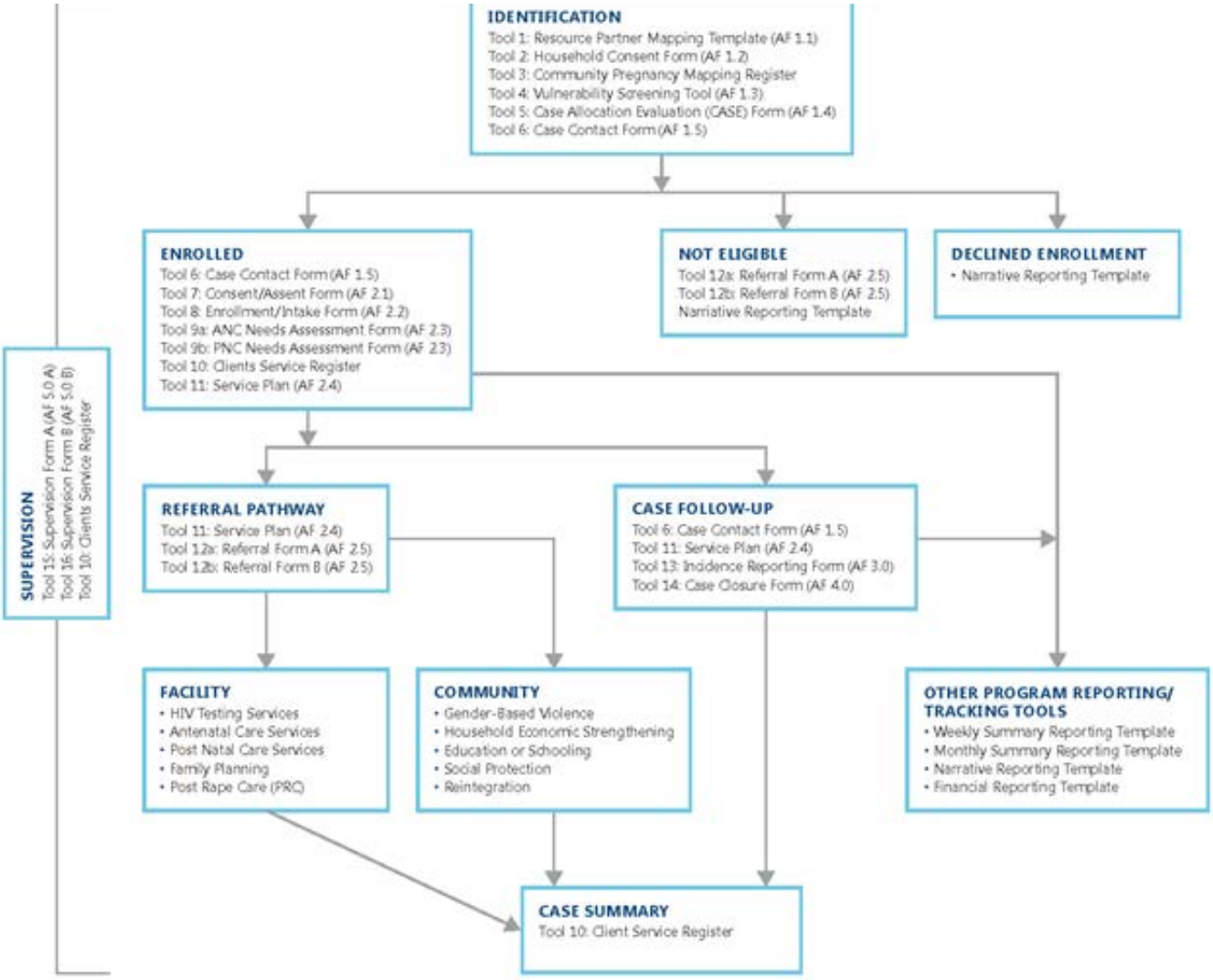
In Kisumu, 13 adolescent clients were linked to the orphans and vulnerable children program implemented by Make Me Smile, 21 clients were enrolled in the DREAMS project implemented by Centre for Study of Adolescents, 23 were enrolled in the DREAMS project implemented by the Partnership for an HIV-Free Generation, and three HIV-positive adolescents and HIV-exposed infants have been transitioned to the U.S. Centers for Disease Control and Prevention-funded FACES Project. In Homa Bay, the nine HIV-positive adolescents and their infants were transitioned to EGPAF's Timiza90-suported project, while Watoto Msilie supports one of the beneficiaries through school fees. In Nairobi, the Afya Jijini DREAMS Project absorbed 17 of the

adolescent clients. The remaining eight were linked to vocational training institutions courtesy of the office of the Member of the County Assembly in Kangemi. 31 beneficiaries were enrolled into the DREAMS project implemented by LVCT Health in Kawangware. All HIV-positive adolescents and HIV-exposed infants were linked to ongoing care and support services.

Monitoring and Evaluation

Data Collection and Monitoring

AIDSFree developed and used a comprehensive data monitoring system (Figure 4), guided by SOP 4: Program Monitoring. The JUA team included designated monitoring and evaluation staff to ensure high-quality data recording, reporting, and documentation; as well as a JUA monitoring and evaluation officer who worked with CBOs and supervisors to provide mentorship, monitor data recording, and support the analysis and use of data to inform program improvement.



Monitoring and Evaluation Tools

Monitoring was intrinsic to the design of the HVT case management flow, whereby cases were monitored on an individual basis. A careful selection of programmatic indicators enabled the team to track progress, including the number of individuals reached, HIV knowledge and status indicators (PEPFAR indicators), treatment/care and service uptake indicators (PEPFAR indicators), knowledge and health outcomes for the infant, social protection indicators, and indicators examining changes in attitudes and norms.

The sources of the indicator metrics included a longitudinal register (a tool to track individual pregnant adolescent/mothers and infants enrolled in the program), the existing Kenyan *Ministry of Health Mother & Child Health Handbook (Afya Ya Mama Na Mtoto)*, and a number of national registers which already captured information on pregnancy and HIV (including the national ART, maternity, and PNC register, the HIV-exposed infant register, the ANC register, the HIV testing services register, the linkage register, and the Ministry of Health Sexual and Gender-Based Violence register). The deliberate integration of JUA monitoring with national Kenyan facility and other service monitoring helped ensure the program did not create duplicate systems and/or create an extra burden on both staff and clients.

See Annex 1 for a summary of tools and templates developed by AIDSFree for the JUA program.

RESULTS

Enrollment in Program

AIDSFree trained 167 individuals to serve as JUA HVT members. These mentors, household facilitators, and supervisors identified and engaged with 960 pregnant adolescents and adolescent mothers, enrolling 384 of them in the JUA program. HVTs conducted 7,344 home visits with adolescents to complete individual service plans. Table 1 is an overview of key JUA program indicators by CBO—Make Me Smile (MMS), Kagwa, Adventist Centre for Care and Support (ACCS), and St. John Community Centre (SJCC).

Retention in Care

The JUA program had a target of a minimum of two household visits monthly for each beneficiary. These visits were structured through the use of a service plan. On average, 80 percent of beneficiaries received the minimum visit dosage. Challenges to completing the minimum requirement included flooding in some regions during the rainy season, clients' occasional absences from their residences due to up-country visits during festive seasons, and migration out of the program area by the beneficiaries' households.

Nearly all enrolled adolescent girls (92 percent) were retained through their anticipated tenure in the JUA program. Case closures included migration out of the program area, age of mother or infant beyond program range, miscarriage, non-cooperation by household; and death of infant or mother (See Table 1).

Table 1. Program Indicators by Community-Based Organization

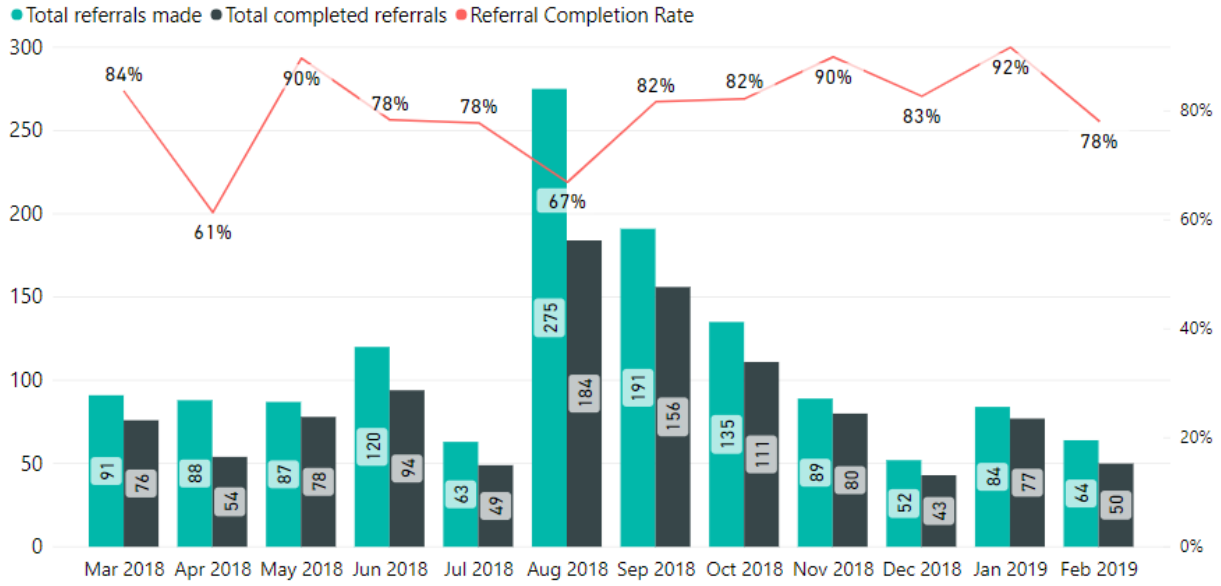
Indicator	SJCC	ACCS	KAGWA	MMS	Total
Total ANC clients identified	109	92	144	74	**419**
Total PNC clients identified	131	148	96	166	**541**
Known HIV-positive clients enrolled	6	1	9	4	**20**
Newly identified HIV-positive	0	0	1	0	**1**
Positives ever enrolled	6	1	10	4	**21**
Positives active at end of program	4	1	9	4	**18**
Known HIV-positive infants enrolled	0	0	0	1	**1**
Total ANC clients enrolled	39	35	42	54	**170**
Total PNC clients enrolled	57	61	54	42	**214**
Cases closed	11	14	4	0	**29**

Referrals

A critically important component of the AIDSFree JUA program was ensuring strong referral networks. JUA focused on ensuring both community-based and facility-based referral systems were in place with an emphasis on ensuring services were appropriate for and well-received by JUA's adolescent clients.

Referral forms were issued in triplicate—one remaining in the referral booklet, one remaining at service delivery point, and one returned to the HVT by the beneficiary to ascertain completion and filed at the CBO. Completion was defined when the adolescent carried out a health or social service referral and accessed a service delivery point, receiving the service or not, but documentation completed to ascertain they visited the facility for the service. Overall a 79 percent completion rate was achieved by the program (see Figure 5).

Figure 5. JUA Program Referrals and Completions



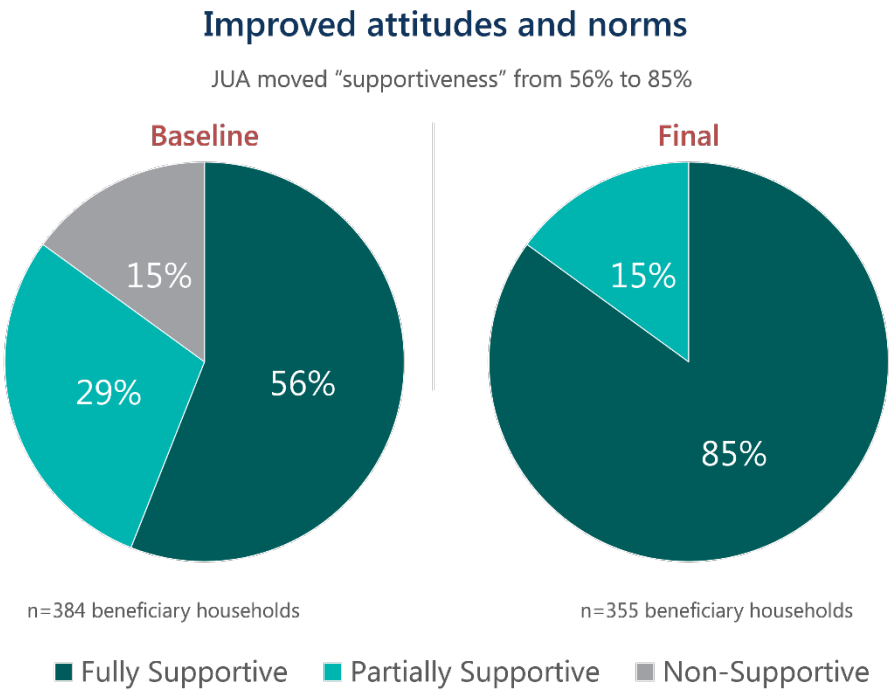
Enabling Environment (Household)

There is stigma against adolescents who become pregnant, with caregivers considering their daughter's pregnancy as a source of shame (especially if it is out of wedlock). Adding to the challenge faced by a young pregnant woman is that many men in Kenya consider pregnancy, motherhood, and child welfare the responsibility of the women in their household. However, when an adolescent girl becomes pregnant and gives birth, she needs the support of all of her family members, including her father and male partner, to successfully access care, give birth to a healthy baby, and subsequently care for herself and the baby.

In addition to mentoring and counseling the adolescent, the AIDSFree JUA program worked

directly with the adolescent's household members and male partner so they better understood the challenges the adolescent faced, and the importance of her receiving ANC and postnatal care as well as HIV services.

Figure 6. Household Support, Baseline to End of Program



The program developed a checklist to categorize household support. The checklist assigned points for household willingness to allow adolescent to remain in household, willingness to pay for health services, and support for the adolescents return to school. At baseline (387 beneficiaries), 56 were from "non-supportive" households, 111 from "partially supportive" households, and 217 from "fully supportive" households. The 56 households initially not supportive were either observed as partially or fully supportive at the end of project. Overall, the JUA program increased household supportiveness from 57 percent to 85 percent (Figure 6).

Health and Social Outcomes (Mother)

Safe Delivery

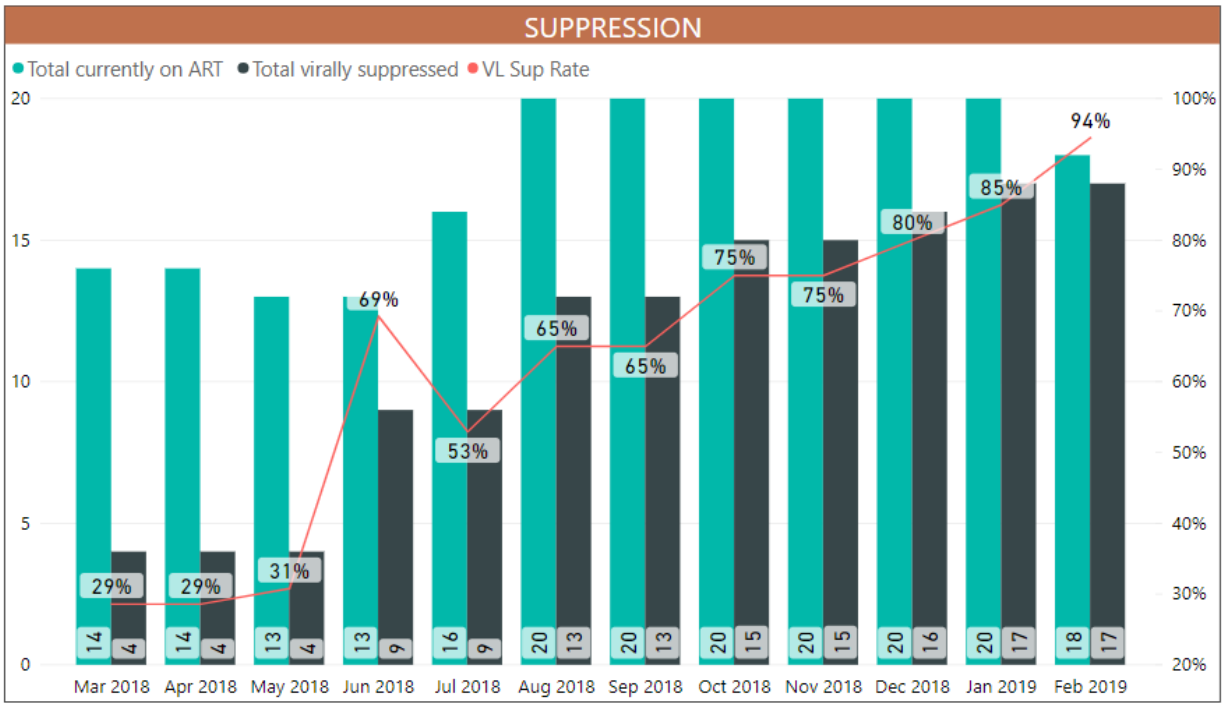
The HVTs provided support during pregnancy and after delivery; ensuring that adolescents give birth with a skilled attendant present dramatically increases their likelihood of a safe delivery and healthy baby, a key goal of the JUA program. By linking adolescents to the *Linda Mama* program, a publicly funded health scheme to ensure that pregnant women and infants have access to quality and affordable health services, 94 percent of beneficiaries who gave birth delivered their babies with the support of a skilled birth attendant. This 94 percent skilled

delivery rate is significantly higher than the Kenyan national average of 61 percent. Most adolescents who did not deliver with a skilled attendant had transportation challenges.

Antiretroviral Therapy and Viral Suppression

The JUA program helped achieve elimination of mother-to-child transmission of HIV among program beneficiaries, having ensured that 100 percent of beneficiary adolescents living with HIV were initiated on ART and 94 percent achieving viral suppression at the end of the activity (Figure 7). Not all infants enrolled reached cessation of breastfeeding; final or up-to-date virologic tests were reviewed to confirm that no HEI tested HIV-positive.

Figure 7. Viral Suppression



Family Planning Utilization

Twenty percent of women in Kenya cannot access the contraceptive they want, a statistic that is higher (25 percent) among adolescents age 15–19, and 73 percent of currently sexually active single women aged 15–19 report not using any contraception method. Postnatal adolescents enrolled in the JUA program continued to voluntarily use family planning services as a result of the continuous sensitization on the benefits of family planning by the HVTs—227 beneficiaries adopted a family planning method (from a baseline of 37 clients at program onset) including oral contraceptive pills and injectables. Overall, the JUA program contributed to raising the family planning uptake among its postnatal beneficiaries from 39 percent at baseline to 64 percent at the end of project.

School Retention and Re-entry

The Kenya school readmission policy states that a pregnant, school-going adolescent should be allowed to continue with her education until the time she delivers, and school-going mothers should be allowed back to school after childbirth. The program supported 10 girls to be retained in school through completion of their primary and secondary education. A total of 69 beneficiaries were also supported to gain re-entry into school by the JUA program. All 25 ANC clients who were either in school or supported to gain readmission were retained in their respective schools through delivery. In total, 72 beneficiaries were retained in school at the end of the program.

Social Services

Home visiting teams linked adolescents to crucial social services—such as those providing livelihoods opportunities, resources to address GBV, and education opportunities—providing 774 referrals and working with their clients to access social services.

Health and Social Outcomes (Baby)

HIV-Exposed Infants

All eligible infants (18/18) received HIV prophylaxis to help them stay HIV-negative, and 100 percent of postnatal clients with infants below six months of age were mentored on the practice of exclusive, safe breastfeeding. All HEIs had up-to-date virologic tests and none tested HIV-positive by the end of the activity.

Immunizations

The AIDSFree JUA program supported 332 infants to access immunization services on the correct schedules, per Kenyan infant immunization guidelines. This outcome was tracked by the use of the infant checklist, which monitored each of the required immunizations at various ages.

Infant Mortality

During the intervention, there were four infant deaths. Two of these infant deaths occurred while the clients were still in the hospital post-delivery and two occurred at home. Of the deaths at home, one was due to complications from a botched traditional birth attendant delivery and one choked during feeding.

Birth Certificates

The HVTs conducted follow-ups to ensure that 206 infants received birth notifications to facilitate registration for birth certificates, as required by Kenyan law. Some of these were infants

of adolescents enrolled as PNC clients, but their infants had never received the vital document. The remainder was those who were born during program implementation and therefore the HVT made follow-ups with facilities whenever an adolescent presented for delivery to ensure registration was handled upon discharge.

LESSONS LEARNED & RECOMMENDATIONS

The AIDSFree JUA design included a number of fundamental elements critical to the programs' success, including:

Photo: EGPAF/Kenya.

1. Working not only with the adolescent but with the gatekeepers around her (including her partner and those in her household, school, and local health facility).
2. Offering a needs-based case management approach.
3. Involving men as part of the core intervention team as male household facilitators.
4. Ensuring a strong network of supervisory support across all levels of the program which also provided care for the caregivers who worked to support the adolescents.
5. Working with community stakeholders, including government representatives, to sensitize them to the needs of these adolescents and foster support.
6. The engagement of schools and school leadership, and particular the schools' participation in pregnancy mapping and identification of prenatal and postnatal adolescents, which facilitated early ANC visits and the retention/re-entry of adolescents in school.
7. The issue of Mama Packs, which were a great morale boost and motivation (as a non-monetary incentive).
8. Responsive health facilities that were open to listening to the JUA team, and adapting improved attitudes around adolescent pregnancy. This cooperation included offering quality services and doing an excellent job in documenting completed referrals;
9. Intensive training that included a strong focus on role-playing, listening and motivational interviewing.
10. The hard work of a highly committed and dedicated team members (both the paid HVTs as well as the core AIDSFree JUA staff), who were passionate advocates and tireless champions in supporting adolescent clients and paving the way for them to have access to key services.

Structural Design and Looking Holistically

Overall, the achievements of the AIDSFree JUA program demonstrate how important it is to consider a girls' entire environment—peers, family, school, health care, and community—when supporting her through her pregnancy, delivery, and successful early motherhood. The inherent design of JUA—working with not only the adolescent herself, but her parents, caregivers, community members, as well as men—sought to address critical sociocultural and behavioral barriers in accessing and using health services. AIDSFree used both female and male facilitators to reach all of the members of the adolescent's household. Parents and guardians play an important role in the lives of their adolescent girls, impacting girls' ability to receive medical care, attend school, and work outside the home. HVTs played a critical role in reducing stigma directed at pregnant adolescents and adolescent mothers in their communities, including at schools and health facilities. The engagement of the family during the visits and counseling sessions enhanced the relationship between the parents and adolescents. With the support of their families and the JUA HVT, adolescents were better able to access medical care in a timely manner.

Engaging Men and Boys

Many men in Kenya consider pregnancy, motherhood, and child welfare the responsibility of the women in their household. However, when an adolescent girl becomes pregnant and gives birth, she needs the support of all of her family members, including her father and male partner, to successfully access care and give birth to a healthy baby. Typically, the male HVT member worked especially closely with men and boys in the adolescents' life to foster their support for the adolescent and baby. As men may be uncomfortable discussing sexual and reproductive health matters with women, the male household facilitators of the JUA program were able to share information with them in an acceptable way. JUA male facilitators provide these men with guidance on how best to support their partner or daughter throughout her pregnancy and the postpartum period; such guidance includes counseling on safer sex practices for male partners and HIV prevention and treatment for fathers.

Training

The rigorous and transparent recruitment and training process helped lead to the success of the JUA program. The minimum recommended training is 10 days with two additional days for practical, hands-on training. It is recommended to run simultaneous trainings (for example, when training commenced for four sites in western Kenya; the JUA program ran four simultaneous trainings requiring approximately 10-12 trainers onsite for 10 days). Additionally, the training not only focused on key HIV, ANC, PNC, and family planning knowledge (among

other topics), but on the skills the HVTs needed to work with adolescents, such as active listening, role-playing, and motivational interviewing. The HVTs routinely role-played with their fellow HVTs, building trust and rapport, learning how to negotiate challenging situations, and getting constructive feedback.

Stakeholder Engagement

Early and continuous engagement with county leadership (via community and subcounty health management teams) throughout the design, implementation, and monitoring of the intervention was key to its success. Collaboration and active engagement of health facilities played a large part in the JUA program design as well.

Engagement of Schools and School Retention/Re-entry

The AIDSFree team worked with public primary and secondary schools to help prevent adolescent clients from dropping out of school when pregnant, and worked to facilitate their re-entry after delivery. The team used the *Kenya School Health Policy* and the *School Re-admission Policy for Adolescent Mothers* to sensitize local school administrators and teachers to implement the provisions.

Care for Staff

HVTs, as well as the AIDSFree support team, encountered numerous challenging situations during visits. These included situations regarding:

- Child welfare/abuse in the household.
- Suicidal and highly depressed adolescents.
- Adolescent clients with mental illness.
- Abandoned infants.
- Adolescent mothers and children with disabilities.
- Strained relationships between the parents and the adolescent girl due to her pregnancy and the hostile environment it created for the girls.
- Traditional beliefs and customs that resulted in the adolescents and their infants being barred from taking refuge in their parents' houses, among others.

These situations were highly taxing for the HVTs, requiring intensive hours and emotional investment. Some cases were also particularly difficult for the HVTs to navigate (for example, a hostile family member) as the HVTs often worked in the same communities in which they lived. These situations were also challenging for the AIDSFree JUA staff who assisted with complex cases. To support the JUA team, the program instituted additional supportive supervision group

discussions to share experiences and provide support, and the AIDSFree JUA staff were always available to support the CBOs and teams. The team also liaised closely with child protection bodies in each community, as well as health facilities offering mental health services. Future iterations of this program should include additional design elements to ensure staff and the team have the resources and support they need to deal with the many highly complex challenges they may encounter. This support could include engagement of mental health professionals from the beginning of the program (to advise program staff), engaging closely with organizations that support disabled adolescents, and ensuring other referee networks are firmly in place to support clients.

Cash Transfer, Daycare, and Other Support

A key issue that should be addressed in future iterations of this project is cash incentives for adolescents. Incorporating a 'Cash + Care' (cash transfer component) and/or similar solution to support adolescent mothers in covering child care costs to support the adolescents' return to school or work). Additional funding to cover the provision of sanitary pads, drugs, tests/scans, and delivery is also recommended.

Mental Health

HVTs were briefly trained to use the Edinburgh Postpartum Depression Screening tool (Cox & Holden 2003) to identify cases of postpartum depression—although in retrospect, this was an area that required more training, on-the-job practice, and guidance. HVTs worked together to help households find support for postpartum depression. Increased support for postpartum depression/psychosocial support for pregnant adolescents, young mothers, and adolescents whose birth resulted in a stillbirth is recommended for future adaptation or scale-up. The postpartum depression training should also be made available for health care workers to equip them with the skills to identify and manage PPD risk factors for the condition. In addition, inclusion of a mentor mother specifically for HIV-positive adolescents and provision of safe spaces for adolescent girls is also recommended.

Challenges

Significant challenges facing the AIDSFree JUA program included the following:

- Short implementation timeframe, which made it difficult to focus on addressing broader structural barriers facing adolescents, as well as complex issues such as adolescent psychosocial well-being.
- JUA's design did not include school fee support (while primary and secondary schools in Kenya are free, there are additional changes such as lunch and supply fees which still make

attendance prohibitive). The majority of girls who were willing to rejoin school could not do so, due to the added cost of child rearing and cost of education.

- Similarly, daycare costs for the children of JUA's adolescent clients were a major deterrent to returning to school or identifying livelihood opportunities. The JUA team strongly recommends future iterations of the program consider Cash + Care (cash transfer) interventions or other interventions to support safe child care options so the adolescents could return to school or work.
- Follow-up for clients migrating out of the JUA target areas was a big challenge, especially in informal settlement communities, which have higher levels of mobility than the rural target areas.
- For cases of GBV, families were not willing to pursue perpetrators. In some instances, cases were handled in traditional courts; there was no way to assess whether the outcome reflected national policies or laws.
- There were difficulties in some areas in transitioning beneficiaries after the program ended. Many projects do not have a socioecological model addressing multiple components facing adolescents.

WAY FORWARD

AIDSFree's JUA program demonstrates how critical it is to consider an adolescent's entire environment—peers, family, school, health care, and community—when supporting her through her pregnancy, birth, and early motherhood. Future iterations of this program should consider a longer timeframe, a cash transfer initiative to support child care costs, and an increased focus on addressing postpartum depression and psychosocial needs. The suite of materials developed to support the JUA model can be used in any setting, but require review and update to align it with local laws, policies, and context.

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ANNEX 1. SUMMARY OF RESOURCES, TOOLS AND TEMPLATES

To receive a copy of these tools and resources, please contact Marcy Levy (marcylevy@gmail.com) or Job Akuno (jobakuno@gmail.com)

Tool	Purpose	Who completes the tool	When the tool is used	Frequency
Tool 1: Resource Partner Mapping Template	To map resources available in the community, including other partner programs, privately offered services, and social services.	HVT	Program onset	Regular refresh to keep the list current is highly recommended
Tool 2: Household Consent Form	To document consent given to HVT by household head to conduct the vulnerability screening assessment for the targeted pregnant adolescent/adolescent mothers in their household.	HVT	During the vulnerability assessment visit	One time (for each targeted pregnant adolescent or adolescent mothers)
Tool 3: Community Pregnancy Mapping Register	To map pregnant adolescents and adolescent mothers in the community	HVT	During the mapping exercise	One-time exercise aimed at identifying potential program beneficiaries
Tool 4: Vulnerability Screening Tool	The tool is used to assess vulnerability of pregnant adolescent or adolescent mothers and determine whether they will be enrolled in the program.	HVT	During the Vulnerability Assessment Visit	One time (for each targeted pregnant adolescent or adolescent mother who are eligible for the program)
Tool 5: Case Summary and Allocation Form	To review all screened cases and determine enrollment and allocate the case to relevant HVTs.	Supervisor	During selection and allocation of cases	One time (during selection and case allocation)
Tool 6: Case Contact Form	To document services provided to pregnant adolescent or adolescent mothers and any noted emerging need during the home visit. The ongoing and/or emerging need will inform the service plan and referral services provided.	HVT	During the home visits	Ongoing (after every home visit)

Tool	Purpose	Who completes the tool	When the tool is used	Frequency
Tool 7: Consent/Assent Form	To document consent or assent given by adolescent or guardian agreeing to be enrolled into the program.	HVT	During the Enrolment Visit	One time (for each enrolled pregnant adolescent or adolescent mother)
Tool 8: Enrollment/Intake Form	To obtain information about pregnant adolescent or adolescent mothers at enrollment.	HVT	During the Enrolment Visit	One time (for each enrolled pregnant adolescent or adolescent mother)
Tool 9a: ANC Needs Assessment Form A Tool 9b: Postnatal Care Needs Assessment Form B	To assess and document service needs for pregnant adolescent or adolescent mothers at enrollment to enable the HVTs to best tailor support to identified need(s).	HVT	During the Enrolment Visit	One time (for each enrolled pregnant adolescent or adolescent mother)
Tool 10: Clients Service Register	To facilitate longitudinal tracking of performance for the pregnant adolescents or adolescent mothers and their infants.	Supervisors and/or CBO's M&E staff	Continuous	Longitudinally updated after every contact visit
Tool 11: Service Plan	To summarize the barriers and enablers from the needs assessment and set the goals/milestones to be achieved by individual adolescents.	HVT	After the needs assessment	Ongoing (after needs assessment and then monthly thereafter as informed by the case contact findings)
Tool 12a: Referral Form A_ Health (**Facility services referral)**	To document referrals for health facility-based services provided to pregnant adolescents or adolescent mothers.	HVT	During the home visits	Any time referral is made
Tool 12b: Referral Form B_ Social (**Community services referral)**	To document referrals for social protection services provided to pregnant adolescents or adolescent mothers.	HVT	During the home visits	Any time referral is made
Tool 13: Incidence Reporting Form	To document incidents and refer pregnant adolescent or adolescent mothers for GBV support services.	HVT	During the home visits	Any time HVT are made aware of a GBV incident among a pregnant adolescent or adolescent mother enrolled in the program

Tool	Purpose	Who completes the tool	When the tool is used	Frequency
Tool 14: Case Closure Form	To document case closure once the adolescent is no longer enrolled in the program. Reasons for closure should be documented.	HVT	During the home visits	Any time adolescent enrolled in the program is exited from the program
Tool 15: Supervision Form A	To prepare a supervision visit.	Supervisor	During supervision	Monthly
Tool 16: Supervision Form B	To document supervision outcomes.	Supervisor	During supervision	Monthly
Weekly Summary Reporting Template	To report to EGPAF on weekly performance on select data elements.	CBO's M&E staff	During weekly reporting	Weekly via SMS
Monthly Summary Reporting Template	To report to EGPAF on monthly basis on performance on select data elements and indicators.	CBO's M&E staff	During monthly reporting	Monthly
Narrative Reporting Template	To provide narrative report on progress on CBO's performance on agreed deliverables	CBO's management	During monthly reporting	Monthly
Financial Reporting Template	To provide financial report in order to facilitate timely resource disbursement, identify any concerns and ensure continuity in service provision to beneficiaries and prudence use of resources	CBO's management	During monthly reporting	Monthly

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