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Qualitative Evaluation of the Lea Toto Adolescent Program in Nairobi, Kenya

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Qualitative Evaluation of the Lea Toto Adolescent Program (LTP) in Nairobi, Kenya

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Abstract

Introduction: The Children of God Relief Institute is a faith-based organization (FBO) providing children and adolescents with the resources to manage infection with Human Immunodeficiency Virus (HIV) in Nairobi, Kenya. Their efforts under the Lea Toto Adolescent Program (LTP) were updated in 2015. Information on how the program is perceived by stakeholders will support program implementation moving forward.
Methods: In-depth interviews and focus group discussions were conducted with program participants, program graduates, caregivers, and program staff. A document review compared the LTP economic empowerment curriculum to a PEPFAR and USAID supported equivalent curriculum.
Results: Results were analyzed within the different populations and by the four main program components including sexual and reproductive health, life skills, economic empowerment, and clinic support. 1)Knowledge about HIV, sex, sexual development, romantic relationships, and contraception increased through participation in the program. The program provided important support in HIV disclosure between caregivers and participants. There was lack of practical guidance in disclosing to romantic partners and condom negotiation which limited the SRH component. 2) Extended program sessions away from LTP centers and talent shows were particularly important in promoting self-esteem, confidence, and relationships within the program. There was need for capacity building for program staff to have more cultural competence and ability to deal with the different stages of development. 3) Specific clinic days for age groups as well as home visits helped participants have good medication adherence, feel healthy, and have a normal appearance. Inadequate transportation, frequent turnover of staff, inadequate support with medication adherence when transitioning to secondary school, inconvenient appointments, and inadequate support during transition to adult care were limitations. 4) Financial support for rent, food, and education were important aspects of the program. However, the program lacked practical skill building in business plan execution, and budgeting.
Recommendations: Recommendations included improving economic empowerment curriculum to use more practical exercises and activities. Moreover, further investigation into how the contraception referral system is working could be helpful to further the program efforts in SRH. Finally, standardizing transition to adult care with use of facility visits and connections to LTP graduates and friends would be helpful for continuity of care.

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Chapter 1. Introduction

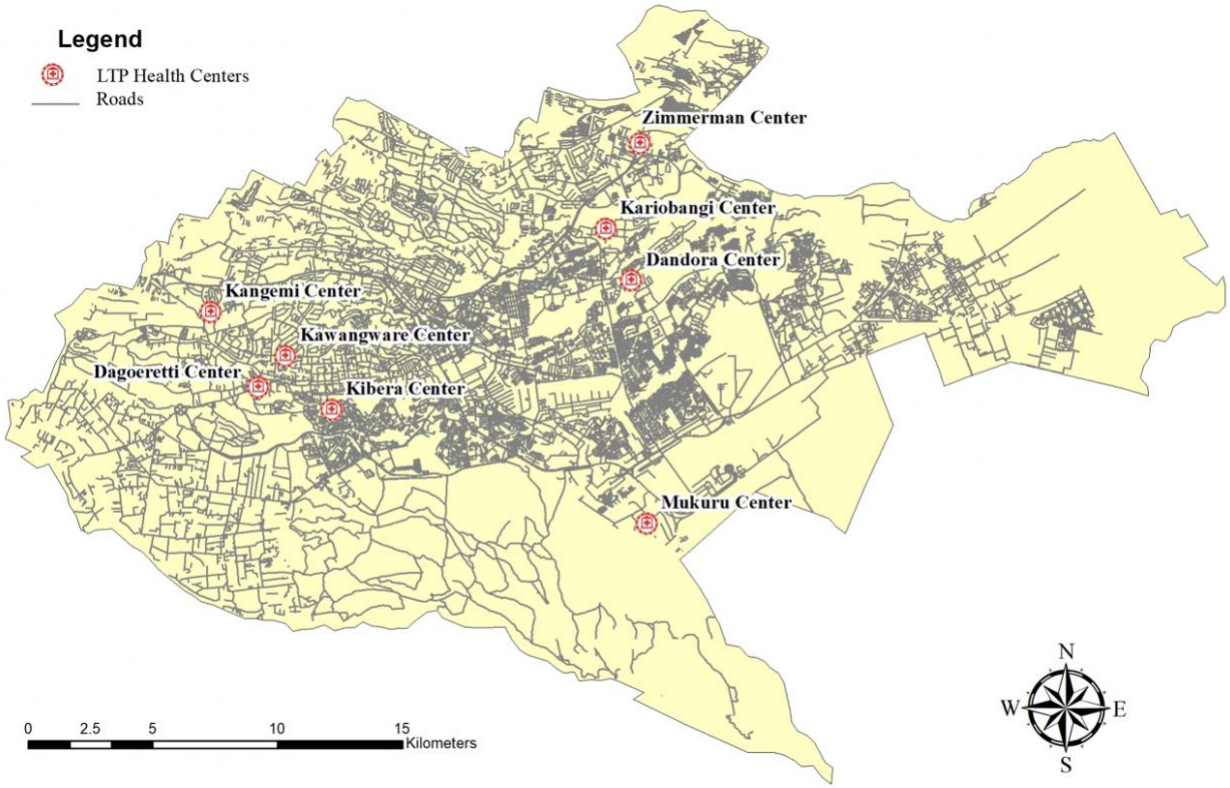
The Children of God Relief Institute is a faith-based organization (FBO) providing children and adolescents with the resources to manage infection with Human Immunodeficiency Virus (HIV) to grow and mature into healthy, productive adults. Children of God Relief Institute was founded in 1992 and provides comprehensive pediatric HIV services across its three programs including Nyumbani Home, Nyumbani Village, and Lea Toto. Nyumbani Home, the oldest program, provides a permanent home and community for approximately 150 children and adolescents living with HIV whose parents have died. Nyumbani Village is located about 120 miles southeast of Nairobi in rural Kitui County. This program provides a community for over 1,000 children and adolescents orphaned by HIV and has about 100 senior adults who serve as house parents in the cottages where the children live. Nyumbani's third program, Lea Toto Adolescent Program (LTP), provides comprehensive HIV primary care services to children and adolescents living with HIV. The newest version of LTP programming began in 2015 and serves roughly 3,000 individuals receive pediatric HIV care through one of the eight health centers run by LTP in eight different informal settlements across Nairobi (Figure 1). As anti-retroviral therapies have been made more widely available, more LTP participants are growing into adolescence and today LTP serves approximately 800 adolescents (14-18 years old) living with HIV (*Lea-Toto Community Based Program: An Integrated Transitional Program For HIV Infected and Affected Children and Their Households*).

LTP has launched several initiatives for their adolescent and youth that focus on prevention and education. Programming has focused on sexual and reproductive health (SRH), economic empowerment, life skills, as well as adolescent and youth friendly clinic support. This programming has been integrated into Saturday training sessions for adolescents (10-15-year

olds) and a residential camp experience over the school holiday for their older youth (16-24-year olds). In addition to the programming with the adolescents and teens, LTP offers training to caregivers on disclosing HIV status. These initiatives are in their beginning stages and there is much that can be learned as LTP continues to work to develop and strengthen its program. Assessing this program and understanding the lessons learned from the first few years of operation will help inform how the program can best move forward.

There are two aims of this thesis, the first is to understand how stakeholders (staff, adolescents, caregivers, graduates) assess the strengths and limitations of LTP in preparing program participants with knowledge and skills in the areas of SRH, economic empowerment, life skills and clinical support. The second aim is to understand how LTP's economic empowerment curriculum compares to an evidence-based model identified by PEPFAR. Additionally, understand how this model could inform the economic empowerment efforts of LTP.

Figure 1. Locations of LTP Health Centers in Nairobi, Kenya



Chapter 2. Literature Review

Growing Adolescent HIV Burden

Worldwide, about 1.8 million adolescents between the ages of 10 and 19 years were living with HIV in 2015 (HIV/AIDS, 2016a, 2016b). Half of this 1.8 million were living in just five countries including Kenya, Nigeria, South Africa, and the United Republic of Tanzania. With the success of anti-retroviral medications (ARTs) dealing with HIV has changed from treating it as an acute, life-threatening illness to managing it as a chronic disease (Fatti, Bock, Eley, Mothibi, & Grimwood, 2011). The total number of 10-24 year olds is expected to rise to more than three quarters of a billion by 2060 (Melorose, Perroy, & Careas, 2015). As a result of a rising adolescent population and the ability to survive decades with HIV, the estimated number of newly HIV infected adolescents is expected to increase even if progress in reducing HIV incidence rate is maintained. This increase in adolescent HIV infections is projected to be highest in Africa (UNICEF, 2016).

HIV Burden on Women and Girls

Women and girls carry a higher HIV burden compared to men and boys in Africa. Two-thirds of the 1.8 million adolescents infected as of 2015 were girls. Exposure to or simply fear of intimate partner violence is associated with lower ability to negotiate condom use and lower use of contraceptives. Moreover, large age differences between males and females in relationships is negatively associated with condom use and positively associated with sexually transmitted diseases among adolescent girls and young women (DiCLEMENTE et al., 2002; Langille, Hughes, Delaney, & Rigby, 2007; Manlove, Terry-Humen, & Ikramullah, 2006; Volpe, Hardie, Cerulli, Sommers, & Morrison-Beedy, 2013). In addition to risky sexual behaviors, “violence

and trauma can lead to lower adherence to [HIV] treatment, lower CD4, count and higher viral loads (Heise & McGrory, 2016)".

Adolescent Transition to Adult HIV Care

UNAIDS and PEPFAR have identified goals of building and sustaining comprehensive HIV programs and lowering the rate of new HIV infections. Adolescence is a time of change, growth, and need of acceptance from peers (Folayan, Odetoyinbo, Brown, & Harrison, 2014; E. D. Lowenthal et al., 2014). These normal adolescent struggles, the reality of managing a chronic stigmatizing disease, and transitions in care can result in poor outcomes. While ART access has expanded AIDS related illness is the most common cause of death among adolescents in Africa (UNICEF). The quality of transition from pediatric to adult HIV care greatly affects medication adherence and care retention (S. Lee & Hazra, 2015). There are no Kenyan national guidelines specifying an age for transition (Dahourou et al., 2017), but it tends to occur across a wide age range (e.g. 13-22 years), with most occurring after 18 years (Soeters H, 2014), 20 years (A., 2016; W., 2016), or 22 years (Nyabigambo et al., 2014). While age could be a good guideline in an organization, it is also important to consider maturity of the patient because maturity at a certain age may vary depending on social support, education, and learning capabilities (O'Sullivan-Oliveira, Fernandes, Borges, & Fishman, 2014).

Medication Adherence Among Adolescents

Medication adherence can be difficult for anyone suffering with HIV, however adolescents tend to struggle more with adherence than other HIV positive populations (Cluver et al., 2016; E. Lowenthal et al., 2012). Shubber et al. (2016) performed a systematic review and meta-analysis in which they found that the most frequenctly reported reasons for missing medication for all age groups were "forgetting, being away from home, and change of daily

routine". While the authors mention that the data are limited and confidence intervals wide, a higher proportion of adolescents reported experienceing each barrier compared to adults. Additionally, secrecy/stigma was more commonly reported among adolescents compared to adults (Shubber et al., 2016). These findings point to some reasons adolescents might experiene higher rates of poor ART adherence compared to adults.

Empowering adolescents to good medication adherence is critical because they will rely on medication over an entire life time. This is coupled with the important fact that poor medication adherence is the most common cause of drug resistance (UNICEF, 2016). A huge contributor to poor medication adherence among adolescents is that only 12 of the 29 ARTs are approved for children and fewer are acceptable regimens for children in terms of effectiveness, pill burden, and side effects (UNAIDS, 2014). Unfortunately, poor medication adherence has resulted in death for many HIV positive individuals who were able to make it to adolescence. UNICEF has estimated that 41,000 HIV positive adolescents between the ages of 10-19 years died in 2015 (UNICEF, 2016). Transition to adult care is an especially vulnerable time for these individuals' health and medication adherence (HIV/AIDS, 2016a). The transition process should include teaching and promoting autonomy in medication adherence as early as possible. Additionally, engaging in consistent employment or education is associated with better outcomes when it comes to HIV positive adolescents. Therefore, programs equipped to address education and employment are better suited to promote lifelong wellness of HIV adolescents (UNICEF, 2016).

HIV stigma reduces access to HIV testing and health promotion services (Kalichman & Simbayi, 2003; McHenry et al., 2017; Obermeyer & Osborn, 2007; Steward, Bharat, Ramakrishna, Heylen, & Ekstrand, 2013), retention in HIV care (Kinsler, Wong, Sayles, Davis,

& Cunningham, 2007; Lifson et al., 2013; Sayles, Wong, Kinsler, Martins, & Cunningham, 2009), freedom and ability to adhere to ART mediation (Dlamini et al., 2009; Kumarasamy et al., 2005; Rintamaki, Davis, Skripkauskas, Bennett, & Wolf, 2006; Vanable, Carey, Blair, & Littlewood, 2006), and risk of transmission through unsafe sex and nondisclosure to sexual partners (Simbayi et al., 2007). HIV stigma including experiences such as social rejection, discrimination, and physical violence put HIV positive individuals at a higher risk for mental health issues like depression, anxiety, hopelessness, and decreased quality of life. These feelings can severely lower someone's ability and motivation to administer good self-care or seek professional care in relation to HIV (Clark, Lindner, Armistead, & Austin, 2004; Greeff et al., 2010; R. S. Lee, Kochman, & Sikkema, 2002; Thomas et al., 2005). In a study completed by McHenry et al. (2017) in western Kenya, participants reported that general public awareness and knowledge about HIV was increasing. However, despite increases in knowledge misconceptions about HIV remained. For example, believing that casual contact like sharing glasses, forks, or plates could spread HIV. There were also some negative beliefs surrounding the immorality of those with HIV, for example, that those who had HIV had sinned and HIV was a punishment. Some of the respondents in this study reported being kicked out of school because of their status, being forced away from HIV negative children during play around the community, and difficulty finding a job because of HIV status. Ultimately, HIV stigma can prevent HIV positive adolescents from going about their healthcare and life normally.

Many of the challenges HIV positive adolescents face are exacerbated for those living in urban informal settlements because of concentrated poverty and other social issues that disproportionately affect them. Sixty percent of Nairobi's residents live in informal settlements which creates quite a challenge in terms of care delivery and support. Only 3 percent of residents

of informal settlements in Nairobi have permanent walls, electricity, and water in their homes (Blevins, 2015).

The Role of Faith-Based Organizations

In sub-Saharan Africa, Faith-based organizations (FBOs) are the largest non-governmental provider of HIV services for children living with HIV. In Nairobi, Kenya roughly 48% of all HIV positive individuals are under the care of an FBO (Foster, 2004). The programs are usually multifaceted and holistic addressing issues from housing to nutrition. Brewer-Smyth and Koenig (2014) argue that FBOs are in a unique position to deliver community resources and services, like ongoing interventions that involve mentoring and personal reflection, to HIV positive individuals that lead to enhanced health, increased resilience, and increased quality of life (Teresa M. Stephens, 2018). Not only are resilient people able to cope well with large, traumatic events they are also able to cope better with everyday stressors and challenges (Teresa Maggard Stephens, 2013; Teresa M Stephens, Smith, & Cherry, 2017). As a result of many women and children receiving ARTs and other HIV related support through FBOs large cohorts of HIV positive children have moved into adolescence, teenage years, and young adulthood. These stages of life bring unique challenges and needs that many FBOs struggle to handle. FBOs are in a unique position because they have the power and influence to enact HIV prevention and treatment programs that are sustainable and holistic. However, when dealing with certain populations such as men who have sex with men or sex workers there is often some negotiation that has to playout within the organizations. This is also true when FBOs face topics relevant to adolescent HIV care including contraception and comprehensive SRH education. FBOs can add to the stigmatization felt by certain populations with HIV or contribute to misinformation concerning SRH and HIV prevention. “The impact of FBOs on services for adolescents living

with HIV is complex, with FBOs serving as both an asset and as a hindrance to the most important health, social, economic, and educational challenges these young people face" (Blevins, 2015).

Chapter 3. Methods

This study is a qualitative evaluation of the Lea Toto Adolescent Program (LTP) in Nairobi, Kenya, and was conducted in collaboration with LTP and the Interfaith Health Program at the Rollin's School of Public Health at Emory University. A qualitative research approach was used for this evaluation because these methods are effective for collecting contextualized detail of the issues and stakeholder perspectives about LTP (Hennink, Hutter, & Bailey, 2010). In order to fully understand how the program was functioning all stakeholders had to be involved including program participants, program graduates, caregivers, and program staff (table 1).

Table 1. Participants by each data collection Method

Participants	**Focus Group Discussions**	**In-depth Interviews**
Program Participants	4	3
Program Graduates	1	4
Caregivers	-	4
Program Staff	-	11

Ethical Considerations

Since 2012, Emory students have worked with the LTP to support various initiatives. In 2012 and again in 2014, Emory determined that these activities did not require ethical review and clearance because they were part of ongoing initiatives that were designed to improve service delivery to children and adolescents in the LTP. The activities in 2017 described in this thesis were related to exempt 2014 activities. Because of the direct relationship of the activities in 2017 no ethical review was required. All study participants were informed that their participation was

voluntary, they could stop at any point, and skip questions. In addition, all adolescents participated in focus groups discussions or key informant interviews only with the written permission of their parent or legal guardian

Tool Development

The tools for focus group discussions (FGDs) and in-depth interviews (IDIs) were developed in collaboration with LTP staff and developed around the main components of LTP curriculum including SRH, life skills, economic empowerment, and clinic support. The final guides are provided in the appendix.

Program Participants

Inclusion criteria for FGDs and IDIs with program participants included being between the ages of 12 and 24, HIV-positive, and currently participating in LTP. Study participants had to be able to speak either Kiswahili or English. No program participants participated in both an individual interview and a focus group discussion. The program coordinator and center directors acted as gatekeepers in recruitment of program participants for both FGDs and IDIs. The program coordinator contacted center directors and asked them to look through their rosters and call program participants that met eligibility criteria. If a program participant met eligibility criteria and agreed to participate they were then scheduled for an interview. Diversity was sought by the program coordinator communicating to the center directors to look for a female and a male as well as a participant that was below 16 years of age and a participant that was above 16 years of age. All interviews and discussions took place in private areas of the different centers. Research assistants, most of whom were counseling interns in the different LTP centers, were trained to conduct the FGDs and IDIs. Training for the research assistants consisted of

understanding the basic goals of the evaluation, understanding of basic qualitative interview methods skills, as well as familiarity and practice with interview and discussion guides.

Four interviews were sufficient because it allowed for recruitment of two program participants in both the eastern and western sites as well as two older program participants and two younger program participants. The aim of the IDIs was to capture individual experiences and perceptions of adolescents currently enrolled in the program. Interviews provided a confidential environment for participants to talk about their own personal experiences and opinions around sensitive topics covered in the program such as SRH and stigma related to HIV (Hennink et al., 2010). The final sample of three program participants was diverse in terms of gender, age, and location of the center the program participant was attending (table 2). The sample only included 3 in-depth interviews as opposed to the desired four because the recording failed with a fourth participant.

Table 2. Program Participant Demographics

Characteristics of Program Participants in IDIs	**Number of Program Participants**
Gender	
Female	1
Male	2
Geographical Location	
Eastern	2
Western	1
Age	
12-15 years old	2
16-24 years old	1
Total	3

A semi-structured interview guide was used that included questions on the main components of the program, including economic empowerment, SRH, life skills, and clinical support. The guide was pilot tested and revised to make sure questions were clear, singular, and

in simple language for adolescents to understand. The topics covered in the guide are summarized in table 3. Interviews with program participants lasted between 60 to 120 minutes.

Table 3. IDI Guide Topics for Program Participant

Program Component	**Topics**
Economic Empowerment	I. Knowledge from and application of program regarding: ➢ saving and budgeting money ➢ business and technical skills ➢ overall financial stability II. Experience and impact of receiving funds for education, food, rent III. Recommendations for the program as far as economic empowerment to better support and prepare program participants in the future
Life Skills	I. Knowledge from and application of program regarding: ➢ dealing with HIV-related stigma in everyday life ➢ navigating relationships – romantic, familial, friendships/social ➢ joining in with and feeling a part of their community ➢ gaining and maintaining self-esteem ➢ making healthy decisions concerning peer pressure II. Recommendations for the program to better support and prepare program participants as far as life skills in the future
Sexual and Reproductive Health	I. Knowledge from and application of program regarding: ➢ identifying and avoiding risky sexual behavior ➢ disclosing HIV- status to family, friends, romantic partners ➢ access and use of contraception methods ➢ dealing with challenges in relation to SRH and being HIV-positive
Clinical Support	I. Assessment of staff treatment and care during clinic visits II. Identification of challenges around visiting the clinic and clinic appointments III. Recommendations for how the program could better support program participants in the future as far as clinical needs

In addition to in-depth interviews, program participants were recruited for focus group discussions in the manner mentioned above until eight program participants were willing and able to participate in a focus group discussion. Four focus group discussions were sufficient because it allowed for two focus group discussion in western sites and two in eastern sites as

well as two focus group discussion with younger program participants and two with older program participants. The aim of the focus groups was to gather a range of opinions and understand any norms in opinion or experience relating to the program for current participants (Hennink et al., 2010). Discussion with program participants lasted between 60 to 120 minutes. The final sample included 4 mixed gender focus group discussions (table 4).

Table 4. Program Participant Demographics

Characteristics of Program Participants in FGDs	Number of FGDs
Geographical Location of LTP center	
Eastern Nairobi	2
Western Nairobi	2
Age	
12-15 years old	2
16-24 years old	2
Total	4

A discussion guide was used for focus group discussions with program participants. The guide had the same basic structure as the guide described for the in-depth interviews. The guide asked what program participants felt were good methods to make and save money. Additionally, they were to describe what they had learned in regard to SRH from the program, and specifically how they felt they could protect themselves and others given their HIV status. Additionally, participants discussed how comfortable they felt disclosing their HIV status to different people in their lives, including family members, friends, and romantic partners. Finally, they were asked about how they felt the clinics were or were not suited to fulfill their needs and what challenges they or their peers faced when coming to the clinic. In order to understand how the program has affected self-esteem an activity called “Toot Your Horn” was used. This involved the program participants finishing statements like “I like myself because…” and “I consider myself a good…” There were then discussion questions about how finishing these statements made the

program participants feel, and any challenges they faced while trying to compete the statements. Lastly, we asked how the program contributed to how they feel about themselves.

Program Graduates

Inclusion criteria for graduates included being HIV-positive, being able to speak English or Kiswahili, and having graduated from the LTP adolescent program into exclusively adult care within the last five years. Graduates were included in this evaluation because they could provide valuable insight into the process of transitioning to adult HIV care facilities the program and reflections on the utility of program since moving into adult care.

Venue-based sampling was used to recruit program graduates for both individual interviews and a focus group discussion. No program graduates participated in both an individual interview and focus group discussion. Program graduates who had gathered at the park and volunteered to participate in the study were screened for eligibility. If they met eligibility criteria they were then either individually interviewed or participated in the focus group discussion on the same day at the park mentioned previously. Program graduates were gathering on one Saturday for a self-organized support group meeting at a public park.

The focus group discussion with program graduates were moderated in English by both the LTP director and the monitoring and evaluation officer and followed a semi-structured guide. The focus group lasted 40 minutes. The discussion guide followed a similar structure described above covering the four major components of the program. The topics covered in this guide are summarized in table 5.

Table 5. FGD Guide Topics for Program Graduates

Program Components	Topics
Economic Empowerment	I. Knowledge from and application of program regarding: ➢ overall financial stability ➢ beliefs about business ownership in community context ➢ book keeping and business plan development skills II. Recommendations for LTP to better support and prepare current and future program participants in relation to economic empowerment
Life Skills	I. Knowledge from and application of program regarding: ➢ gaining and maintaining self-esteem ➢ dealing with conflict resolution ➢ facing challenges since leaving LTP II. Recommendations for LTP to better support and prepare current and future program participants in relation to life skills
Sexual and Reproductive Health	I. Different scenarios posed: *Example:* Ashura, 19 years old, has big plans to become a hairdresser. She received a grant from LTP and is all set to execute her business plan. She and Beno, 29 years old, met at a club five months ago, he has been pressuring her to take their relationship to the next level. Beno shares that he is in love with Ashura and wants to show her how much. Ashura is torn, she doesn't know what to do, especially since Beno has shared that doesn't believe in using condoms, it makes him less than a man. Beno is Ashura's first boyfriend, unlike her other girlfriends at school. Ashura also has a secret that she has yet to share with Beno. Discussion Questions for scenarios: ➢ How appropriate is this scenario to your life? ➢ What are the major conflicts in this scenario? ➢ What are some things you would advise Ashura to do? II. Recommendations for LTP to better support and prepare current and future program participants in relation to SRH
Clinical Support	I. Experience visiting and receiving care at the LTP center II. Recommendations for LTP to better support and prepare current and future program participants in relation to clinical support

The in-depth interviews with program graduates were conducted in English by members of the Emory University field research team and followed a semi-structured guide. Four

interviews were sufficient because it allowed for two interviews with females and two with males. The guide followed the four main components of the program and the topics of the guide are summarized in table 7. Interviews lasted between 40-60 minutes. The final sample of program graduates that participated in the IDIs included 2 females and 2 males (table 6).

Table 6. Program Graduates Demographics

Characteristics	**Number of Program Graduates**
Gender	
Female	2
Male	2
Years since graduating LTP	
1-2 years	2
3-5 years	2
Total	4

Table 7. IDI Guide Topics for Program Graduate

Program Component	**Topics**
Economic Empowerment	I. Knowledge from and application of program regarding: ➢ overall financial stability ➢ business/technical skills II. Experience and impact of receiving funds for education, food, rent III. Recommendations for the program to better prepare and support program participants in the future as far as economic empowerment
Life Skills	I. Knowledge from and application of program regarding: ➢ joining in with and feeling a part of their community ➢ dealing with HIV-related stigma in everyday life ➢ navigating relationships – romantic, familial, friendships/social III. Recommendations for the program could better prepare and support program participants in the future as far as life skills
Sexual and Reproductive Health	I. Knowledge from and application of program regarding: ➢ identifying and avoiding risky sexual behavior ➢ disclosing HIV- status to family, friends, romantic partners ➢ access and use of contraception ➢ medication adherence ➢ managing challenges since graduating II. Effect of transitioning to a new care facility on: ➢ medication adherence/access to medication ➢ access and use of contraception
Clinical Support	I. Experience visiting and receiving care at the LTP center II. Comparisons between the LTP clinic and current clinic

Caregivers

Inclusion criteria for caregivers included being the main caretaker for an adolescent currently participating in the program and able to speak English or Kiswahili. The perspective of the caregivers was important because when dealing with adolescents it is vital to have caregiver support. The perspective of caregivers is needed for the program to make meaningful, positive changes moving forward. Furthermore, it was important to capture caregivers' perspectives on money transfers they receive from the program as well as sessions, for caregivers, on HIV status disclosure to the children.

The program coordinator and center directors acted as gatekeepers in recruitment of caregivers. The program coordinator contacted center directors and asked them to look through their rosters and call caregivers that met eligibility criteria. If a caregiver met eligibility criteria and agreed to participate they were then scheduled for an interview. Diversity was sought by the program coordinators specifically recruiting two caregivers with children attending an LTP center in eastern Nairobi and two caregivers with children attending LTP centers in western Nairobi. Caregivers were interviewed in a private place in the program center where their adolescent was attending. The final sample of caregivers included 4 female caregivers, two with adolescents receiving care at LTP centers in eastern Nairobi and two with adolescents receiving care at LTP centers in western Nairobi. Four interviews were sufficient because it captured diversity in perspective between eastern centers and western centers.

Individual in-depth interviews were conducted by trained research assistants described above and followed a semi-structured guide. The interviews with caregivers lasted between 30-60 minutes. The interview guide included four sections corresponding to different parts of the

program including the economic empowerment, SRH, life skills and clinical support. The topics of the guide are summarized in table 8.

Table 8. IDI Guide Topics for Caregivers

Program Component	Topics
Economic Empowerment	I. Impact of program on: ➢ family's overall financial stability ➢ personal stress level II. Experience and impact of receiving funds for education, food, or rent III. Recommendations for how the program could better support and prepare caregivers and program participants in relation to economic empowerment
Life Skills	I. Program participants' knowledge from and application of program regarding: ➢ gaining and maintaining self-esteem and self-confidence ➢ interactions with peers and community II. Impact of program on: ➢ Caregiver-adolescent relationship III. Recommendations for how the program could better prepare and support program participants in relation to life skills
Sexual and Reproductive Health	I. Impact of program on: ➢ caregiver- adolescent relationship specifically regarding taboo subjects like sex and contraception ➢ fears or anxieties about HIV ➢ program participant's medication adherence II. Recommendations for how the program could better prepare and support program participants in relation to SRH
Clinical Support	I. Experience of child visiting and receiving care at the LTP center II. Recommendations for how the program should better prepare and support program participants in relation to clinical support

Program Staff

Inclusion criteria for staff included holding a full-time position within LTP and able to speak English. A range of staff were purposively sampled for diversity in level of position within the program. The research team used the familiarity with the program from previous collaboration to identify key participants. The participants were then called or emailed and

screened for eligibility. If they met eligibility requirements and agreed to participate an interview was scheduled. The perspective of the staff was valuable because they were able to speak to the logistical, curricular, and financial aspects of the program. Additionally, staff brought understanding of the program's connection with the Catholic Church as well as their own faith convictions and how these might affect program operations.

The final sample of staff included 5 counselors/social workers, 4 individuals in management positions, and 2 administrators. Eleven interviews were sufficient because it allowed for diversity in terms of gender and employment position (table 9).

Table 9. Program Staff Demographics

Characteristics of Program Staff	**Number of Program Staff**
Gender	
Female	6
Male	5
Age	
25-34	6
35-44	3
>44	2
Employment Position	
Management	5
Counselor/Social Worker	4
Administrative	2
Geographical Location Covered by Employment	
Eastern LTP center/multiple eastern LTP centers	2
Western LTP center/multiple western LTP centers	6
Overall – covering multiple centers across eastern and western centers	3
Total	11

A semi-structured interview guide was used, and all interviews were conducted by members of the Emory University field research team. Interviews took place in private rooms of the different program centers. Interviews with staff lasted 60 to 90 minutes. The interview guide included four sections corresponding to different parts of the program including the economic

empowerment, SRH, life skills and clinical support. The topics of the guide are summarized in table 10.

Table 10. IDI Guide Topics for Program Staff

Program Components	Topics
Economic Empowerment	I. How the program: ➢ defines the goals of this component ➢ defines how those goals fit into the overall program ➢ is meeting or failing to meet these goals II. Challenges the program faces in reaching these goals III. Differences of impact or response to the program between: ➢ girls vs boys ➢ individuals attending eastern vs western Nairobi centers ➢ program participants of different ages
Life Skills	I. How the program: ➢ defines the goals of this component ➢ defines how those goals fit into the overall program ➢ is meeting or failing to meet these goals II. Challenges the program faces in reaching these goals III. Differences of impact or response to the program between: ➢ girls vs boys ➢ individuals attending eastern vs western Nairobi centers program participants of different ages
Sexual and Reproductive Health	I. How the program: ➢ defines the goals of this component ➢ defines how those goals fit into the overall program ➢ is meeting or failing to meet these goals II. Challenges the program faces in reaching these goals III. Differences of impact or response to the program between: ➢ girls vs boys ➢ individuals attending eastern vs western Nairobi centers program participants of different ages

Data Preparation

In-depth interviews and focus group discussions were conducted in English (staff and graduates) or Kiswahili (LTP participants and caregivers) and recorded via smart phones. Six password protected phones were used to record qualitative interviews. The recordings were uploaded to a google drive folder to which only the research team members had access. Once

interviews were recorded, research assistants helped to translate the recordings that had been recorded in Swahili into English. Translation was completed by research assistants verbally translating the interview into a separate recording and identifying the inflections, pauses, and other gestures through voice. This new English recording was then transcribed verbatim and de-identified by members of the research team. This method was used because some of the research assistants felt they could work more quickly and accurately by speaking the English translation. All translations and transcriptions were stored in the same google drive folder mentioned above.

Data Analysis

All transcriptions were read in full to gather general understanding. During this process memos on general concepts were written and then a set of codes was developed. The codes were based on recurring concepts and the research question. The data was coded according to the definitions developed for each code. The data was interpreted and analyzed within the different sub-populations identified above.

Curriculum Document Review

In order to understand how LTP's economic empowerment efforts compare to the evidence-based model called *Impumelelo,* created by ASPIRES and Save the Children, to LTP's economic empowerment curriculum a document review was completed(Save the Children Federation, 2016). Both curriculums were uploaded to MAXQDA and major themes, concepts, and instruction techniques were identified through close reading. A set of codes were developed, and the curriculums were coded according to the definitions developed for each code. The curriculums were then analyzed and compared by treating each curriculum as a case.

Chapter 4. Results

Through investigation of major themes, strengths and limitations pertaining to each component of the program were identified. These are summarized in table 11 and expanded upon in this chapter. The analysis is presented by sub-population (program participants, caregivers, staff, and program graduates) first and then by program component.

Table 11. Strengths and Limitations of Program Components by Study Participants

Study Participant	Program Component	Strengths	Weaknesses
Program Participants	Economic Empowerment Component	-Cultivated hope for economic future -Increased knowledge regarding: ➢ Budgeting ➢ Saving ➢ Marketable skills ➢ Goal setting ➢ Executing a business plan	-Lacked support for program participants with talents in the arts
	SRH component	-Increased knowledge regarding: ➢ Menstruation ➢ Sexual body parts ➢ How to clean and manage themselves ➢ Boy and girl puberty ➢ How pregnancy happens ➢ HIV transmission pathways ➢ Medication adherence ➢ Contraceptive options and their differences -Prompted candid conversations about SRH subjects between caregivers and program participants (i.e. sex, relationships, STIs) -Developed understanding: ➢ among male program participants about why and how to respect the opposite sex ➢ of the importance and benefits of abstinence -Increased confidence of program participants:	-Lacked instruction and practical guidance on: ➢ Condom negotiation and actualization ➢ Communication skills to disclose HIV status disclosure to romantic partners -Lacked instruction to dispel misconceptions, particularly among younger program participants, that casual contact could not spread HIV (i.e. sharing towels or spoons)

		➢ to approach and initiate romantic relationships with HIV negative individuals ➢ to evaluate situations and make sound decisions about sex	
	Life Skills Component	-Contributed to: ➢ Good health and healthy appearance ➢ Ability to perform normal activities ➢ Consistent Medication adherence ➢ Feeling less stigma ➢ Healthy decisions ➢ Positively dealing with peer pressure -Cultivated: ➢ Social Relationships ➢ Confidence ➢ Self-esteem	-Invited the same program participants to the camps repeatedly causing some program participants to not receive a chance to participate in these activities
	Clinical Support Component	-Clinic days separated by age groups and home visits contributed to: ➢ Good health and healthy appearance ➢ Ability to perform normal activities	-Staff used unconstructive scare tactics aimed at promoting medication adherence during clinic visits and counseling sessions -Frequent change-over of staff caused anxiety in program participants -Lacked reminders/support regarding paperwork and identification needed for medication -Required long waits for services in clinic -Provided inadequate ➢ transportation to and from clinic ➢ support in process of transitioning to adult care

Caregivers	Economic Empowerment Component	-Provided financial transfers for education, rent, food, and hospital costs -Increased knowledge regarding marketable skills	-Lacked ➢ sewing machines, computers, and books in all centers ➢ instruction regarding poultry and farming skills ➢ attention to cases involving special needs and quick changes in economic status
	SRH component	-Provided: ➢ support and guidance to caregivers during HIV status disclosure to participants ➢ information to program participants regarding STIs and pregnancy -Cultivated conversations between program participants and caregivers about SRH subjects	
	Life Skills Component	- Cultivated: ➢ Social relationships for participants ➢ Hope for future livelihood ➢ Respect between program participant and caregiver	
	Clinical Support Component	-Provided instruction and practical guidance to participants regarding concealing medication	-Offered clinic appointments and wait times that interfered with school exams -Lacked holistic explanation regarding certain questions and protocols during clinical visits -Frequent staff turn-over caused anxiety during clinic appointments -Provided inadequate support regarding medication adherence for program participants beginning secondary school

Program Graduates	Economic Empowerment Component	-Provided financial transfers for school fees -Cultivated hope regarding economic future -Increased knowledge regarding: ➢ Sweets making ➢ Saving ➢ Budgeting ➢ Executing a business plan	-Lacked: ➢ support for program participants with interests in the arts ➢ practical instruction and guidance regarding executing a business plan and budgeting
	SRH Component	-Trustworthy reputation of the LTP program made it a place where participants felt comfortable and receptive -Promoted and facilitated early caregiver-adolescent HIV status disclosure	-Lacked instruction and practical guidance in skills to disclose HIV status to romantic partner
	Life Skills Component	-Cultivated: ➢ Social relationships ➢ Confidence	-Group sessions were not sufficient for quiet or unique cases and more one-on-one counseling should be targeted toward these individuals
	Clinical Support Component	-Facilitated drug partners -Provided one-on-one counseling	- Lacked support in preparation and process of transitioning to adult care -Drug Holidays were too tempting and not helpful in promoting drug adherence
Program Staff	Economic Empowerment Component	-Promoted and facilitated: ➢ technical training and informal education/trainings ➢ educational opportunities	-Ambiguity between the roles of social worker and economic empowerment officer in the program -Lacked empowerment for girls to advocate for themselves regarding financial support and business investment

		-Provided practical skills to avoid drug and alcohol abuse -Provided financial support for existing businesses	-Inadequate communication between the accounts department and social worker department lead to inefficiency in dispensing financial support to participants and loss of trust between caregivers and program -Lacked a curriculum with: ➢ comprehensive scope ➢ flexibility to accommodate multiple ages -Provided inadequate communication with caregivers around educational support and opportunities
	SRH Component	Increased program participants' knowledge regarding: - menstruation - pregnancy - sexual body parts and systems - condom access, use, and negotiation	-Lacked a comprehensive, up to date curriculum covering how to deal with and avoid coerced, transactional, and forced sex -Disagreements and differing opinions regarding direct distribution of PrEP and contraception
	Life Skills Component	Interactions with peers and peer educators promoted: ➢ open communication ➢ confidence ➢ self-esteem - Referring to religious teachings during program sessions promoted a strong moral foundation among the program participants	Lacked: ➢ adequate number of staff to provide continuity of program sessions and lighten the burden for other staff members ➢ cultural competency training as well as ➢ training for staff regarding different developmental stages in adolescence ➢ comprehensive curriculum tailored to different developmental stages -Fast staff turnover caused inefficiency due to the need for trainings each time new staff were on-boarded

			- Personal and center insecurity caused fear among staff as well as inefficiency due to stolen files and computers
	Clinical Support Component	-Clinic locations in commercial areas reduced stigma and increased program attendance and care access compared to those located in residential district	-Used inadequate clinical per visit procedures -Provided inadequate support in the process of transition to adult care

Program Participants
Sexual and Reproductive Health (SRH) Component

Program participants' responses regarding the SRH component of LTP took on two major themes including preparation for sex, HIV and STI protection, and navigating romantic relationships. Strengths and limitations of the program were identified within these themes (table 11).

Preparation for Sex

Overall, program participants felt they had adequate information about sex and reproduction from the program and that the program opened up opportunities for them to speak with their parents about more sensitive issues. One program participant said that shortly after he learned about STIs in the program he became concerned about some swelling on his genitals and was able to speak to his mother about the issue, despite the fact that it was a taboo subject. Program participants reported gaining knowledge from the program about menstruation, sexual body parts, how to clean and manage themselves, boy and girl puberty, and how pregnancy happens. The program participants unanimously agreed that abstaining from sex was the best and safest option, but that using contraception was an option if necessary. The vast majority of older program participants recounted being taught about condoms and the effects of using the wrong condoms during program sessions. Moreover, they felt they knew about the different advantages and disadvantages to using condoms versus pills.

Overwhelmingly program participants agreed that expressing their understanding of the consequences of risky sex made them "sound alien to their peers." This meant they were seen as different from their peers. One female highlighted the issues of condom use when she expressed she may intend to use a condom, as a result of the program, but it is hard if the other person does not want to do the same. Condom negotiation, particularly for some females in the program, is

still difficult because of inadequate training from LTP on this subject as well as societal expectations and norms. In addition to condom negotiation, access to contraception was a potential barrier to following through with information received in the program. Some of the older program participants found no problem with getting contraceptives at a chemist but others found it extremely stigmatizing. For example, a few talked about being "counseled" by the chemist when accessing contraceptives which made it an undesirable place to get contraceptives. One older, male participant summed it up well by saying, "Wherever you get from, people will judge you, especially if you pick in the morning". Even though the program is getting the information to the program participants, they face barriers in consistently performing safe sex.

All of the program participants believed that as a result of the program they understood what HIV was and why they were taking medication. Additionally, they all understood the importance of taking the medication per the doctor's directions to lower viral loads and avoid other infections. The majority of the program participants understood the major ways the virus can be spread, for example, sex, breastfeeding, between open wounds, and donating blood. They were also aware of transmission pathways that are unlikely but still possible, for example while kissing, sharing toothbrushes, or sharing chewing gum. However, there was no indication that they knew that some of these posed a much lower risk of spreading disease compared to the others. Some younger program participants had misconceptions and believed it was possible to spread the disease by casual contact and sharing personal items like towels and spoons.

Navigating Romantic Relationships

One of the older program participants talked about how the program had given him the confidence to approach girls that were outside of the program. His current girlfriend was HIV negative and not part of the program. The majority of the males agreed that the program had

taught them how and why to respect the opposite sex. In addition, they agreed that individuals in the program could avoid impulse decisions and instead evaluate situations to make sound decisions about sex. Despite articulating the importance of knowing a partner's HIV status before having sex, most participants thought it was extremely difficult to disclose to a romantic partner. One male described a hypothetical situation in which a partner has asked for a HIV test, but he doesn't want to take a HIV test because he already knows his status. So, he says the only option is "trying to [convince the girl to have sex] with sweet words". Participants understood the importance of respect and avoiding impulse decisions in romantic relationships, however disclosing HIV status to a partner was still difficult for most participants.

Life Skills Component

Program participants' responses regarding the life skills component of LTP took on four major themes. Strengths and limitations of the program were identified within these themes (table 11).

Camps and Talent Shows

The camps were a time that the program participants could let their guard down and get away from their normal routine and stressors. This space promoted friendship and connections with peers in the program. These bonds were important because it allowed the program participants to feel they had people their age who could truly understand their issues and not feel alone in their struggle with HIV. This setting cultivated discussion, knowledge, and understanding between the program participants as well as staff. Not only did these bonds promote social skills but also comprehension of other concepts from the program curriculum. Some program participants felt the same program participants were invited for the camps repeatedly, causing other program participants to not have the opportunity to be a part these

sessions. They felt there should be a system to make sure a larger portion of individuals in the program had the chance to participate in the camps. In addition to the camps many of the older program participants voiced their desire for opportunities to foster one on one mentorship relationships with younger program participants in the program.

Program participants felt that activities like talent shows were extremely helpful in promoting their confidence and self-esteem. They loved the opportunity to express their unique talents and desired more opportunities like this. One respondent talked about not having the confidence to talk to people or speak in front of groups before the program. As a result of sessions in which the program participants were given the chance to speak up and voice their opinion, he felt prepared to address people and confidently answer questions in group settings. The program participants agreed they were motivated to keep attending the program because of improvements they saw in their confidence and self-esteem they experienced. Confidence gained from the program resulted in joining in with community activities including choir groups, sports teams, and other similar activities.

Health and Wellbeing

Program participants unanimously reported home visits as extremely valuable. The intense follow-up made the program participants feel protected and taken care of.

> I thank LTP for always coming to our homes and checking on our welfare, I thank them for my health as other people are as thin as khat branches… I've been taught how to manage the virus and how to prevent contracting to others (12-15-year-old program participant).

The program participants drew a connection between the intense follow-up and their physical health improving. Physical health and a good healthy appearance allowed program participants to move through everyday life confidently and normally.

Program participants understood the importance of medication adherence. They understood why the medication was important in their lives and believed that the program took medication adherence seriously. The program helped the program participants realize the connection between medication adherence and their ability to physically conceal their disease from others. This was motivation for good medication adherence and program attendance. One program participant talked about how he struggled with medication adherence in the beginning and was appreciative that the program took the time to get to know him and address his unique challenges. The program participants were less likely to be adherent with medication if they were in a place in which they had not or could not disclose their status. Program participants agreed that the program addressed these situations well by teaching them how to conceal and take the medication without raising suspicion from others.

Some specific limitations decreased the program's ability to promote medication adherence. In some cases, they felt staff were too extreme and sometimes didn't treat them with respect. For example, some of the tactics to increase medication adherence, like scaring program participants with extreme negative consequences, discouraged them from continuing a close relationship with the center. The agreed that many program participants become anxious when they are invited for sessions outside of their normal clinic visits because they fear discussion of their poor medication adherence with staff who use fear tactics. They suggest at least some of the sessions be held at a different location, more like the structure of the camps, to encourage more program participants to participate. Additionally, a few of the program participants felt

program staff weren't in touch with their struggles and experience. This caused a desire for more interaction with peers and other individuals who could truly empathize with their situation. For the most part the program participants felt they were able to talk and open up to staff, however, they desired more people that truly understood the experience of living with HIV.

Stigma Related to HIV Status and HIV status Disclosure

An important part of learning to deal with stigma was what the program participants called "having the right information". When the program participants had accurate, comprehensive understanding about HIV they were able to ignore any overtly negative messages from their peers or teachers. Specifically, when people said extremely negative things about being HIV positive, the program participants could disregard it because they knew the truth about HIV and that their disease was being managed well.

The vast majority of program participants said they had not and would not feel comfortable disclosing to friends or other people in their life besides close, trusted family members. Despite the program's efforts to highlight the importance of disclosure, participants did not feel comfortable disclosing because they believed refraining from disclosing their status kept them from experiencing stigma. The measure of whether or not to disclose was based on how confident the program participant was in the person's potential reaction. If there was any uncertainty about how the person would react or if they would tell someone else, then that was a person that could not be trusted to know their HIV status. Many of the younger program participants feared being ridiculed by fellow classmates or community members who questioned them about their clinic visits. A huge part of protecting themselves from stigma was keeping their status a secret from people in their lives.

Healthy Decision Making

Some older program participants mentioned that the program helped them avoid alcohol and drug addiction. One younger program participant said he thought he would be, "dead or caught up in drug addiction…" if not for the program. Even with these positive feelings toward the drug and alcohol sessions a few older program participants wanted even more training and support in this area. A younger male program participant reflected on how the program had allowed him to re-evaluate his video game playing. The program helped him identify that playing too much video games was affecting his school performance and subsequently worrying his grandmother. Through critical thinking and good decision-making skills, gained through the program, he was able to decide that he should limit his video gaming and he believed he was now worrying his grandmother less. Program participants also felt the program helped them deal with peer pressure and understand how to identify peer pressure. One program participant was able to define peer pressure as, "your friend smokes cigarettes, and your friends, and when they ask you to smoke cigarettes you can't say no so you can yes at times, but because you have self-esteem you refuse and say no. And your yes to be yes and no to be no." The program helps participants identify and resist peer pressure and rash choices.

Clinical Support Component

Program participants' responses regarding clinical support from LTP took on three major themes. Strengths and limitations of the program were identified within these themes (table 11).

Clinic Appointments and Service

The unique and persistent attention that the program participants received from clinic staff was appreciated.

> I can say that they [staff] are friendly because the process of talking to me on the drugs took time. For me to understand what are these drugs for, so they really

helped me, and when we reached there they collect and serve you like individual, a Kenyan, like citizen, like others (16-24 year old program participant).

Program participants felt the program assisted them in their unique health challenges no matter how long the issue persisted.

A few program participants voiced fear associated with change-over of staff which was perceived to happen frequently. New staff at the centers were not trusted and caused some anxiety for program participants because they were afraid new staff would spread information about them. This fear and lack of continuity strained the relationship between clinic staff and program participants.

The vast majority of program participants appreciated the separation of ages by specific clinic days. The older program participants said the youth clinic days were valued because they didn't feel lumped into a group with young kids and babies. Moreover, this scheduling allowed them to have individuals their own age to socialize with while they waited and allowed them to connect with friends in the program.

Many of the program participants mentioned that picking up HIV medication posed a challenge because of missed educational material at school and the ensuing explanation of the absence to school peers. Some program participants felt long lines or waits when coming to the clinic exacerbated these problems by forcing them to miss more school than was necessary. Moreover, older program participants specifically were frustrated at times when they were denied medication, after taking the time and energy to travel to the clinic, because they had forgotten their medication card. They felt it was unfair, and a waste of time, in these instances to refuse the memorized number on the card in lieu of the physical card.

Transportation

Most program participants mentioned experiencing HIV-related stigma when they were traveling to, from, and around the LTP clinics. The stigma resulted from people seeing them enter the LTP clinic or fear that someone would hear the medication as they were in transit. For girls there was anxiety about starting your period or feeling sick on the way to the center if the travel took a long time. Some program participants felt the cost for more efficient transportation would be better spent on food or other necessities, so they would skip sessions.

Transitioning to Adult HIV Care Facility

The vast majority of program participants were fearful of the process of transitioning to an adult care facility.

> For me it's a challenge because there are some people who reach exit age and they are very short. When they go to the adult clinic they find grown lady saying that this child is too small now. Why did this happen to him? Now you feel like you are being discriminated. So, his idea was good such that when you exit, there is a specific hospital which hold LTP children in it so that they won't feel discriminated (16-24-year-old adolescent participant).

The program participants fear the transition to adult care will leave them feeling like an outsider because they will not have the same supportive community around them. In facilities other than LTP they are likely to be a minority, as far as age, which increases the stigma they might feel. The program participants believe having others from LTP in the adult facility would help the transition.

Economic Empowerment Component

Program participants' responses regarding the economic empowerment component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Managing Personal Finances

Many of the program participants felt they had gathered important and useful skills as far as counting and keeping records of their money. Another skill was saving money which helped participants to be independent in purchasing uniforms or school books. The older program participants enjoyed how the program helped them set up groups in which they could promote saving and the sharing of ideas in relation to economic livelihood. They expressed an understanding about the importance of teamwork and getting a diverse perspective when making financial plans or decisions. These groups provided this outlet and allowed them to put skills into practice. All ages understood the value of sticking to a budget. They believed that the program had taught them the importance of ignoring the feelings of greed and insatiability in order to stick to a budget.

Planning and Executing Business Plans and Start-ups

Learning marketable skills was extremely valuable and an aspect of the program participants found fun. Some examples of enjoyable useful skills included planting coriander and basket making. The skills learned in the program could help with making ends meet, especially after they graduated high school or if they found themselves between jobs. Along with this, program participants found the trainings on setting short term and long-term goals very helpful. They specifically enjoyed the session in which they learned to set goals by making small changes every day. Along with this they learned about leadership and the idea of taking ownership of your own actions before you are able to lead others.

The program participants showed understanding of how to conduct business and what might go into starting and operating a business, shop, or market stand. Many of the program participants were able to develop an outline of how they might go about setting up a business. They mentioned the importance of assessing the need for the potential product or service within the community, assessing any financial or personal risk, getting good quality raw products, attracting trustworthy people to build capacity and help with different aspects of the business, acquiring capital through loans, and finally a location and aesthetic that is attractive to customers. They found this knowledge empowering, inspiring, and something feasible to put into action.

The program participants unanimously believed that their status would not affect their opportunities in the future and that they could achieve whatever they wanted. For example, they could be a driver, lecturer, teacher, engineer, pilot, musician, doctor, join the army, and attend college. These were all things the program participants had plans to do and believed they would be able to do. Other hobbies, interests, and side hustles showed that the program participants interacted a lot with their community and felt comfortable moving through that space, just like any other adolescent. For example, being part of dance groups, playing sports, painting.

There was a desire among some participants for the program to build capacity to support program participants with talents in the arts. The program participants felt they themselves or their peers had real talent that could be supported by the program through identifying networking or paid opportunities.

Caregivers

Sexual and Reproductive Health Component

Caregivers' responses regarding the SRH component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Adolescent Disclosure

Caregivers shared that disclosing the HIV status to the adolescent was difficult because of outside pressures and stigma associated with HIV. Caregivers feared the child would blame them and have resentment toward them because of their HIV status. Caregivers overwhelmingly believed the program relieved some of their stress about disclosure by making sure the program participants have a full understanding of HIV and how to manage the disease. The program participants are getting peer support, medical support, and the tools to manage the disease to live a long life. This relieves the program participants of the catastrophic beliefs and feelings which makes disclosing less stressful for caregivers as well as program participants.

Communication with program participant regarding SRH subjects

The caregivers were unanimously supportive of the program giving the participants information about sex and contraception. For example, they believed the participants should be told how to avoid contracting diseases and the consequences of unsafe sex like pregnancy because these issues could interfere with future dreams and goals. Caregivers felt that this information was important in empowering adolescents to make good decisions regarding safe sex. One caregiver felt most parents and caregivers didn't have time for discussions with their adolescent, especially conversations that involved these taboo subjects, because caregivers spend a lot of time trying to earn cash or gather necessities for living. In addition to lack of time there is also a strong cultural understanding that parents and children don't talk about these subjects.

Therefore, caregivers believed it was even more important that the adolescents receive this information from a program like LTP.

One caregiver cited the "sex matters" session as a time when the program caused her to talk more with her child about sex and contraception use. She felt that through the program she learned how truly harmful spreading STIs could be and since youth may not abstain it was important to have open conversations with them. Other caregivers talked about their child openly telling her they had chosen to abstain sometimes, but other times they might not. Another caregiver talked about her child opening up about desires to have a significant other or decisions about being sexually active. There was space for that conversation that hadn't been there before because the child's understanding had increased. Additionally, this caregiver talked about having familial debates and discussions about taboo subjects since the program. This was not something their family touched before in conversation.

Life Skills Component

Caregivers' responses regarding life skills component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Hope

Caregivers noted that group sessions really allowed the program participants to socialize and get to know each other. They saw that their adolescent had more hope once they had met others through the program that were in their position and could relate to them. This not only promotes hope but also self-acceptance.

Caregiver – Adolescent relationship

The close relationships and community of LTP not only instilled hope in the program participants but also seemed to be change the dynamic at home. One caregiver talked about how

once the child interacted with other participants in the program he gained hope, and this altered his attitude toward his mother for the better.

> …he is able to see that they have been able to reach university it suppresses his arrogance and ignorance towards me. Through this he can be closer to me and he is able to think or ignore the fact that even if this happened because of my mother she is still my mother and I should respect her (caregiver of a program participant attending an eastern LTP center).

Ultimately the program promoted respect between caregiver and program participants.

Clinical Support Component

Caregivers' responses regarding clinical support from LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Staff and Appointments

Caregivers felt that the staff treated and cared for the adolescents well, staff accepted them fully when they came into the clinics, and that generally appointments were acceptable overall.

> They are ready to offer their services to us every time. For instance, my child is in class eight so by 8 or 8:30 he is supposed to be in school so the times he needs to come to the clinic he is usually there by 7:30 and the doctor is available to attend to my child. Through this early service giving the child is able to attend classes without missing any of the lessons (caregiver of a program participant attending an eastern LTP center).

Although generally the caregivers were satisfied with the amount they spent waiting for appointments at the clinic there did seem to be some room for improvement. Caregivers were

concerned, similar to the program participants, when appointments interfered with school time and the program participants fell behind. The seamless process described above didn't seem to happen consistently or across the whole program.

> When the children come and some have exams and others do not have exams [at school], instead of them following the line, those who have exams can skip [and should] be attended to first so they can come back to schools and write their exams (caregiver of a program participant attending a western LTP center).

In slight contrast to the program participants, the caregivers were particularly worried when appointments interfered with exams. They believed the program should adopt a system for prioritizing those who were missing exams. Caregivers reiterated the concerns the program participants brought up with high staff turnover. They felt as though they saw new people every time they went to the clinic.

One caregiver's perceptions and experiences stood out. She expressed irritation surrounding the lack of explanation for questions asked of her children during clinical appointments. Specifically, questions the social worker asked about diet during visits frustrated the caregiver and the child because they were seen as irrelevant, a waste of time, and too advanced for the adolescent.

> …they should understand their stage and treat them well as they are not complete adults yet. For example, one was asking my child what he had for supper the previous night…So I wondered how what he ate the previous night is associated with the treatment (caregiver of a program participant attending an eastern LTP center).

This family had been previously treated at another clinic that did not have comprehensive care like LTP, so these questions, with little context and understanding on the caregiver/adolescent side, caused frustration.

Medication Adherence

All of the caregivers approved of the medication and believed that the it was effective in treating their adolescent's HIV. The caregivers agreed that techniques to conceal medication like disguising or lying about medication were effective and helpful in promoting good adherence. Additionally, caregivers appreciated that the medication allowed the program participants to both look physically healthy and blend in with peers. Caregivers noted that this severely lowered their stress level.

> It has also relieved me of the stress of making sure he is adhering because when he comes he is taught on the importance of the adherence to the drugs. So, through that he is able to take his medications on-time every day because now he knows that this is his life and his health is all under his own care. Right now, he is not able to ignore because you see the stage he is at there is a lot of peer pressure which can lead to ignorance even in drug taking. But through the lessons he gets at LTP he is able to take his medication adherently (caregiver of a program participant attending an eastern LTP center).

One issue that was brought up was the importance of supporting program participants in medication adherence as they move into high school. Caregivers feel this is when the program participants are most vulnerable in their care and more could always be done. One caregiver suggested that the program promote program participants going to their local school instead of a boarding school because this allows for more check-ins and support. This was especially true if

the child wasn't mature or one had special needs. Additionally, they wanted even more activities for the program participants when they were out of school. Caregivers felt that the more activities and the more time the program participants are kept busy the less likely they are to get caught up in bad crowds or involved in unhealthy behaviors like drug use.

Economic Empowerment Component

Caregivers' responses regarding economic empowerment component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Financial Assistance

Caregivers were positive about the financial transfers that the program offers families. Specifically, money transfers for education, rent, food, and hospital costs. These all were welcomed because they helped allow the families and lives of the program participants to move on and avoid lapses in education, homelessness, and food insecurity.

One caregiver stood out regarding her experiences receiving financial support from the program. Despite the programs ability to provide assistance for education costs, only her oldest of three children had been supported through secondary school by the program while the other two had received nothing or just uniforms. The caregiver was given a referral to send her middle child to a special needs school but was not given any financial or logistical support from the program for this transition. Without any help from the program this did not seem like a viable option and therefore a source of further frustration. She also has had a problem with paying rent since political disturbances forced her to move her stand where she sells bleach. The caregiver has felt unable to share these needs and concerns openly with the social worker her family worked with because of past negative experiences. Lack of understanding of the breadth of the

program as well as negative interactions with staff could have led to the reported lapse in program assistance for this family.

Marketable Skills

While these types of financial assistance were welcomed there were some things that the caregivers felt that the program could improve. For example, sewing machines were important tools that the caregivers wanted to be provided so they could work towards financial independence themselves.

Caregivers valued all of the skills their adolescents had learned from the program that could lead to financial independence like bead making, animal rearing, computer skills, yogurt making, and soap making. Caregivers requested increased access to computer and books for program participants. This would promote skills that could provide full-time or even short-term employment for the program participants. Specifically, a computer lab or library was seen as something that not only would promote technical skills but also another place for social interaction among peers. One caregiver said, "Those in class 8 can meet those in form 4 and they will be like oh ok there are people like us with HIV and are able to go to form 4. And also, they will interact with those in colleges and this will motivate them in their studies and in their life."

In addition to technical skills parents thought the program could assist program participants in learning agricultural and poultry skills. The caregivers thought this could involve grouping program participants for trainings from multiple informal settlements and focusing on program participants with no native lands. The caregiver thought it would be a good because they are the ones likely to never get exposure to opportunities in farming or poultry.

Program Graduates

Sexual and Reproductive Health Component

Program Graduates' responses regarding the SRH component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Curriculum and Structure

One of the older male graduates wished he would have received more SRH information and instruction from LTP. He "trusted LTP staff with his life" and listened to them, so it would have been the perfect environment to give him this information. He believed more SRH information could prevent current participants from getting false information from the internet or their peers. The information that graduates had received was deemed "straight" and the majority felt the curriculum was truthful and practical. The LTP curriculum was straight because it was useful and refrained from using fear tactics in delivering SRH information that he described as useless and only "buy time."

HIV Status Disclosure

The graduates believed that disclosing to children as early as possible was extremely important because you couldn't predict when the program participant might become sexually active. Therefore, disclosing as early as possible was best because it avoided any guilt from unknowingly spreading HIV. Graduates believed the earlier the program could empower caregivers to disclose to program participants the better the outcomes the program produced.

Despite knowing the importance of disclosure in relationships from the program the majority of the graduates did not believe they would be able to disclose. One female graduate talked about being able to freely disclose to her boyfriend because of the program. She understood the importance of disclosing early in a relationship and felt that it was because she saw a future with this person, so they deserved to know.

Life Skills Component

Program graduates' responses regarding the life skills component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Individualized Care

Many graduates agreed that the program should target quiet and reserved program participants for more individualized counseling. They felt this would help because the big personalities dominated the group sessions and the quiet ones didn't always get to express themselves. Graduates also believed that specific cases like being an orphan should be given more attention. One graduate talked about their own experience of being transitioned out of both LTP and a group home at the same time. Having both transitions at the same time caused severe disruption in the graduate's life, it was a "double tragedy."

> I'd like to take you back a bit on that part of challenges…… But uhh given that I'm an orphan I grew up in a home. When I was leaving Lea Toto I had also to leave the home, so it was double tragedy and here I have to cope with my medication, I have to cope on how I am going to live. The sponsors whom I had, they are now washing their hands. It's me and me alone. So, if we look much into these kids' personal life it would be great because this would boost even their self-esteem and also their adherence (LTP graduate).

Targeting cases like individuals that are very quiet during group sessions or those that have unique home situations should be prioritized for individual counseling and care.

Confidence and Self-Esteem

The close relationships formed within LTP are important and missed when participants start secondary school or university. They don't feel they can be as open with their school mates so having an outlet like the one program graduates created with "Phoenix" (graduate-organized monthly support group) or groups within their adult healthcare facilities are critical. Interactions with other HIV positive individuals builds confidence and self-esteem which increases their ability to interact in the broader community. Graduates also felt that being able to affect the lives of current program participants influenced them in a positive way. When they educate and support individuals still in the program as peer mentors, they build their own knowledge and self-esteem. Graduates felt it was important for LTP to promote and increase referrals of new graduates to support groups and peer mentorship.

Economic Empowerment Component

Program graduates' responses regarding the economic empowerment component of LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Financial Assistance

Financial assistance with school fees was important for almost all graduates. One graduate specifically spoke about being able to complete secondary school and move on to college because of the financial help from LTP. Another was able to go to beautician school and become gainfully employed. Help with school lifted weight and stress from the graduates and they were able to more forward positively in life.

Business Planning

Graduates unanimously agreed that everyone could be business owners. If you have the drive, then you can be successful. They enjoyed and had confidence in their knowledge of skills like sweet making and saving. They felt these practical skills could keep them from poverty if they were between jobs. The vast majority felt they had gained business skills from the program and could develop a business plan. However, writing it down, making it tangible, and carrying it out would still be a challenge.

Similar to the caregivers, graduates thought the program should support program participants with interests and talents in the arts. For example, if they can sing or paint the program should help them find ways for them to market themselves, get training, or even paid jobs. There is more to education and success than traditional school. Fostering unique talents early could allow program participants to excel and achieve even more than graduates.

Clinical Support Component

Program graduates' responses regarding clinical support from LTP took on two major themes. Strengths and limitations of the program were identified within these themes (table 11).

Transitioning to Adult HIV Healthcare Facility

As graduates reflected on the program's process of transitioning participants to adult care the vast majority agreed that it would be more successful if it was longer and if direct referrals were given. The extended process could allow for a more informed decision to be made because of more information about different providers and facility procedures. Graduate thought LTP should be referring to programs and care facilities that include psychosocial support or support groups. The information provided from LTP to the new adult care facility should include psychosocial needs and history in addition to medical information. The biggest issue with transitioning to adult care seemed to be the fear of losing the community that surrounds LTP.

One graduate talked about feeling lonely without her friends and mentors at LTP which caused her to have poor medication adherence and subsequently a high viral load count. This prompted her to talk to the counselors at the adult care facility. In addition to talking about simply fearing the loss of their LTP community, graduates spoke about the sadness they had for missing their friends and mentors from LTP. Graduates believed that the program should allow for time to gather information to make an informed decision, refer to facilities with support groups, and include full histories with psychosocial information.

In contrast to the majority experience with transitioning to adult care one graduate was able to move to a care facility where his father was being treated. He felt he was welcomed into another family and didn't feel like the transition process affected his health or treatment. Another felt that there was no challenge because they had already gained independence during their time at LTP. They didn't rely much on the support of LTP and learned how to keep appointments and take care of themselves. They already felt like they were on their own, so the transition process didn't bother them all that much. One graduate summed up the tension surrounding transition to adult care nicely.

> Yeah from Lea Toto. But when they came out, there was no one. There was no one. You see, when a bird is in the nest, it's always getting fed. I don't refuse. Maybe you gave us too much care that we don't know how to fight for ourselves. But you don't take me out of the nest and throw me away to fly. Just to fly. You have to teach me slowly. You have to take me to a place where I can find another nest. You can recommend. If you don't have the capacity, talk to other clinics. Try and see how they are going. If it follows up your trend, the way you do your things here.

> Then, tell us if you want to exit, these are our suitable places. Because if you just tell me to exit, I don't know what is out here (LTP graduate).

Medication Adherence

Many of the graduates cited one on one counseling at LTP as key in their ability to get back on track with medication adherence throughout different times in the program. Additionally, having drug partners during the program also helped them keep on track with their medication adherence. One graduate explained that poor medication adherence happens because program participants want to experiment and see what will happen if they don't take the medication or they are around friends and can't take the medication without raising suspicion. These are the main reasons program participants will fail to take their medication for multiple days or weeks and why graduates felt the distinction between care and treatment was an important line to draw.

> Most of the clinics, they give us treatment. They don't give you care. When you don't have care, the drugs that you take are not going to be effective to you. You won't have the urge to take the medicines. You won't have anything. It's going to be like you're only taking malaria drugs. And it's going to come, I've talked to so many people. It's going to come to a question that "I'm no longer sick. Why am I taking the drugs?" But you, LTP you were telling us that we don't have to wait for that moment (LTP graduate).

The extensive follow up and holistic care that is offered is different from other clinics and this is why one graduate wanted LTP to serve adults and not force individuals to go into adult care. The graduate believed that the mortality rate from HIV was high among those that had moved on to adult care because they were not prepared to lose this intensive, holistic support.

> The mortality down there [among those at LTP] is too less than those people who have exited [moved to adult care facilities]. Because when you come out here, people don't care about you. Ok that's one thing I still blame [LTP]. Maybe They didn't tell me or maybe they didn't have the capacity to tell me about it. But that lack of caring is really going to finish the youths around. The four pillars of curing this disease is always care and treatment. Most of the clinics, they give us treatment. They don't give you care (LTP graduate).

Graduates felt that preparation for this transition was vital since care beyond LTP was very different required more self-dependence. Getting medication from the program was believed by graduates to be the most important part of their involvement in the program. Graduates unanimously agreed it was easy to get medication both during the program and now at their current care facilities. However, one graduate did mention the challenge of the expense of viral load tests at their new facilities. He felt the program should prepare program participants for these costs early in the transition to adult care process.

The graduates felt the program generally approached drug adherence well, but some felt drug holidays were not helpful because graduates believed it was too tempting to just continue without the medication. Similarly, to caregivers, one graduate felt they could have been more successful with their treatment during the program if they had been going to a day school as opposed to a boarding school.

Staff

Economic Empowerment Component

Staff responses regarding the economic empowerment component of LTP took on four major themes. Strengths and limitations of the program were identified within these themes (table 11).

Education, Business and Technical skills

Staff unanimously believed that the program did a good job of offering options besides formal education and professional positions. They also believe the efforts to provide technical training are helping and being successful. Not only are these efforts furthering the livelihood of program participants it also prevents them from participating in risky behaviors involving drugs and alcohol.

> …but when the economic empowerment came it was like we offered another option… you can really do something for yourself and – so we have seen a lot – in fact a lot our supports are going to the youths because they are coming up and they want to go a technical school and do a certain course. That is the biggest impact I have seen. And good thing most of them are graduating. I haven't seen someone falling out or dropping out of school. So, most of them – and with that – keeping them in school helps them not to engage in other deviant behavior that maybe bad peer pressure – maybe engaging in crime, drug abuse, ya. I think that is a positive (management level, male, LTP staff member).

The program helped program participants manage some of the limitations they deal with by being from a low resource community, and taught ways of being financially stable besides professional jobs.

A specific challenge the program's economic empowerment effort faced was differences in the way caregivers see education compared to the program. The program promotes and supports formal education, but many caregivers didn't have a formal education and don't understand the benefits, especially if the quality of education available is low.

> One time I heard the father asking, "Why do you want to go to school? Me, I never went to school and yet you eat and sleep?" He's a big boy. He's almost a teenager. So, the fact that the father never was taken to school, he doesn't see the need to be in school. What he thinks is the most important need is the need to eat and sleep. It doesn't matter what kind of house he is sleeping in (female, LTP social worker).

This difference in opinion and experience is an issue the program has to face in order for the program to run efficiently. Specifically, social workers believed this issue affected caregivers' motivation to help pay school fees or offer support throughout schooling. Staff believed the program was able to address this by promoting options like technical education along with supporting formal education which can open up more pathways for practical skill building. Additionally, in order to continue supporting educational opportunities the program ensures other needs in the home are taken care of, so money for school fees is not needed for food or rent. Despite these efforts, social workers believed more could be done to promote both the importance of education to caregivers and strategies for them to better support the education of program participants.

A few of the staff noticed some differences between the way those attending western centers as opposed to eastern centers responded to the program.

> Because more you'll find more of them in the eastern region have either dropped out of school or they don't want to go back to school … they are very um proactive when it comes to businesses…Especially the ones who have finished school and they don't have much they are doing they are very pro-business because they don't want to go to school. They want to just start something that doesn't have to do with school (female, management level LTP staff member).

Program participants in the east may be particularly interested and proactive in pursuing technical skills or starting a business as opposed to continuing in school. Staff not only mentioned differences between those at western versus eastern sites but some mentioned differences in how males versus females respond to the economic empowerment efforts of the program.

> Ya I have seen like three cases of boys – they themselves pushing – they know the economic empowerment is supposed to pay for school for them, or pay for a cause, or help them start up – I've seen them really push and come to the economic empowerment and really remind. But for the girls, I think the caregiver steps in for them mostly (female, LTP social worker).

Generally, the staff felt boys were better about coming in to follow up about enrolling in economic empowerment sessions and receiving financial assistance. Social workers felt that compared to boys the girls were more likely to rely on other people to be their advocate.

The majority of staff believed that giving financial support to existing businesses (boosting) as opposed to supporting start-ups was more successful.

> Now for those whom you boost there is a high chance they will still move up with the idea because it was originally – and they tried to do something before you

> intervened. But for the startup, that's where you find a challenge, bringing up that business (male, management level LTP staff member).

This belief was held because it was thought that those who had put their own time, money and effort into starting some effort will do a better more proactive job as opposed to those that are asking for money from the outset.

Financial Transfers

Many staff mentioned the issue with the process of transferring financial assistance to families of program participants. Specifically, the time it takes to distribute the money is too long and hurts the program's credibility.

> I've also felt sometimes our supports… the finances it takes to support a child are taking too long from the accounts department. So, if you're supporting these children to be in school, there you are going to school to tell the head teacher 'we are going to support this child please keep them in school. Give me about 2-3 weeks. Then a month comes, another one comes, again the children are sent home… But still it really affects me because as a social worker you're supposed to do social support. Sometimes it feels like the caregivers aren't trusting what you are doing. You tell them [the support] will be there next week and then the next week comes and you feel like you're losing credibility and trust (female, LTP social worker).

In addition to the program's credibility, long-term program outcomes are affected when financial assistance transfers are not efficient. When the money is not disbursed in a timely manner the money can be re-directed to other more immediate needs as opposed to the intended purpose of supporting their business and long-term financial gains.

> I feel them taking too much time. Like for example, I have identified a need - like they need to support – what they do is they help adolescents like for example this adolescent has not performed well in class 8 so they will be taken to a technical course... So I'll go make my skill of braiding hair. And then after that I'll be able to put up a salon or to do hair as a mobile – or as a mobile salonist and then I will be able to get a source of income and my life will be able to move on from there. So, I think they really derail that support…So, I was talking about this particular case that I saw of a girl and this girl wanted to go and make curtains. And it took almost more than four months, and this girl got pregnant. Soooo… that is a gap (female, LTP social worker).

Staff believe there needs to be clearer communication between the accounts department and the economic empowerment officers. Specifically, staff pointed to lack of notification to tell the economic officer money has been delivered. As a result no follow-up can be made until the notification arrives that money has been spent. If stronger linkages existed within this process, the economic empowerment officers could be more active in advising on how to spend the money and be more in tune with the financial needs and stressors of each household.

Ambiguity between social worker and economic empowerment roles

Staff in the west also talked about issues surrounding the relationship between economic empowerment officer roles and social worker roles. There have been some misunderstandings about when and how the support provided by these roles interact. One social worker explained, "I should first solve the social problems…So, I think there should be that boundary – I [economic empowerment officer] will only come in after you [social worker] have done the social…" If the economic empowerment officers are intervening too early in the process it

interferes with the psychosocial support individual receive from counselors and socials workers. One social worker also said that the foundation of psychosocial support allows for the outcomes from economic empowerment support to be more substantial.

Economic Empowerment Curriculum

An important need expressed by many staff about the economic empowerment portion of the program was the need for a comprehensive curriculum that could accommodate different age groups.

> So I think the younger kids they try to understand it, but if there is a curriculum be followed for age specific. I haven't seen that curriculum yet. But we try to get the information we have and tailor towards different age groups that we have. But that curriculum is not yet there (male, management level LTP staff member).

Staff felt that more comprehensive, age appropriate, and practical lessons should be incorporated into the economic empowerment sessions.

Sexual and Reproductive Health Component

Staff responses regarding the SRH component of LTP took on three major themes. Strengths and limitations of the program were identified within these themes (table 11).

Program participants' SRH knowledge and application

Generally, staff were pleased with the increase in knowledge and understanding they saw among the program participants regarding SRH.

> So far those we have seen in the adolescent groups and trainings we have seen significant progress. I can see based on the ones from Kangemi I have seen them coming more vibrant in expressing themselves, their body systems, and they are

> much aware of where they can get information about condoms and family planning and how they can approach. They can say no in a way the other person can understand and they can negotiate. The same to gents. I know that I'm a teenager, but I don't need to have sex to show that I am a man. Because I know that if I mate I know how to do it in a way that is mutually respected, and which is respected by both parties and healthy to both parties (male, management level staff member).

Program participants know more about their body systems and know where to access and get information about contraception. They additionally know more about speaking with romantic partners about contraception. Staff believe the reason the program is performing well involves the multiple points of contact that happen when program participants come to the center. For example, program participants may be asked about their relationship status and assessed on their knowledge of safe sexual practices by the clinician, the counselor, and even the economic empowerment office. Even though this is not a formal part of the program there is a responsibility that every staff feels to check-in and they believe this is making a difference in outcomes for program participants.

The staff unanimously agreed that giving accurate information was important and vital to accomplishing the goals of the program. Specifically, information on how to protect yourself and others from STIs, unwanted pregnancy, and secondary HIV infections. Most staff believed the program was doing a good job of disseminating this information, however one social worker felt that the information given was old fashioned and not relevant to the adolescent context. She felt the program was not teaching enough about contraception and ways for program participants to protect themselves and their partner if they did engage in sex. She believed the SRH information

could be more comprehensive because there are still instances of the program participants not being prepared for sex and becoming pregnant.

> Today we were discussing one of the cases… three weeks ago who admitted she was pregnant. Age 14. So, I was quick to look for [LTP staff member's name] and we went to visit … that family and we talked to the mother and we didn't find the girl, she was in school…That is one of the girls we took to the camp. The last camp we had...You know it would be very bad if we said, "Oh I wish we had given them information." But here we have given so they can choose what to do. But we're still having issues (female, LTP social worker).

Other staff, particularly administrators, were concerned that exposure to the information from the program could increase sexual activity among the program participants. Particularly if this information was given without talking about the importance of commitment, trust, and vulnerability going along with a sexual relationship.

PrEP, condoms, and contraception

Administrative staff were hesitant toward the distribution of pre-exposure prophylaxis (PrEP) even though it is available, accompanied by education, in other Nairobi clinics. Administrators have prevented LTP from distributing it in their clinics for now because it is still new, and they don't want people to take it without having full knowledge they believe their capacity still needs to be built up in the clinics before distributing PrEP. One of the managers felt the main reason the organization had not distributed PrEP was a denial that the teenagers were sexually active. He saw this belief as incorrect and a barrier to distributing the PrEP which would be extremely helpful for individuals in the program.

Every staff member mentioned the restriction on distributing condoms as a result of being a Catholic FBO. Many staff felt this policy should be adjusted and the program should distribute condoms at the LTP centers because it would allow for increased interaction with the program participants leading staff to have a better idea of their needs. Additionally, distributing condoms directly from LTP would be more convenient since participants are already attending the center to receive care. This change in policy would lead to less stigma because program participants are already familiar and trusting of LTP centers and staff. They don't believe that the referral process is successful in allowing the program participants to access contraception.

> We actually have a major problem, we can teach, but we cannot provide. So, we lose some of the people who need to use the contraceptive in between. One thing I know for sure is that if you send an adolescent to a health facility, like a government health facility, to get contraceptives, they will not go. That is one thing I keep talking to our clinicians and say we need to have somebody at the health facility that we can link our adolescents to. That is why we started with the peer health program so we can work with a closer facility and especially the government facility and have a youth desk, at the facility. The desk can be manned by the youth themselves, you who have been trained. If I send someone from Kangame lea toto to Kangame health center, they will specifically go to the youth health desk and say I have been sent from lea toto and I need contraceptives. So, they will be shown to where they will be gone. You can imagine that you have a queue of 30 people who are all mothers carrying their children, and then you have a 16 or 17-year-old girl queueing for contraceptives. Even the way people will look at her and tell her she is in the wrong place. So that

> is the reality. It is easier to say I will refer you, but the practicability is the problem (female, administrative level staff member).

In addition to the barrier of distributing contraception, the majority of staff said there were contraceptive methods that were less effective among people taking ARVs. One of the administrators said these differences in the effectiveness of different contraception for HIV positive individuals is only discussed if the program participants initiates a conversation about contraception. Without a systematic way to assess sexual activity and contraceptive use the program relies on participants to bring it up and ask for a referral, which most of the staff thought was unlikely. Additionally, the clinics to which LTP refers for distribution of contraception do not ask about HIV status, so there is gap in care because many program participants are not aware of how different contraception methods can be affected by ARVs.

Addressing Changing Population Needs

Most staff also agreed that the program participants were not abstaining from sex which is why accurate and relevant SRH information was important for good program outcomes. Staff mentioned that the camps were not only fun and useful for the program participants, but they also made some staff aware that participants were not abstaining from sex.

> I know most of them have slowly started getting to terms that they're sexually active because it's also been a challenge even when we go to camps. If you don't bodyguard and separate. Actually, I heard the adolescent program coordinator say that boys and girls are treated in a different venue. Because when you bring them to a common venue for 5 days, you actually don't sleep. At night, you have not to sleep and become a bodyguard, lest you find people paired on the corridors. So, I think during these camps, actually they have played a big role to make the staff

> acknowledge that our adolescents are sexually active. And also, the rising number of reported pregnancies and miscarriages (male, management level LTP staff member).

Conducting camps and paying attention to pregnancy and miscarriage statistics were a good way to really allow staff to understand and reevaluate the population's needs to a fuller extent.

Most of the managers, social workers, and counselor see that it is important to acknowledge the growing teenage population that the program is facing and will continue to face in the coming years.

> Because PMTCT is has worked. It has worked. So now the concentration is on the youth, the teenagers because that is now where the rate of infection is again starting to come up. Yeah. So we need to know as to how we can be able to make it better for them. As much as it is, we're in pediatric care. Again, how can we be able to accommodate the youth and see to it that they go into adulthood and they are prepared and that they don't again spread the infection to the community (male, management level LTP staff member).

Addressing SRH needs of teenagers is vital because teenagers and adolescents deal with peer pressure and need guidance to make safe choice to avoid secondary HIV infections, pregnancy, or other infections. In addition to dealing with peer pressure, social workers and managers agreed that autonomy around sexual decisions is not always present and giving the program participants tools to keep themselves safe in these difficult circumstances is important. A manager gave the example of a girl in the program who would go to a hotel owner and have sex with him in exchange for food. Education around transactional and coerced sex should be included in the

program to truly address the needs of program participants. Staff also noted that when conversations and topics were covered the program participants responded positively.

> Recently, I saw some that went for a camp and they were taught on how to teach the community on how to use contraceptives. And I came and they gave me a demonstration to me on what they learned and I told them even you, you should utilize that information. And I think that was a good opportunity for that (male, management level LTP staff member).

Program participants were excited and proud of the knowledge they received from the program on this subject.

Life Skills Component

Staff responses regarding the life skills component of LTP took on four major themes. Strengths and limitations of the program were identified within these themes (table 11).

Comradery between Program Participants

Staff unanimously feel as though the program is improving. A male management level staff member specifically identified camps as well as initiation and circumcision events to be important positive additions to the program. Additionally, peer education and recruiting more peer educators was successful and important to getting messages across.

> Yeah their behavior has dramatically changed mostly confidence, yeah, since the economic since the adolescents program begin we had very much who had esteem issues, low low self-esteem but we have noticed especially in Kawangware now we have teens who are able to express themselves before they were timid and they didn't want to participate in anything but now you see they come out and they will

> talk to you confidently. They will be able to air their views to you confidently uh drug adherence has improved (female, management LTP staff member).

Not only are the program participants increasing in their own confidence, self-esteem, and ability to effectively communicate; program participants are able to encourage one another and support one another as friends and mentors.

> So, the adolescent ones, we do trainings to these youths and the adolescents. They are able to pick up and others identify themselves like, ya, all is not lost. I can go back to taking [inaudible] and find my way into labor jobs, something, or I can do business, I can sell something. So, the adolescent program has helped us identify these youths. They like the program because they meet friends, friends who maybe within themselves. We have different people, some doing good and some not doing good, but when they meet together they do some encouragement. You learn from your friend (male, management level LTP staff member).

Comradery built among the program participants instills hope and allows life to continue as normal despite HIV.

Incorporating Religious Leaders and Teachings

The staff overwhelmingly felt referring to specific biblical teachings helped give grounded moral direction for the program participants. For example, forgiveness and understanding the idea that every human is equal and valuable in the eyes of God. There were multiple staff that thought the program could be improved by incorporating religious leaders into the program. One of the big issues they felt this could tackle was forgiveness between program participants and their caregivers. A religious leader could better support these deeper needs compared to a counselor or social worker.

Investment in Staff Wellbeing

Multiple staff brought up the need for staff to be supported by counseling. One staff talked about the benefit a trauma counselor was to her and the other staff at her center. The counseling allows staff to talk about emotions and experiences they have dealt with working with this population. The comradery between staff at specific centers as well as external counselors helps staff heal and continue performing services at a high level. This staff member felt that these counseling services should be offered across the program to all staff.

> Secondly, we are grateful that now we have a stable counselor.... We started last week and we're doing it again this week with an external counselor…. For the staff just for the staff.… So, I think it's a great idea because it now gives us a window to vent out those in-depth feelings that we've had about things that have happened to us while we're here (female LTP social worker).

The trauma counseling is seen as an investment for the program because it strengthens the program and ensures that the program will continue to serve those in the program well.

Flow of information was important for all staff and specifically counselors and social workers. Counselors, social workers, and managers believed they would feel more supported by the program if there was a steady and systematic flow of information up and down chains of command. One social worker suggested a point person at each center that was in charge of passing information to everyone else. If everyone in the program knew who these people were information might flow much more quickly. This person can also make sure that unique concerns from the different center are represented and heard by administrators.

Support from Caregivers

The majority of the staff talked about how caregivers speak with them about improvements in their child's behavior. For example, becoming more independent, acting more respectfully towards their caregivers, and accepting their status. The staff have heard the caregivers express the feeling that it is easier for them to speak with their children and fill in any gaps once they have gained basic knowledge from the program. It is difficult to start the conversation, but the program alleviates that stress. The program acts as an outlet and a place to get questions resolved that parents might be too busy to deal with or lack information to answer. Staff feel encouraged that the caregivers are supportive of the program and the support their child is receiving. Having the support and positive reputation with caregivers is a strength of the program.

Need for capacity building

In the pursuit of more peer educators most administrators thought that more staff should be trained to be trainers of trainers. Moreover, more staff should be hired to lighten the load on the few people that are running sessions. There was an overwhelming consensus that having more sessions and more opportunities for the staff, program participants, and peer educators to interact the better the program will perform. Multiple staff members brought up how inconvenient it is to have different staff members conduct sessions each time. Staff believed there should be both varying of the experience for the program participants and consistency in the curriculum and teachers. If the program was able to hire, train, and maintain more people solely in charge of conducting aspects of the program it would increase consistency and efficiency of the program.

> Making staff in a position to handle adolescent issues. Because we have found that there is always a gap. Training the staff to be efficient to do it and to retain them [trained staff] because that is another challenge… So, we are bringing in a

> new person who does not have that training and information so it leaves a gap (male, management level LTP staff member).

One administrator felt a way to increase the capacity of staff would be to collaborate with another organization in the city that was using experts in psychology and psychiatry to better their program.

> They gave us their process of implementing it. When I compared it to our adolescent program, there is a dimension they have because many of the people directing it are medical doctors and psychiatrists who are doing some psychological element in their program… see I am a psychological counselor, so that dimension of knowing of the developmental stages of the human person and also knowing trauma. Because all of them are traumatized, even when they are disclosed to. And they accept this is why I am taking medicine, and this is why I am different from my brothers and sisters. It takes away the certain amount of unknown. But when you come into adolescence after puberty and you are capable of reproduction, the whole issue of sexuality comes up and the trauma associated with that. So, having a deeper psychological component to our program is what I am going to suggest too (female, LTP administrative level staff member)..

Collaboration and incorporating experts during program sessions was believed by a few staff as a change that would both build capacity of the staff and keep the program interesting and varied for the participants.

Most staff felt that their training should be more attune to the different developmental stages of adolescence and young adulthood. They believed the life skills curriculum should also take shape around these different age groups and be comprehensive in addressing issues at each stage. This would help the staff to do their job even better and develop deeper relationships with

the program participants. In addition to staff understanding different developmental stages, a few staff mentioned the need for cultural competency surrounding the varied backgrounds from which the participants come from as vital for the program to continue improving. The efforts to understand the different terminologies and customs of the different tribes the participants represent should continue and enhance so that the program can better support all of the program participants.

Clinical Support Component

Staff responses regarding clinical support from of LTP took on three major themes. Strengths and limitations of the program were identified within these themes (table 11).

Clinical Visit Protocol

A policy change that many social workers brought up was the need to amend the "clinical per visit" or clinical visit protocol. For example, social workers and some staff with medical backgrounds feel there is a need for questions like "time of last menstrual period" and "Are you sexually active?". These questions would allow for a standard of care for every program participant and would move away from relying on them to bring it up themselves during clinic visits.

Clinic Locations and Accessibility

Social workers and counselors mentioned locations of each of the centers as an issue. The centers in commercial areas are better as opposed to residential areas because it is harder for people to pinpoint who is going to LTP, resulting in less stigma. Another part of lowering stigma was having age-specific clinic days. Staff agreed that this was happening at most clinics but that this was extremely helpful and should be standard across the program.

Transition to Adult HIV Care

Transition out of the program was a large issue that every staff member mentioned as an important issue for the program to address over the next few years. First, all staff believed that a

standard transition procedure should be decided upon and followed. Exchange visits had been used in the past during transitions, but staff believed that these should be universal and standard in the program. The visits allow the young adults graduating from the program a glimpse of options for transitioning and to ask questions to assess the different facilities. Some may want a facility that is hands off and some may only thrive that has support groups similar to LTP. Speaking about transition early to adolescents, specifically incorporating it into camp sessions, and having repeated conversations about transition was seen as positive and helpful to the process. Additionally, providing opportunities for graduates to speak and connect with current LTP participants continues the conversation about transition and the opportunities outside of that LTP in the adult care facilities.

> Actually, there is talk at the camps where we say they are going to transition into the adult ccc. I think this is what was lacking originally. We would wait until they were 18 and say no it is time to exit and you've reached the age. It would come as a shocker to them. Now we repeat to them that when they reach this age, it will be time to transition. The peer program is helping, especially the graduates. When they come back and tell them there are different programs outside of lea toto and different activities then the children here can see there are activities like lea toto. Then they also see there is someone from lea toto who is in that program and then when I transition I will not be alone. In the graduate program, they've incorporated youths who did not come from lea toto. They all belong to a group called Phoenix, they say I've been raised in coptic or mgbathi hospital and I'm good. So that has helped (female, administrative level LTP staff member).

Some staff felt that the program should not transition the program participants and expand to accommodate caregivers and other HIV positive adults. A social worker believed expanding could aid in identifying adolescents in the community that need the support of LTP. As of right now the program has been conducting HIV testing in schools and working through community health workers to identify new HIV positive adolescents for the program. Scaling up and treating adults could attract more adolescents whose parents prefer to be treated at the same facility as their children.

Staff identified the complicated side of the transition that involved the emotional connection that staff build with program participants. The bonds staff build with participants can complicate the transition process further because staff have a hard time letting go and their care to a new facility.

Personal and center security challenges

One key issue brought up by staff in the west was security for the staff as well as the center itself.

> Our biggest challenge in [name of center] has been the security. We are very grateful that none of us has been harmed. But we don't feel very secure… especially when you come to the office and find it has been broken in and you find you don't have computers, all the resources are gone. You feel you've lost a lot. For example, I'm one of the victims of theft. It happened a week ago, a laptop was stolen and it had sensitive information that is needed and if I am going to work on all of these files again. You feel like you're not progressing. You feel like you don't have all that it takes. Like right now we only have one computer

> for all of us. So, if I want to do something, right now I am incapacitated at this point (female LTP social worker).

Not only is there fear associated with not feeling safe while working, resources necessary for work are not secure. This leads to inefficiency and data insecurity for the program.

Economic Empowerment Curricula Document Review

Economic Vulnerability and HIV

HIV is strongly connected with poverty and economic vulnerability. Some strategies to address economic vulnerability can involve risky behaviors for those with HIV and especially adolescent girls and young women (Ricardo, Barker, Pulerwitz, & Rocha, 2006). A study done across 12 African countries, including Kenya, found that economic independence may increase girls ability to negotiate condom use and timing of sex (Chatterji, Murray, London, & Anglewicz, 2005).

Training on how to earn, use, invest and protect money allows young people to pursue goals, avoid risk, and have some sustainable ways to support themselves and the people they love. In a randomized control trial done with adolescents in Zimbabwe it was found that an economic intervention combined with health and life skills resulted in greater food security, chances of a girl having a source of income, and condom use compared to an intervention with only education in health and life skills (Dunbar et al., 2014). As a result, PEPFAR has funded FHI 360 which manages the Accelerating Strategies for Practical Innovation and Research in Economic Strengthening Project (ASPIRES) (Save the Children Federation, 2016). The primary goal of the project is to support gender sensitive programming, research, and learning to improve the economic security of highly vulnerable individual, families, and children. Specifically, ASPIRES targets those infected or affected by HIV/AIDS. Under ASPIRES South Africa from 2015-2017

Save the Children provided local implementing partners with training and technical assistance to conduct a comprehensive economic strengthening program. This program called *Impumelelo* was implemented alongside a HIV prevention education curriculum. This program is funded and endorsed by PEPFAR and has the similar goals as the economic empowerment component of LTP (Save the Children Federation, 2016). For this reason, comparing these curriculums could inform LTP moving forward in bolstering their economic empowerment program.

When comparing the LTP curriculum and the *Impumelelo* curriculum there were differences in both the topics covered and the methods used to deliver instruction. Themes were developed around the major curriculum topics. Overall, the *Impumelelo* curriculum was more comprehensive in the topics it covered as well as the method in which it covered topics. While LTP used group discussion and some stories, the *Impumelelo* curriculum had participants play games, act out different scenarios and interact with bank employees as well as successful business owners in the community. Moreover, the curriculum used easy-to-memorize mottos and sayings. For example, "Count to 10, think again, and be money wise." While LTP used a few stories, for example, when talking about saving, the majority of information was presented in a didactic or discussion-based format. The LTP curriculum had very few suggestions in the curriculum as to how to engage with participants. Therefore, a lot was left up to the instructor as to how to conduct the sessions. This was different from the *Impumelelo* curriculum which provided detailed instructions on how to engage and deliver the curriculum

Budgeting, Saving, and Spending

The *Impumelelo* curriculum covered spending by having the participants identify wants and needs in their own weekly spending habits. The LTP curriculum provided a tool to walk

through weekly spending but did not provide a tool for budgeting or provide information about how to identify wants versus needs. Both programs covered refraining from carrying cash around to avoid theft and as well as impulse purchases.

Both curriculums covered the definition of saving specifically that saving is putting aside money for the future. Additionally, both described different kinds of saving for example, cash saving versus saving in-kind and the different goals for saving including security for future emergencies, life milestone events like weddings, or investment. Both curriculums connected goals with savings. They both used stories to show the importance of thinking of long-term goals and investments (for example, the importance of saving money and investing in things that will advance their livelihood or the process of weighing an investment in salon necessities or buying a chicken to one day sell eggs). For practical application both curricula provided a template for thinking through savings goals. However, the *Impumelelo* curriculum provided an example and instruction regarding how to explain each mathematical step in filling out the template during a personal exercise.

The *Impumelelo* curriculum also provided a step-by-step script for beginning and conducting a savings group meeting. LTP promoted savings groups by connecting and grouping individuals for this purpose; however, there were no defined roles or description of how meetings should occur. The *Impumelelo* curriculum took participants through how to address different situations that might occur in a savings group. For example, someone not contributing to the fund, someone being disruptive, developing a social fund, and the importance of record-keeping at every point so that no one has any doubt the money is secure. These are all aspects of a savings group that were not explicitly covered in the LTP curriculum.

Both curricula communicated that saving is for everyone no matter the amount of money. The *Impumelelo* curriculum further spoke about saving as being for both genders and at any age. Breaking down the disparities in savings, earnings potential, and opportunities between girls and boys was a theme throughout the *Impumelelo* curriculum. The *Impumelelo* curriculum addressed this by having the participants brainstorm practical ways they could reduce differences in treatment between a brother and a sister within a contextually relevant scenario. Additionally, females were mandated to be included in leadership positions within the structure of *Impumelelo*'s savings groups. These aspects gave the *Impumelelo* curriculum an emphasis on gender equity throughout the program.

Sources of Money

The *Impumelelo* curriculum additionally covered different sources of money and promoted discussion and identification of good versus bad sources of money. This message is reinforced by discussion and culturally relevant stories. Regarding sources of money, LTP covered the importance of understanding and keeping up to date on technology. Skills in technology could be a good way to advance in many different careers as well as a way to fill gaps between employment. LTP hosted a talent show as part of their curriculum. The talent show was an opportunity for the participants to explore different marketable talents.

Borrowing and Securely Storing Money

Both curricula covered the advantages and disadvantages of storing money in formal banks, savings groups, and at home. Additionally, lessons covered the different levels of paperwork, security, and accessibility that go along with these different methods for saving and storing money. The *Impumelelo* curriculum employed games that were active and had the participants decide when they would save money, get a loan, or combine these methods to gain

capital towards fulfilling different types of financial goals. The *Impumelelo* curriculum covered the rights of individuals who are borrowing money according to the law and included a presentation from a bank employee to shed light on the banking process and make it more accessible.

The *Impumelelo* curriculum included a tool for breaking down ways for participants to know the true cost of loans from different entities. The *Impumelelo* curriculum warned against buying items on instalment through the example of purchasing a TV and its vastly different prices when comparing payment with cash versus on installments.

Biblical and historical examples and stories

LTP's curriculum highlighted Jesus, his life, and his love for entrepreneurship. It talked about the ways Jesus blesses hard work and does not like laziness. The LTP curriculum specifically cited verses in the Bible such as Matthew 25: 14-29 and Luke 19:11-26. The LTP curriculum stressed that participants could change their life and create opportunities through hard work. Additionally, that an individual doesn't have to have a lot of start-up capital to begin a business or put an idea into action. In addition to biblical references, LTP used African culture and history in their curriculum. This part of the curriculum emphasized the idea of valuing the community and working together above materialistic possessions. The curriculum pointed out the fallacy of believing that some communities are meant for business and others aren't.

Financial Negotiations

The *Impumelelo* curriculum emphasized negotiation being a privilege of freedom. It is because of freedom that participants are even able to partake in negotiation. Moreover, the *Impumelelo* curriculum covered the different possible outcomes of negotiations like win-win, lose-lose, win-lose and how to conduct themselves and approach negotiations.

Chapter 5. Discussion

The purpose of this evaluation was to identify how stakeholders (staff, adolescents, caregivers, graduates) assess the strengths and limitations of LTP. Specifically, this evaluation identified strengths and limitations in preparing participants with knowledge and skills in the areas of SRH, economic empowerment, life skills and clinical support. In addition to the evaluation, a document review of the LTP economic empowerment curriculum and the *Impumelelo* curriculum, developed by Accelerating Strategies for Practical Innovation and Research in Economic Strengthening Project (ASPIRES) and Save the Children, was conducted. The major themes and modes of instruction used in both curricula were compared to understand how the LTP curriculum could be informed by the *Impumelelo* curriculum.

Transition to Adult Care

Overall, the preparation for LTP participants to make the transition to adult care was seen as inadequate. Adolescents feared leaving their community and intensive follow-up at LTP for adult care facilities that were perceived as stigmatizing and lacking resources. Program graduates spoke about the loss of their LTP support system and community negatively affecting their medication adherence. Staff and program graduates believed that there should be a standard process of transitioning to adult care that would provide enough time for program participants to receive direct referral options to specific physicians or care facilities; gather information from program graduates, friends, and family members about differences between adult care facilities; and have a holistic transfer of information regarding medical and psychosocial history to selected adult care facility. Opportunities to visit different adult care facility choices and having relationships with other patients or staff at the new care facility were also viewed as important for a positive transition. Other studies found similar recommendations to strengthen the

transition to adult care, such as facilitating visits to adult clinics to start the transition process early, improving communication and flow of information between the different providers, and making referrals to physicians to addressing different cultures and levels of development among patients (Edwards, Clapson, & Miles, 2004; Sharma, Willen, Garcia, & Sharma, 2014; Valenzuela et al., 2011; Wiener, Kohrt, Battles, & Pao, 2011) .

In addition to a lack of standard process for transition, staff also believed their emotional connection with the program participants complicated the transition period. Staff had difficulty leaving participants they have been working with since a young age and entrust them to another care facility. The literature supports these findings on difficulties of HIV positive adolescents transitioning to adult HIV care. Edwards et al. (2004) found that adolescents less attached to program staff and community described their transition as less complicated while those who were more attached described delaying their transition because of anxieties about leaving. Our study results reflect these findings with program participants, graduates, and staff reporting that the close attachments that developed between adolescents and staff were beneficial for their care while they were in the program but could complicate their transition to adult care.

Distribution of condoms and contraception

Improving access to condoms and contraception was important and desired by participants in the program. Additionally, participants wanted more direction and advice on how to negotiate condom use, especially among females. Although, program staff overwhelmingly agreed that condom provision was important, they reiterated that the main reason LTP referred participants to other sources rather than directly distributing condoms and contraception was because of its association with the Catholic Church. Two opinions formed around this policy of indirect referral condoms. One opinion was that changing the current policy and distributing

condoms directly would be a more efficient way for participants to access contraception. Direct distribution would additionally reduce the stigma around access to contraception because of the trusted relationships between program participants and LTP staff. Another opinion was that changing the policy on direct condom distribution would be wrong and impossible both because of LTP's association with the catholic church and because it could promote increased sexual activity among program participants. As a result, they believed referring participants to other sources for condoms should be made more efficient.

Program support of staff

Staff were concerned about violence and theft that made them feel unsafe and reduced the efficiency of LTP. Staff cited computers that were stolen from the LTP center leaving one staff member without a computer, which reduced her immediate efficiency. Moreover, some files were lost in this process, so staff felt that this event not only negatively affected program efficiency but was also threatened the confidentiality of their participants.

Staff desired more trauma counseling for themselves. They felt this helped them continue their work without becoming overwhelmed. Multiple staff mentioned mental and emotional stress that came along with constantly interacting and working with individuals facing HIV, psychosocial issues, and poverty. Lack of staff trauma counseling was seen as very limiting to the program because it reduced program staff's efficiency, while having staff trauma counseling was seen as helpful and invigorating for staff. The outlet to express mental and emotional stress allowed staff to function at a higher caliber and enjoy their work.

Economic empowerment curriculum

LTP used practical tools for program participants such as making a savings plan, setting goals, and tracking spending. Program participants reiterated the importance and usefulness of

this aspect of the program which they felt allowed them to gain not only knowledge but practical skills in saving and goal setting. LTP program participants praised the savings groups that offered diversity of opinions and ideas, hope for the future, as well as the opportunity they offered to save and take out loans. This positive outcome is also reported in findings of other studies which found that savings programs promote financial security and are associated with improved perceptions of future vocational opportunities and expectations as well as improved confidence in carrying out educational plans (Jennings, Ssewamala, & Nabunya, 2016; Karimli, Ssewamala, & Neilands, 2014).

Other aspects of the program that supported economic empowerment included learning marketable skills such as planting coriander, basket making, computer and technical skills, as well as small business skills. The curriculum, according to LTP staff and participants, should evolve to be more comprehensive and have more of a practical application for multiple ages. The curriculum document review conducted in this study reinforced these interview findings. Specifically, that LTP's curriculum used methods like didactic lecture or story-telling to deliver messages to participants while the *Impumelelo* curriculum also included action-oriented and guided practice methods such as games, acting out, and individual or group exercises. LTP participants and graduates clearly understood the importance and implications of saving money, business planning and execution, and budgeting. However, there were no practical tools or guided practices in the curriculum regarding budgeting or executing a business plan which may have contributed to participants' and graduates' hesitation regarding actual ability to implement these skills. Overwhelmingly, evidence-based teaching methods that are action-oriented increase learning, understanding, and achievement. When learning is hands on, interactive, and applicable to relevant scenarios it provides better outcomes (Eddy, Converse, & Wenderoth, 2015; Freeman

et al., 2014). This could explain some of the reasons adolescents and graduates enjoyed and felt more comfortable with aspects of the curriculum, for example saving and marketable skills, that used more active teaching styles. Incorporating more of these evidence-based practices along with more comprehensive instruction to session facilitators could improve the ability of participants to put the knowledge into action and cause the curriculum to be presented more uniformly across the LTP centers.

LTP staff felt boys in the program were more proactive and empowered to check up on loans, financial assistance, or enrollment in program sessions compared to girls who relied on others to be their advocate. The curriculum document review additionally demonstrated that the LTP curriculum lacked discussion and instruction on gender equity or questions regarding the differences in treatment between boys and girls. ASPIRES included both discussion on the different barriers that girls face compared to boys and prompted discussion on this topic when introducing saving strategies and goals, different sources of income, and strategies for tackling barriers to financial goals and security. Kabir (2016) highlights the way society affects beliefs about masculinity and femininity. These beliefs in turn lead to differences in value between the genders and their prospective work.

> …norms, beliefs and values define the dominant models of masculinity and femininity in different societies and allocate men and women, boys and girls to different roles and responsibilities on the basis of these definitions, generally assigning a lower value to those aptitudes, abilities and activities conventional defined as ‘feminine’ relative to those conventionally defined as ‘masculine’. They thus define constraints which apply to women and men by virtue of their gender (Kabir, 2016).

It is important for LTP to talk to participants about the different struggles both genders face; however, it is particularly important to recognize the tendency of females to move away from important means of financial stability and livelihood. Without intentional conversations on gender equity LTP might be losing an opportunity to empower girls in the program.

Medication Adherence and Disclosure

Camps, or extended program sessions away from the center, and talent shows were viewed very positively by all stakeholders in the program. Program participants loved the chance to display their talents and caregivers loved that program participants were given this opportunity. Program staff felt that camps and talent shows were opportunities to connect with program participants more personally and address each participant's needs in a more efficient and holistic way. Camps and talent shows were overwhelmingly identified as contributing to program participants' increased self-esteem, confidence, hope, and ability to socialize both with those at LTP and the broader community.

LTP also helped alleviate stress and anxiety for caregivers and program participants' regarding medication adherence and any misinformation from school, peers, or other community members. Staff saw need for training for instructors regarding cultural competency, involvement of religious leaders in program counseling, and experts to build capacity of the program's psychological support. Other studies have shown that religious leaders are in an important position because they hold lots of influence and respect within communities. Moreover, they are significant sources of information regarding sex and morality. In Malawi members of congregations with leaders actively engaged in the HIV epidemic have higher levels of adherence to the ABCs (abstain, be faithful, use condoms) of HIV prevention (Trinitapoli, 2009). Faith has also been shown to be crucial in coping with HIV and AIDS. A study of Congolese

women showed that they often consulted religious leaders when making decisions about disclosure of their status to family and friends (Maman, Cathcart, Burkhardt, Omba, & Behets, 2009). As a result of their influence and expertise integrating religious leaders into programmatic efforts could allow for better outcomes through deeper counseling on issues of inherent human dignity, forgiveness, and reconciliation (Trinitapoli, 2009; UNicEF, 2003). This coincides well with the results of this study in that managers and administrators felt religious leaders could affect medication adherence by dealing with deeper issues like those mentioned in the Trinitapoli study.

Generally, program participants felt comfortable and respected when speaking and interacting with program staff. However, when staff used scare tactics in an effort to improve medication adherence program participants and graduates felt it was rude and unhelpful. Additionally, both caregivers and program participants felt sometimes the staff did not truly understand their struggle. Staff agreed that cultural competency trainings were needed as well as more linkages between the program participants and mentors that could really understand their experience.

Chapter 6. Recommendations

We suggest the following recommendations for the four main components of the program. 1) First, LTP should continue and work towards increasing camps, talent shows, and opportunities for adolescents to gain community amongst themselves as well with mentors that understand their particular struggles. Increased inclusion of peer mentors or others that can empathize with the participants while also imparting hope would promote preparation in life skills.

2) Additionally, LTP should continue promoting evidence-based information about sex, contraception, HIV, and sexual development. The instruction should adapt to include practical guidance and strategies regarding disclosing to romantic partner and condom negotiation. A more in-depth study would be useful to understand what effect direct distribution of condoms would have on access and use of contraception among participants. Moreover, investigating what might be the strengths and limitations of their current contraception referral system would also aid in understanding the gaps in preparation as far as preparation in SRH.

3) LTP should work to promote medication adherence throughout the program with strategies including drug partners, one on one counseling with trusted staff or religious leaders and ending drug holidays except in unique cases. LTP should continue empowering and instructing caregivers in early disclosure to adolescents so that any guilt or uncertainty about spreading HIV among participants can be avoided. During transition to adult care the program should give direct and holistic referrals, talk to participants about transition early and often, and create linkages between those in care transition and program graduates.

4) LTP should work to build capacity, by involving experts and professionals, to better address psychological issues among participants and increase the ability of LTP to promote talents in the arts. LTP should continue to support start-ups and businesses. Specifically, focusing on strategic and logistical support for those with start-ups and focusing on financial support for existing businesses. Additionally, financial support should continue for educational endeavors as well as rent and food expenses for caregivers and adolescents. Moreover, standardizing and ensuring all caregivers and adolescents throughout the program have access to resources like books, computers, and sewing machines which promote financial independence.

LTP should focus their instruction on evidence-based teaching that is active and emphasizes guided practice and examples. Economic empowerment training should also expand to include topics like budgeting, financial negotiation, and borrowing money. While tackling these topics the program should cover differences between issues affecting females and males and provide practical ways to move towards equity in every day interactions and behavior.

Study Limitations

There were some limitations in conducting this evaluation. Due to political unrest, the field work had to be scheduled while the program participants and graduates were still completing the current school term. This was not an optimum time for program participants and graduates to participate in interviews because most were at boarding school, university, or busy the majority of the day during weekdays. Therefore, all individual interviews and group discussions had to be scheduled on Saturdays. As a result of fewer opportunities to conduct interviews and discussions the discussions were mixed gender. This was a limitation because some participants, particularly females, may not have felt comfortable contributing honestly and openly in front of their peers since sensitive subjects like sex and contraception use were discussed. Additionally, the focus group discussion with program graduates was not only mixed gender but also moderated by the LTP director. This hierarchy could have impacted the answers the graduates gave to show the program in a more positive light. In order to mitigate biased responses, the director repeatedly emphasized that the point of the evaluation was to receive honest feedback to better care for and support future participants. Additionally, the director reassured the graduates that their responses would have no bearing on their relationship with the center.

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Appendix

A. PROGRAM PARTICIPANT IDI GUIDE

INTRODUCTION

Thank you so much for talking to me today. My name is _____ and I want to talk today about Lea Toto Adolescent program you've been involved in. I really want to hear about your personal perspective and experiences, but always remember your involvement is completely voluntary. There are absolutely no right or wrong answers. The goal is for you to be the leader and the expert. I want to learn from you. Everything you say will be kept confidential and any identifying information you say will be changed to make sure you are not identifiable. If it is ok we would like to record what we talk about today as well as take notes. After the interview we will then transcribe the recording and the transcription will only be shared with members of my team. Is it alright if we record the conversation and my assistant takes notes?

The conversation today will take about 45min - hour. If you need to leave early, skip a question, or stop the conversation at anytime, that is totally fine.

Do you have any questions?

Address any questions and then continue

Would it be ok to begin?

Start recording - state date and indicate oral consent received

OPENING QUESTIONS

1. How do you spend time with friends and family?
2. What are some of your favorite activities you've done with Lea Toto Adolescent Program?
    - Why were these activities your favorite?

KEY QUESTIONS

THEME 1: Economic Activities and Skills

3. What are some things you remember learning from the Economic Empowerment Program?

4. Based on what you have learned during the Economic Empowerment program; what do you want to do in the future?
- What about education?
- What about supporting yourself financially?

5. How has the Economic Empowerment program helped you prepare yourself for the future financially?
- What about saving money?

6. What do you think are good ways to earn a good source of income?
- How have you been able to gain business skills for a future source of income?
  - What about technical skills?
- How has Economic Empowerment program in the Lea Toto adolescent Program helped in this, if at all?
- How could Economic Empowerment program in the Lea Toto Adolescent Program have better helped you gain skills for a future source of income?

7. Have you received any grants/support/funding to help support your business plan or business start up?
- How did this grant/support/funding impact you financially? DO NOT ASK THIS IF THEY HAVE NOT RECEIVED A GRANT
- How is your business performing if you have one?
- If you do not have a business, what are your current life plans? (college, job, etc.)
- What recommendations would you like to suggest to help improve the process of creating business plans or business start ups
  - What about the process of financing business plan or business start ups?

THEME 2: Life Skills

8. Do you feel a part of your community (school, home, village, neighborhood, church)?
- Describe what makes you feel apart of your community? (school, home, village, neighborhood, church)

9. How have you been treated differently in your community because of your HIV status?
Follow up to Q10.How has the Life Skills Program in the Lea Toto Adolescent Program helped you to deal with stigma?

10. How has the Life Skills Program in the Lea Toto Adolescent Program helped you build relationships?
- Romantic relationships?
- Friendships?
- Family relationships?

11. How has the Life Skills Program in the Lea Toto program influenced your interpersonal skills?
- Sharing?
- Asking the right question?
- Joining an activity?
- Decision Making?

12. Based on what you have learned during the Life Skills Program; what do you like about yourself? (to clarify maybe ask… What are things you do well?)
- What do other people like about you?

13. Based on what you have learned during the Life Skills Program; what are the things you do well?

14. As a young person with HIV what are some things that challenge you in life?

- What are things that you go to other people for help when faced with a challenge?

THEME 3: Sexual & Reproductive Health and HIV
Now we are going to talk about the Sexual & Reproductive Health and HIV Program in the Lea Toto Adolescent Program

15. Describe what you've learned about sexual and reproductive health at Lea Toto Adolescent Program, thus far.

16. Describe the biggest challenges you face in relation to sexual health and being HIV positive.
- How has the Lea Toto Adolescent Program helped you overcome these challenges?

17. Based on what you've learned in the *Sexual & Reproductive Health and HIV Program in the Lea Toto Adolescent Program*, how would you describe the effects of risky sexual behaviors?

18. After finishing the *Sexual & Reproductive Health and HIV Program in the Lea Toto Adolescent Program* how comfortable do you feel disclosing your HIV status...?
- ...to your boyfriend/girlfriend?
- ...to your family member?
- ...to your teacher?
- ...to your friend?
- ...to your Pastor/Priest/Imam

19. After finishing the *Sexual & Reproductive Health and HIV Program in the Lea Toto Adolescent Program, h*ow would you disclose your HIV status?
- ...to your boyfriend/girlfriend?
- ...to your family member?
- ...to your teacher?
- ...to your friend?
- ...to your Pastor/Priest/Imam?

20. After finishing the *Sexual & Reproductive Health and HIV Program in the Lea Toto Adolescent Program,* how would you obtain contraceptives if you wanted them?
- Where would you obtain the contraceptives? Why at this place?
- What would be difficult about obtaining the contraceptives?

Theme 4. Clinic Support
21. What is your experience with the Lea Toto clinic visits?
- How do the staff treat you during clinic visits?
- How are the clinics adolescent friendly?
- What is challenging about going to the clinic as an adolescent?

22. How are the clinic visits at Lea Toto helpful?
23. What would you recommend to the Lea Toto program to make clinic visits better?

CLOSING QUESTIONS
24. What are some activities at Lea Toto Adolescent Program that can be improved?
- How do you think they can be improved?

25. If you were in charge of the Lea Toto adolescent program what would you change?
26. Is there anything else that you would like to share that you haven't already?

Thank you so much for taking the time to talk with me. I so appreciate it and I know that Lea Toto will improve because of information you've told us today.

B. CAREGIVER IDI GUIDE

INTRODUCTION:

Thank you so much for talking to me today. My name is _____ and I want to talk today about Lea Toto Adolescent program you and your son/daughter have been involved in. I really want to hear about your personal perspective and experiences, but always remember your involvement is completely voluntary. There are absolutely no right or wrong answers. The goal is for you to be the leader and the expert. I want to learn from you. Everything you say will be kept confidential and any identifying information you say will be changed to make sure you are not identifiable. If it is ok we would like to record what we talk about today as well as take notes. After the interview we will then transcribe the recording and the transcription will only be shared with members of my team. Is it alright if we record the conversation and my assistant takes notes?

The conversation today will take about an hour. If you need to leave early, skip a question, or stop the conversation at anytime, that is totally fine.

Do you have any questions?

Make sure you are both talking about the correct/same son/daughter that has been involved in the Lea Toto Adolescent Program

Address any questions and then continue

Would it be ok to begin?

Start recording - state date and indicate oral consent received

OPENING QUESTIONS:

1. Tell me about your son/daughter that has been involved in the Lea Toto Adolescent Program
2. How has your experience been thus far with the Lea Toto Adolescent Program?
3. What is the most valuable part of the Lea Toto Adolescent Program?

KEY QUESTIONS:

THEME 1: Economic Empowerment Support

1. How has the Lea Toto Adolescent program helped with allowing your son/daughter to learn about meeting financial needs?
2. What else would you like Lea Toto Adolescent Program to do in order to help your son/daughter meet financial needs?
3. How has the micro-loans(monetary funds/support/loans) you received from the Lea Toto program impacted your quality of life, if you have received one?
4. How has Lea Toto prepared your son/daughter with financial knowledge to earn a source of income in your community?
5. How has the Lea Toto adolescent program impacted your stress level?
6. What does son/daughter need to know to meet financial needs?

THEME 2: Life skills

8. How has Lea Toto Adolescent Program helped your son/daughter express themselves more effectively?
- self confidence, self-esteem, communication and outgoingness
- How has this impacted your relationship with your son/daughter?

9. How has the Lea Toto Adolescent Program helped your son/daughter contribute to their community?
10. What changes, if any, have you seen in your son/daughter's behavior since attending the Lea Toto Adolescent Program?
11. In your opinion, what more can Lea Toto Adolescent Program do to help further "your son/daughter's life skills?

THEME 3: Sexual & Reproductive Health
12. What does your son/daughter being healthy mean to you?
13. How does HIV impact your family?
14. How do you feel about your son/daughter participating in a sexual education program?
15. How have you seen changes in your son/daughter sexual (social) behavior based on what they have learned at Lea Toto Adolescent Program? (partying, drinking, sexual partners, etc.)
16. How has talking to your son/daughter about topics like HIV, sexuality, and sexual health changed since they attended the Lea Toto Adolescent Program?
17. What fears for your son/daughter have been relieved since the Lea Toto Adolescent Program?
- What fears of your son/daughter have been relieved since the Lea Toto Adolescent Program?

18. What improvements would you like to see to the Lea Toto Adolescent Program?
19. How has adherence to ARV medication improved for your son/daughter since starting participation in the Lea Toto Adolescent Program activities?

Theme 4. Clinic Support
20. What are the most valuable aspects of clinic visits at Lea Toto?
21. How have the staff treated you and your son/daughter during clinic visits?
22. What more can the Lea Toto Adolescent Program do to make clinic visits better, in relation to your son/daughter?

CLOSING QUESTIONS:
23.What are any additional recommendations you would like to make to improve the Lea Toto Adolescent Program?
24. Is there anything else that you would like to share that you haven't already?

Thank you so much for taking the time to talk with me. I so appreciate it and I know that Lea Toto will improve because of information you've told us today.

C. PROGRAM GRADUATE IDI GUIDE

INTRODUCTION:
Thank you so much for talking to me today. My name is _____ and I want to talk today about Lea Toto Adolescent Program you've been involved in. I really want to hear about your personal perspective and experiences, but always remember your involvement is completely voluntary. There are absolutely no right or wrong answers. The goal is for you to be the leader and the expert. I want to learn from you. Everything you say will be kept confidential and any identifying information you say will be changed to make sure you are not identifiable. If it is ok we would like to record what we talk about today as well as take notes. After the interview we will then transcribe the recording and the transcription will

only be shared with members of my team. Is it alright if we record the conversation and my assistant takes notes?
The conversation today will take about 45min - hour. If you need to leave early, skip a question, or stop the conversation at anytime, that is totally fine.
Do you have any questions?

Address any questions and then continue

Would it be ok to begin?

Start recording - state date and indicate oral consent received

OPENING QUESTIONS:
Thinking back to when you were in the Lea Toto Adolescent Program what were your future plans?

- Education objectives?
- For supporting yourself financially?
- Creating a business plan or business start up?
- Financing business plan or business start up?
- How did Lea Toto Adolescent Program help you in these efforts?

KEY QUESTIONS:
THEME 1: Economic Activities and Skills

When you think about skills needed for a future source of income what comes to mind?

- How have you been able to gain business skills for a future source of income?
    - What about technical skills?
- How did Lea Toto Adolescent Program help in this, if at all?
- How could Lea Toto Adolescent Program have better helped you gain skills for a future source of income?

What resources do you think you need to be successful in getting a source of income?

- How did Lea Toto Adolescent Program help you with resources needed for a future source of income, if at all?

During the Lea Toto Adolescent program, did you receive any grants/support/funding to help support your business plan or business start up?

- How did this grant/support/funding impact you financially? DO NOT ASK THIS IF THEY HAVE NOT RECEIVED A GRANT
- How is your business performing if you have one?
- If you do not have a business, what are your current life plans? (college, job, etc.)
- What recommendations would you like to suggest to help improve the process of creating business plans or business start ups
    - What about the process of financing the business plan or business start up?

THEME 2: Life Skills
Do you feel a part of your community?

- Describe what makes you feel a part of your community

Since graduating from the Lea Toto Adolescent Program how do you add value to the community?
How has Lea Toto Adolescent Program helped you to deal with facing stigma due to HIV?

- How have you been treated differently in your community because of your HIV status?

How has the Lea Toto Adolescent Program helped you build relationships?

- Romantic relationships
- Friendship
- Family members?
- How has Lea Toto Adolescent Program changed your thinking about relationships, if at all?

How has the Lea Toto Adolescent Program influenced your interpersonal skills?

- Sharing?
- Asking the right question?
- Joining an activity?
- Decision making?

What do you like about yourself?

- What do other people like about you?

What are the things you do well?

- What are things that challenge you?
    - Are there things that you go to other people for help?

THEME 3: Sexual & Reproductive Health

How would you describe what you've learned about sexual and reproductive health at Lea Toto adolescent program

How would you describe the biggest challenges you face after graduating the Lea Toto Adolescent Program?

- What about in relation to HIV?
- How has it been challenging transitioning to a new care facility?
    - How has Lea Toto Adolescent Program prepared you to succeed in this process?

What does it mean to you to be sexually healthy?

- How has the Lea Toto Adolescent Program impacted your sexual health decisions?

Tell me about your last visit to the clinic?

- How is it talking to people in the clinic about topics like HIV, sexuality, and sexual health?

How comfortable are you in obtaining contraceptives if you wanted them?

- Are there difficulties in obtaining the contraceptives?
- Where would you obtain the contraceptives? Why at this place?

How has the Lea Toto Adolescent Program impacted your adherence to your ARV (or medication)?

-Since leaving the Lea Toto Adolescent Program, are there difficulties in adhering to ARV?

-Have you faced difficulties in obtaining ARV?

Theme 4. Clinic Support

What was your experience with the Lea Toto clinic visits?

- How did the staff treat you during clinic visits?
- How were the clinics adolescent friendly?
- What was challenging about going to the clinic as an adolescents?

How were the clinic visits at Lea Toto helpful?

What would you recommend to the Lea Toto program to make clinic visits better?

How would you describe the differences between the Lea Toto clinic and the clinic were you are receiving care now?

CLOSING QUESTIONS:

If you were in charge of Lea Toto Adolescent Program what would you change?

Is there anything else that you would like to share that you haven't already?

Thank you so much for taking the time to talk with me. I so appreciate it and I know that Lea Toto Adolescent Program will improve because of information you've told us today.

D. PROGRAM STAFF IDI GUIDE

INTRODUCTION:

Thank you so much for talking to me today. My name is _____ and I want to talk today about Lea Toto Adolescent Program you've been involved in. I really want to hear about your personal perspective and experiences, but always remember your involvement is completely voluntary. There are absolutely no right or wrong answers. The goal is for you to be the leader and the expert. I want to learn from you. Everything you say will be kept confidential and any identifying information you say will be changed to make sure you are not identifiable. If it is ok we would like to record what we talk about today as well as take notes. After the interview we will then transcribe the recording and the transcription will only be shared with members of my team. Is it alright if we record the conversation and my assistant takes notes?

The conversation today will take about 45min - hour. If you need to leave early, skip a question, or stop the conversation at anytime, that is totally fine.

Do you have any questions?

-Were you aware why were asked to be interviewed?

Address any questions and then continue

Would it be ok to begin?

Start recording - state date and indicate oral consent received

OPENING QUESTIONS:

1. How did you begin working with the Lea Toto Adolescent Program?

2. How is it working with the Lea Toto Adolescent Program?

KEY QUESTIONS:

THEME 1: Economic Activities and Skills

3. Describe the goals of the economic empowerment program.

4. How does the Economic empowerment program accomplish the the overall goals of the Lea Toto Adolescent program??

- How good is it at accomplishing the goals?

5. How do adolescents respond to the economic empowerment program?

- What did you see before the Lea Toto Adolescent program as far as economic/business skills?
- What changes do you see in the adolescents as a result of the economic empowerment portion of the program?
- Are there differences between boys and girls? How would you describe those differences?
- Are there differences between adolescents of different ages? How would you describe those differences?
- Are there differences between adolescents of east versus west Nairobi? How would you describe those differences?

6. Tell me about challenges the economic empowerment program deals with
   - Financing business plans and business start ups?

THEME 2: Life Skills

7. Describe the goals of the Lea Toto Adolescent Program Life Skills portion.

8. How does the Life Skills portion of the program help accomplish the overall goals of the Lea Toto Adolescent program?
   - How good is it at accomplishing the goals?

9. How do adolescents respond to the life skills portion of the program?
   - What did you see before the Lea Toto Adolescent program as far as life skills?
   - What changes do you see in the adolescents as a result of the life skills portion of the program?
   - Are there differences between boys and girls? How would you describe those differences?
   - Are there differences between adolescents of different ages? How would you describe those differences?
   - Are there differences between adolescents of east versus west Nairobi? How would you describe those differences?

10. Tell me about challenges the Life Skills program deals with.

THEME 3: Sexual & Reproductive Health

11. Describe the goals of the Lea Toto Adolescent Program sexual and reproductive portion.

12. How does the sexual and reproductive health portion of the program help accomplish the overall goals of the Lea Toto Adolescent program?
   - In what ways is the program good at accomplishing these goals?

13. How do the adolescents respond to the sexual health program?
   - What did you see before the Lea Toto Adolescent Program as far as sexual and reproductive health?
   - What changes do you see in the adolescents as a result of the sexual and reproductive health portion of the program?
   - Are there differences between boys and girls? How would you describe those differences?
   - Are there differences between adolescents of different ages? How would you describe those differences?
   - Are there differences between adolescents of east versus west Nairobi? How would you describe those differences?

14. Tell me about the challenges the sexual and reproductive health program faces.

15. How do you feel the caregivers react to the sexual health program?

CLOSING QUESTIONS:

16. What challenges has the Lea Toto Adolescent Program faced?

17. How would you change the Lea Toto Adolescent Program to make it better?

18. Is there anything else that you would like to share that you haven't already?

Thank you so much for taking the time to talk with me. I so appreciate it and I know that Lea Toto will improve because of information you've told us today.

E. PROGRAM GRADUATE FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Hi everyone! I would like to thank you all for coming to this meeting today. My name is _____ and this is my colleague_____ who is here to help make sure everything runs smoothly and take notes. We are evaluating the Lea Toto program and would love to hear you all opinions.

I want to let everyone know that your participation in this study is completely voluntary and your identity will be kept confidential. If anyone would like to stop at any time, please do not hesitate to let me know if and when you feel uncomfortable answering a question or don't want to continue the conversation. We would like to take notes and tape-record our discussion so that we do not miss or forget anything that is discussed. Is it ok for us to record our conversation today? After the interview we will then transcribe the recording and this transcription will only be shared with members of my team.

Our interview will last about an hour. I will like this to be more of a conversation so feel free to interrupt or go back to any question that you may have any additional thoughts on. Do you have any questions or concerns for me before we start?

WARM UP (5 minutes)

1. What were some of your favorite activities, that you enjoyed doing at Lea Toto? (follow up prompt: football, fashion show, etc.)
2. What are some activities you engaged in outside of Lea Toto during your breaks and weekends?

THEME 1:Economics Empowerment (15 minutes)

3. How did the Lea Toto program change your perception of how someone in your community can be financially successful in life?

Potential follow up probe: How have you incorporated this change in perception, practically into your own life?

4. Who are the people in your community that should be business owners?
5. Based on what you learned during your time at Lea Toto program, how has your ability to do bookkeeping changed?

Potential follow up probe: Can you share instances where you have used this skill?

Do you know how to create a business plan?

THEME 2:Lifestyle/Self-Esteem (15 minutes)

6. Tell me about how you add value to your communities?
7. How did the Lea Toto program impact your self-esteem as an individual?
8. What are ways that you have seen yourself dealing with conflict in an appropriate manner as a result of being a part of the Lea Toto program?
9. What are some challenges you face post the Lea Toto program?
    - How have you been able to deal with these challenges in a positive manner based on what you have learned from Lea Toto?

THEME 3: Sexual and Reproductive Health (20 minutes)

Hot seat scenario

Using hot seating helps to:

• provide a lively way to explore sensitive and complex issues about HIV/AIDS
• identify what adolescents already do and don't do about HIV/AIDS based on
• explore how adolescents feel about issues relating to HIV/AIDS after graduating from the program

Activity Description

Prepare three case studies for graduates to explore, these should be real-life dilemmas. For example, if you are exploring HIV prevention a case study could read, 'I am a man who is pressurised to go to a brothel after work each day by my work colleagues.' Alternatively, ask participants to think of dilemmas.

2 Ask for a volunteer to sit in the 'hot seat'. This means to sit down in a chair or on the floor in front of all the other participants.

3 Ask the person to read out the case study as if they were the person in the case study.

4 Invite the rest of the participants to ask questions addressing the person in the case study as if they are that person's friend – for example, 'Why do you feel pressured to go to the brothel?'

5 Where questions require information that is not provided in the case study, encourage the volunteer in the hot seat to fill in the details.

6 Repeat the activity with other volunteers and other case studies.

7 When the activity is complete, encourage the participants to discuss what they have learned. For example, why was it easy or difficult to respond to the questions? What choices did the person have? What did the responses show about people's knowledge and attitudes? How do these affect a person's risk of HIV? Clarify any misunderstandings that people may have about HIV/AIDS.

Scenarios

- **Ashura**, 19 years old, has big plans to become a hairdresser. She received a grant from Lea Toto and is all set to execute her business plan. She and Beno, 29 years old, met at a club five months ago, he has been pressuring her to take their relationship to the next level. Beno shares that he is in love with Ashura and wants to show her how much. Ashura is torn, she doesn't know what to do, especially since Beno has shared that doesn't believe in using condoms, it makes him less than a man. Beno is Ashura's first boyfriend, unlike her other girlfriends at school. Ashura also has a secret that she has yet to share with Beno.

Themes: pressuring to have sex by boyfriend, doesn't like to use contraceptives, did not disclose she is HIV+

Discussion Questions:

1. How appropriate is this scenario to your life?
2. What are the major conflicts in this scenario? OR Please identify the major conflicts in this scenario?

3. What are some things you would advise Ashura to do?

- **Fanaka** meets Hali on a Saturday night; they get really drunk and she can't really remember exactly what happened the night before. She thinks she might have given Hali a blow job; there was certainly a lot of kissing and touching each other's genitals. She's fairly sure she didn't have sexual intercourse. She doesn't have his number.

Themes: drinking too much, unsafe sexual activities, unknown sexual partner

Discussion Questions:

4. How appropriate is this scenario to your life?
5. What are the major conflicts in this scenario? OR Please identify the major conflicts in this scenario
6. What are some things you would advise Fanaka to do?

- **Jatar** goes to a party with some of his friends downtown; there's a lot of drinking and some people are taking drugs. He has never used drugs and is hesitant when his friend Koffi suggests he takes a shot using an injection. He allows Koffi to inject him and has a hard time focusing. Koffi brings over a girl to sit on Jatar's lap and then takes him into a room for them to engage in sexual activities.

Themes: drug use with unsterile, drinking, engaging in sexual activity with unknown partner

Discussion Questions:

7. How appropriate is this scenario to your life?
8. What are the major conflicts in this scenario? OR Please identify the major conflicts in this scenario
9. What are some things you would advise Jatar to do?

THEME 4: Clinics (5 minutes)

10. What was your experience with the Lea Toto clinic visits?
    - How are clinics adolescent friendly?
    - What is challenging about going to the clinic as an adolescents?

Recommendations for the future of Lea Toto and Closing (10 minutes)

11. What are things you would change about the Lea Toto program that would help adolescents in Kenya successfully transition into adulthood?
12. Where do you all see yourself in the next 10 years? (could be a warm up question)
13. Is there anything else that you would like to share that we didn't cover during our discussion?

F. PROGRAM PARTICIPANT FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Hi everyone! I would like to thank you all for coming to this meeting today. My name is _____ and this is my colleague_____ who is here to help make sure everything runs smoothly and take notes. We are evaluating the Lea Toto program and would love to hear you all opinions.

I want to let everyone know that your participation in this study is completely voluntary and your identity will be kept confidential. If anyone would like to stop at any time, please do not hesitate to let me know if and when you feel uncomfortable answering a question or don't want to continue the conversation. We would like to take notes and tape-record our discussion so that we do not miss or forget anything that is discussed. Is it ok for us to record our conversation today? After the interview we will then transcribe the recording and this transcription will only be shared with members of my team.

Our interview will last about an hour. I will like this to be more of a conversation so feel free to interrupt or go back to any question that you may have any additional thoughts on. Do you have any questions or concerns for me before we start?

WARM UP (5 minutes)

1. Tell me about some of your favorite activities that you enjoy doing here at Lea Toto Adolescent Program ? (follow up prompt: football, fashion show, etc.)
2. What are some activities you engage in outside of Lea Toto during your breaks and weekends?

CONTENT

THEME 1: Economic/Social Structure (10minutes)

4. How has the Lea Toto program changed your perception of how you can meet your financial needs?
5. How has executing your business plan or business start up helped to make you more successful in life?
6. Please describe some things you have learned since implementing your business plan or business start up?
7. In your own words, what do you think have been the most valuable lessons learned from Lea Toto's program to help assist you with your business and future plans?
8. Do you know how to create a business plan?

THEME 2: Lifestyle/Self-Esteem (25 minutes) [Activity]

ACTIVITY

This group activity will assess the following: Communication, Interpersonal skills, Decision making skills & Critical thinking

"Survival Shopping"

Objective: For the group of adolescents to make group decisions together
Materials: At least one large store catalog or access to the Internet
Paper, pens or pencils
Optional—play money

Description: Provide group with a large catalog from a store that sells a variety of items or if you have access to the Internet, find a website that sells a variety of items.

Give each team "money" to spend ($200 is a good amount). Tell the group the following story: "You and your colleagues have been selected to spend one year in a spaceship traveling to a distant planet and back. You will have one year's supply of food and water on your ship and you each will be issued two sets of clothing. Your team is allotted 2000ksd to buy anything else

you will need. You must agree on the items and cannot go over the allotted dollar amount."

The group will receive paper and a pen or pencil to make a list on. Set a time limit, and at the end of the time limit ask the group to report back with their list.

Discussion Questions:
1) Did everyone on your team agree on what to spend your money on?
2) If everyone didn't agree, how did you finally come to a decision?
3) Was it difficult to make decisions as a group? Why or why not?
4) What is the best way to make decisions when in a group? Is this easy or difficult for you?

Alternative Activity

"Create a Country"

When the founding fathers of Kenya first got together to form a government, they had many issues to agree on and many decisions to make. I'm sure discussion, compromise, problem solving, and teamwork were a large part of the process when they tackled the tough task of forming a government. Creating a country wouldn't be an easy task, but in this activity it can be fun when the group pulls together and uses teamwork to solve the problems they face.

Objective: For people to get together as a group and participate in a group decision-making process.
Materials: Paper; pens or pencils; colored markers, colored pencils or crayons
Description: The group will be provided with the following information and the materials listed above:

"You and a group of people have claimed an uninhabited island as a new country off the coast of Kenya. You have been selected to be the new government. Your first assignment is to make the following decisions and accomplish the following tasks…
1) Name the country
2) Design a flag
3) Create any laws that you feel are necessary

The group must work together to complete the task and then present it to the leaders or to the rest of the group when finished.

Discussion Prompts:
1) How were decisions made in your group?
2) Is everyone happy with what was decided? Why or why not?
3) What things are important to remember when making group decisions?
4) What role do you usually take when making decisions with others?
5) How can you tell if a group has been successful when making a decision?
6) Why is it important to be able to make decisions as a member of a group?

THEME 3: Sexual and Reproductive Health (15 minutes)

9. (In what ways has)How has the Lea Toto Adolescent program impacted your ability to practice safe sexual behaviors?

10. How has your sexual behaviors changed from those of your friends who did not attend the Lea Toto Adolescent Program?

11. When engaging in sexual activities how have you practiced specific safe behaviors learned from the Lea Toto Adolescent Program?

12. What are some challenges you've faced when engaging in sexual activities?

- How difficult has it been to practice safe sexual behaviors or What are the barriers to practicing safe sexual behaviors (partner pressure, access to contraceptives, etc.)

THEME 4: Clinic (5 minutes)

What is your experience with the Lea Toto clinic visits?

- How are clinics adolescent friendly?
- What is challenging about going to the clinic as an adolescents?

Recommendations for the future of Lea Toto & Closing (10 minutes)

13. What are things you would like to change in the Lea Toto program that you think would make you more successful in life as you transitioned into adulthood?

14. Where do you all see yourself in the next 10 years? (could be a warm up question)

15. Is there anything else that you would like to share that we didn't cover during our discussion?