Sexual Reproductive Health Service Provision to Young People in Kenya; what is the best model?

by

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Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy

Liverpool School of Tropical Medicine

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Declaration

The material presented in this thesis is as a result of my own work and has not been presented, nor is it currently being presented, either in part or wholly as part of any other degree or another qualification.
Dedication

To

My dear mother, Hannah Gahai Godia

Thank you for giving me the strength and determination to push on

Nothing comes easily, were your famous words. May you Rest in Peace.
Acknowledgements

I take this opportunity to appreciate everyone who has supported me and contributed to my completing this thesis.

First and foremost, my special thanks go to my supervisors Dr Nynke Van Den Broek and Dr Jan Hofman for their relentless encouragement and timely advice during this journey. Completion of this thesis would not have been possible without their immense guidance.

Special recognition goes to my Advisory Panel Dr Rachel Tolhurst and Dr Angela Obasi. Thank you for your constant encouragement and advice. My heart goes out to Deborah Quinney for enormous technical advice on the methodology chapter.

My sincere gratitude goes to my employer, the Ministry of Public Health and Sanitation, Nairobi, Kenya for the financial support and granting me time off work to complete this thesis. Special thanks also go to the GTZ-MOH Health Support Programme and WHO-Kenya Country Office for their financial assistance in undertaking this study.

I am also grateful to the Medical Officers of Health from Nairobi, Laikipia, Meru Central and Kirinyaga districts for granting me undue support during the data collection process. My appreciation also goes to my research assistants and all the participants who took part in this study. All this would not have been possible without their cooperation and patience.

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Special thanks goes to my family for their constant encouragement, patience, and enduring my absence during the duration of this study. May God pour his blessings upon you all.
Abstract

Sexual Reproductive Health Service Provision for Young people in Kenya; what is the best model?

Pamela Miloya Godia

Background: Young people are a demographic force and their sexual and reproductive health (SRH) has become an area of focus for many national governments in both developed and developing countries. Addressing the SRH problems of young people is essential for the social and economic development of any nation and presents an opportunity for building human capital, respecting human rights and alleviating the intergenerational cycle of poverty across societies.

Aim: This study aimed at firstly exploring experiences and perceptions of young people aged 10-24, community members, health service providers (HSP), programme managers and policy makers on the SRH problems of young people and available SRH services. Secondly, the study sought to explore the different models of SRH service provision and, through a stakeholder consultative process, develop an SRH service delivery model for young people in Kenya. The development of the model was also informed by findings from literature review on ASRH interventions and components of models of health service delivery.

Methodology: This was a qualitative study which took a social constructionism approach. The study took place in four areas, Nairobi city and three district hospitals (Laikipia, Meru central, and Kirinyaga). Data was collected from a total of 8 health facilities, 5 integrated facilities and three youth centres, using focus group discussions (FGDs) and in-depth interviews (IDIs). 18 FGDs and 39 IDIs were conducted with young people; 10 FGDs with community members; 19 IDIs with health service providers; and 11 IDIs with facility managers and programme managers. Interviews were tape recorded and transcribed. With the assistance of NVIVO8 data was coded and analysed using the thematic framework approach.

Results: Young people’s perceptions of available SRH services show variations between boys and girls with regards to the model of service delivery. Young girls seeking ANC and FP services at integrated facilities characterised the available services as good. On the contrary, boys indicated that SRH services at integrated facilities have been designed for women and children, and so they felt uncomfortable seeking services from these facilities. Apart from receiving SRH services at youth centres, young people place emphasis on the non-health benefits they personally receive from youth centres such as preventing idleness, confidence building, information gap-bridging, improving interpersonal communication skills, vocational training and facilitating career progression.

Majority of community members are not aware of the SRH services available at the health facilities even in areas where youth centres are present. Community members approve of young people receiving services which they feel are educative and preventive in nature and disapprove of services which they feel encourage young people to engage in sexual activity such as promotion of contraceptives.

HSP report not being competent in adolescent counselling, facing a dilemma and not being comfortable with providing SRH services to young people. HSP also report being torn between their personal feelings, cultural norms and values and respecting young people’s right to accessing SRH services.

Broadly two models of SRH services are examined in this study: the integrated model and youth centres. Youth centres can either be facility-based or community-based. The findings presented in this study do not point to one single model as the best SRH service provision model as each have their own strengths and weaknesses. However, both models face implementation challenges which include: a weak monitoring and supervisory system, weak linkages with other government line ministries and departments and heavy reliance on donor funding. Specific to facility-based youth centres implementation challenges include: lack of ownership and support by district managers, being seen as parallel health structures and conflicts of interest in youth centre utilization between district managers and young people. Although the youth centre is reported as the preferred model by some young people and healthcare providers, its sustainability is not guaranteed. Moreover, the range of services it’s able to provide is limited due to deficiencies in staffing, supplies and equipments.

Conclusion: Addressing the SRH problems of young people in Kenya remain a big challenge for the health sector. Although some progress has been made with regards to creating a friendly policy environment for SRH service provision, the major drawback lies in implementation of these policies. This study recommends a multi-component SRH service delivery model with six core services, a strong support structure onto which to anchor service delivery and linkages to existing government systems and processes to enhance sustainability. This is the first study to be conducted in Kenya using qualitative methodology and result in the development of a SRH service delivery model for young people after triangulation of views and experiences of young people themselves, community members, health care providers, programme managers and policy makers.
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<tr>
<td>AIDS</td>
<td>Acquired Immune deficiency Syndrome</td>
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<td>ANC</td>
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<td>Adolescent Reproductive Health</td>
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<td>African Youth Alliance</td>
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<td>BCC</td>
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<td>CAQDAS</td>
<td>Computer-Aided Qualitative Data Analysis Software</td>
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<td>CDC</td>
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<td>DSW</td>
<td>German abbreviation for German Foundation for World Population</td>
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<td>EC</td>
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<td>FGD</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KCO</td>
<td>Kenya Country Office</td>
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<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
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<td>Low and Middle Income Countries</td>
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<td>MCH</td>
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<td>National Campaign against Drug Abuse Authority</td>
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<td>NAFCI</td>
<td>National Adolescent Friendly Clinic Initiative</td>
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<td>NCAPD</td>
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<td>NGO</td>
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<td>National Health Service</td>
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<td>OPD</td>
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<tr>
<td>NVIVO</td>
<td>Qualitative data analysis software</td>
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<td>PAC</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>SSA</td>
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<td>STD</td>
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<td>Treponema Pallidum</td>
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<td>UK</td>
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<td>United Nations General Assembly Special Session</td>
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<td>United States of America</td>
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<td>Water and Sanitation Issues in relation to Sexual and Reproductive Health</td>
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Chapter 1: Introduction

1.0 Introduction

The introductory chapter provides an overview of international efforts addressing the sexual and reproductive health problems of young people and provides an explanation of the importance of addressing these problems, especially in sub-Saharan Africa. The section also outlines definitions of general terms used throughout the thesis, states the study aims and objectives and presents the outline of the thesis.

1.1 International efforts to address the SRH problems of young people

The 1994 International Conference for Population and Development (ICPD) set the stage for putting adolescent sexual and reproductive health on the international agenda. During the conference it was recognised that reproductive health problems of young people had largely been ignored by existing health, education and other social programmes. The conference adopted a plan of action which has formed the basis for programmes addressing the SRH problems of adolescents globally. The plan outlined two objectives;

1. “To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.”

2. “To substantially reduce all adolescent pregnancies.”

The plan of action put an emphasis on educational, economic and social concerns, including sexual exploitation, as key determinants of adolescent sexuality and childbearing (ICPD 1994).

The five year progress review (ICPD+5) made a further call for governments to ensure that adolescents have access to user-friendly services that effectively address their SRH problems including reproductive health education and information, counselling and health promotion activities while encouraging their active participation (United Nations 1999). A subsequent review conducted 10 years later (ICPD+15) showed that teenage births were still a major concern, especially in sub-Saharan Africa where rates of more than 120 births per 1000 women aged 15-19
are recorded and young women continue being vulnerable to HIV infection especially adolescent girls (UNFPA and PRB 2009).

In the year 2000, world leaders from 192 United Nations member states adopted eight international Millennium Development Goals (MDGs) which were to be achieved by the year 2015. These MDGs included: fighting extreme poverty, achieving universal primary education, promoting gender equity, reducing child mortality, improving maternal health, combating HIV/AIDS, TB, malaria and other diseases, ensuring environmental sustainability and developing global partnerships (United Nations 2000).

In refocusing global efforts towards addressing reproductive health as an area of concern, the 2005 world health summit incorporated MDG 5b – “achieve, by 2015, universal access to reproductive health”- as an additional development target (United Nations 2005). Indicator 5.4 measuring adolescent birth rate was also included (United Nations 2010). Adolescent birth rate is used to measure the annual number of births to women aged 15-19 per 1000 women of the same age group (United Nations 2011a). The purpose of this indicator is to help track progress made towards improving the sexual and reproductive health problems of adolescents (United Nations 2008).

In the year 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS during the United Nations General Assembly Special Session (UNGASS) (United Nations 2001). This commitment provides a framework for achieving MGD 6 by indentifying global, regional and country-level responses to prevent new HIV infections, expanding access to health services and mitigating the epidemic’s impact (UNAIDS 2007). UNGASS thereafter developed indicators, seven of which have a direct bearing on the SRH of young people (see Table 1).
<table>
<thead>
<tr>
<th>MDG</th>
<th>Target</th>
<th>Indicator definition</th>
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| MDG 5   | 5.B- Achieve by 2015, universal access to reproductive health         | ▪ 5.3. Contraceptive prevalence rate  
▪ 5.4. Adolescent birth rate  
▪ 5.5. Antenatal coverage  
▪ 5.6. Unmet need for family planning |
| MDG 6   | 6.A- Have halted by 2015 and begun to reverse the spread of HIV/AIDS | ▪ 6.1. HIV prevalence among population aged 15-24  
▪ 6.2. Condom use at last high-risk sex  
▪ 6.3. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS |
|         | **United Nations General Assembly Special Session (UNGASS)**          |                                                                                                                                                      |
|         | National programme Indicators                                         | ▪ **Indicator 7:** Percentage of women and men aged 15-49 who received HIV test in the last 12 months and who know their result  
▪ **Indicator 11:** Percentage of schools that provided life skills-based HIV education in the last academic year |
|         | Knowledge and behaviour indicators                                    | ▪ **Indicator 13:** Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission  
▪ **Indicator 15:** Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15  
▪ **Indicator 16:** percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months  
▪ **Indicator 17:** percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse |
|         | Impact indicators                                                      | ▪ **Indicator 22:** percentage of young women and men aged 15-24 who are HIV infected |
1.2 Why focus on the sexual and reproductive health of young people?

Adolescents and youth constitute a large proportion of the world and sub-Saharan Africa population. Almost half of the world population consists of young people below 25 years of age. Investing in the health of young people is essential for the economic and social development of any nation and presents an opportunity for building human capital and alleviating intergenerational poverty across societies (The World Bank Group 2011).

Young people from sub-Saharan Africa are more at risk of experiencing reproductive health problems than other youth from around the world due to the social and low economic conditions in the region (Ringheim and Gribble 2010). Multiple sexual relationships and unprotected sexual encounters are common among young men and women and especially those who reside in urban areas (Khan and Vinod 2008). With the increase in the interval between age at first sex and age at marriage, young people are predisposed to adverse reproductive health outcomes such as infection with STI/HIV/AIDS, unwanted pregnancy and unsafe abortion (Ringheim and Gribble 2010). Adolescent girls who are disadvantaged economically may opt for commercial sex or early marriage as an economic cushion and this may increase their vulnerability to negative reproductive health outcomes (Guttmacher Institute and IPPF 2010; WHO 2007e).

The highest adolescent childbearing rates are seen in Africa (115 births per 1000 women) and the lowest in Europe (25 births per 1000 women) (WHO 2007a). While adolescent childbearing in sub-Saharan Africa often occurs within marriage or a union, a significant proportion occurs outside marriage; this ranges from 6 percent in Niger to 88 percent in Botswana (Singh 1998). In Kenya almost half of all births among adolescents are unintended (unwanted or mistimed) (Ringheim and Gribble 2010). Adolescent girls and their off-spring are more at risk of experiencing morbidity and mortality. Girls aged 15-19 are twice as more likely to die from pregnancy related complications than women in their 20s, while for girls aged 14 and below the risk is fivefold (UNICEF 2000). In addition, children born of adolescent mothers are more likely to be underweight and die before their fifth birthday (UNICEF 2000). Addressing adolescent childbearing effectively will make a significant contribution to the achievement of MDG 5b (United Nations 2010).

Of all the age groups, young people have the highest unmet need for contraception. DHS data indicate that a large proportion (67 percent) of married adolescents in sub-Saharan Africa want to avoid pregnancy for at least two years but are not using any form of contraception (Guttmacher Institute and IPPF 2010). Youth from sub-Saharan Africa also face the greatest risk of STI and HIV.
infection compared with other youths in the world. Over half of all new HIV infections occur among young people aged 15-24, with young women being four times more likely to be infected with HIV than young men of the same age group (Ringheim and Gribble 2010). In spite of this, condom use is still very low and testing for HIV is rare (Khan and Vinod 2008).

Although adolescence is a stage in life where young people may be exposed to a number of risks and dangers, there is potential for promotion of healthy behaviour through appropriate education (Kleinert 2007;WHO 2007b). Behaviour initiated or learnt during adolescence may be long lasting and have either negative or positive influences on young people’s future lives. Efforts therefore have to be geared towards promoting healthy and preventive behaviour during this stage of life (Call et al. 2002). Adolescents are “parents of tomorrow” and preventive behaviour learnt during this period may be retained and passed onto future generations.

1.3 Rationale for the study

This study was designed to explore the SRH problems of young people and perceptions of available SRH services from the perspective of young people themselves, community members and health service providers in Kenya. The idea was conceived out of the need to provide more information on how SRH services could best be provided to young people in Kenya.

Stakeholders within the health sector have acknowledged the fact that young people in Kenya experience a myriad of SRH problems, which need specific attention within the framework of a sector-wide approach. This is well envisaged in the National Health Sector Strategic Plan II (2005-2010), where adolescent SRH has been recognised as a priority within the Kenya Essential Package of Health (KEPH). Within the KEPH the Ministry of Health commits itself to providing services that are specific to this age group including reproductive health counselling, contraceptives and HIV/AIDS related services. This is to be achieved through the establishment of youth-friendly SRH health services within the existing health facilities. In spite of this commitment, there is still some scepticism among policy makers and other development partners with regards to allocating resources to SRH services targeting young people. One of the reasons for this opinion could be that stakeholders are not fully convinced about the best model of service provision to which to allocate resources (Speizer et al. 2003)

Youth-friendly service provision in Kenya has, to date, largely been implemented under the auspices of Non-governmental Organisations (NGOs), with little government support. Family Health Options of Kenya (FHOK) formally known as Family Planning Association of Kenya
(FPAK) has been the pioneer and advocate of youth-friendly service provision in Kenya since the late 1990’s when the first youth centre, Nairobi youth centre, was established. This led to the establishment of other youth centres by other NGOs in different parts of the country. The launch of the ARH&D policy in 2003 marked the beginning of the government’s recognition of the importance of addressing SRH problems of adolescents and youths which later formed part of the NHSSP II (2005-2010). This plan focuses on the health problems of different age groups or cohorts, with adolescence and youth forming the age cohort 13-24 years. According to the NHSSP II (2005-2010), the government intended to increase the number of facilities providing youth-friendly services from five in 2004/5 to 60 in the year 2010. However, currently there is limited documentation on the state of SRH services for young people in Kenya. This study intends to fill this information gap by exploring experiences and opinions of health providers, young people and community members, of these services. These findings will then be used to inform the development of an ideal model of SRH service delivery for young people in Kenya.

1.4 Definition of terms used in this study

1.4.1. Adolescence

Stanley Hall G (1844-1924), an American psychologist and educator, is regarded as the father of adolescence. In 1904 Hall published his book “Adolescence” which marked the beginning of the scientific study of adolescence (Santrock 1990). Hall focused on the impact of social change on the lives of adolescents and made suggestions on processes potentially linking social change to adolescent development (Pinquart and Silbereisen 2005). His suggestions highlighted the fact that adolescents are more likely to adopt new behaviour which occurs as a result of social change such as new technologies, use of internet and change in lifestyles. This may in turn expose them to the highest risks of adverse health (Hall 1904 cited in (Pinquart and Silbereisen 2005). Adolescence can be regarded as a socially defined stage in the life cycle of human development whereby the “social reality of adolescence, its boundaries, duration and experiences are variables that are socially constructed, constantly changing and exhibiting different characteristics between urban and rural settings” (Dragastin 1975a).

Several theories including psychoanalytical, cognitive and psychological have been used to define and put meaning to the concept of adolescence. For the psychoanalytical theorists, adolescent development is “primarily unconscious (beyond awareness) and to understand it we have to look at the symbolic meaning of behaviour and the deeper inner workings of the mind” (Santrock 1990). Moreover, our development is determined not only by current experiences but by experiences from
our early life. Early life experiences are important determinants of personality and it is proposed that we can better understand personality by examining it developmentally (Santrock 1990). Cognitive theories emphasize conscious thoughts and cognition as a developmental phenomenon. Over the course of childhood and during early adolescence, individuals actively create new ways of acquiring knowledge and reasoning and this process improves over time, with the knowledge acquired later on being better shaped and processed cognitively compared with earlier acquired knowledge (Moshman 2005).

The social learning theory is the view of psychologists who emphasize behaviour, environment and cognition as key factors in development. Albert Bandura (1977) is the main architect of the contemporary version of the social learning theory known as cognitive social learning theory. Bandura believed that much of our learning occurs by observing and modelling what others do. Through observational learning we cognitively represent the behaviour of others and then possibly adopt this behaviour ourselves (Bandura 1977). Social learning theorists also emphasize that we can regulate and control our own behaviour (Santrock 1990).

1.4.2 Current definition of adolescence

The World Health Organization categorises adolescents as persons aged between 10-19 (WHO 2002a). The period of adolescence is divided into three phases: early adolescence (10-13 years) which is characterized by a spurt of growth together with the beginning of sexual maturation and abstract thinking; mid-adolescence (14-15 years) where the main physical changes are completed, the individual develops a stronger sense of identity, relates more strongly to his or her peer group, while thinking becomes more important; and late adolescence (16-19) where the body takes its adult form and the individual acquires a distinct identity, develops own ideas and opinions (WHO 2002a).

“Adolescence is a period of rapid physical growth and development. Physical growth is accompanied by sexual maturation, often leading to intimate relationships. One’s capacity for abstract and critical thought also develops, along with a heightened sense of self-awareness and emotional independence. As the attitudes, values and behaviour that determine the young person’s future begin to crystallize and take shape, society expects the adolescent to assume greater personal responsibility. This process is marked by increased exposure and experimentation.” (WHO, 2002a)

The second decade of life is regarded as a period of experimentation because of the “first time” behaviour adolescents try to acquire under the influence of their peers; especially the use of tobacco, alcohol and other drugs, along with sexual activity (WHO 2002a). This risky behaviour which adolescents acquire through imitation and by observing their peers may be retained into
adulthood and, if not checked well, may lead to poor health outcomes. All United Nations (UN) agencies, governments and civil societies working in the area of adolescent health have adopted the WHO definition of adolescence as the official universal definition.

1.4.3 Youth and young people


1.4.4 Reproductive health

Reproductive health has been defined by the ICPD 1994 as

“.. a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD 1994).

1.4.5 Reproductive health services

In reference to the ICPD (1994) definition of reproductive health, reproductive health services can be defined as

“...the constellation of methods, techniques and services that contributes to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases” (ICPD 1994)

Reproductive health care in the context of primary health care as described in ICPD (1994) includes the following:

- family-planning counselling, information, education, communication and services
- education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding, infant and women's health care
- prevention and appropriate treatment of infertility
 abortion including prevention of abortion and the management of the consequences of abortion
 treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions
 information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood
 referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases and HIV/AIDS should always be available, as required
 active discouragement of harmful practices such as female genital mutilation should also be an integral component of primary health care including reproductive health care programmes. (ICPD 1994).

1.4.6 Sex, sexuality, sexual health and sexual rights

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females (WHO 2006).

Sexuality:

“Sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors” (Glasier et al. 2006; WHO 2002b)

Sexual health: The first definition of sexual health was formulated in 1975 during a WHO consultative meeting as follows:

“Sexual health is the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhances personality, communication, and love” (WHO 1975).

Over time the WHO (1975) sexual health definition has evolved. A review of the literature by Edwards and Coleman (2004) identified eight definitions of sexual health that have evolved from the original WHO 1975 definition. More recent definitions have added concepts of mental health,
responsibility and sexual rights as basic and fundamental human rights to the definition of sexual health (Edwards and Coleman 2004).

Although not representing an official WHO position, the current working definition of sexual health was arrived at during a WHO-convened technical consultative meeting held in 2002 as a guide for policy makers and programme managers working in the field of human sexuality and sexual and reproductive health.

“Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied” (WHO 2006).

Sexual rights: Sexual rights embrace already existing human rights recognized in international and national laws, international human rights documents and other consensus statements. They include “the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health: (Glassier at al 2006: WHO 2002b). There are ten basic sexual health rights articles stated in the declaration agreed upon by the governing council of International Planned Parenthood Federation (IPPF) and they include the following:

1: Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender
2: The right to participation for all persons, regardless of sex, sexuality or gender
3: The rights to life, liberty, security of the person and bodily integrity
4: Right to privacy
5: Right to personal autonomy and recognition before the law
6: Right to freedom of thought, opinion and expression; right to association
7: Right to health and to the benefits of scientific progress
8: Right to education and information
9: Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children
10: Right to accountability and redress  

Source: (IPPF 2008b)
1.4.7 Youth friendly services

SRH services that target young people aged 10-24 years are commonly referred to as youth-friendly services. Youth friendly sexual and reproductive health services have been described by WHO (2002) as “services that are accessible, acceptable, equitable and appropriate to meet the SRH needs of young people.” Young people receive services within an environment that is friendly and welcoming, are able to come back again and also refer their friends for the same services (WHO 2002a). Elements such as friendly policies, friendly health service providers and support staff, friendly service delivery mechanisms such as convenient hours, privacy and comprehensiveness of services have been cited as essential for youth-friendly service provision (IPPF 2008a;WHO 2002a).

Youth friendly services (YFS) and adolescent sexual and reproductive health (ASRH) services are terms which are used interchangeably by different authors in the international literature to mean SRH services which are specific to either young people (10-24), adolescents (10-19) or older adolescents (15-19). YFS are also referred to as adolescent friendly services. Other terms used in the literature but with similar meanings to youth friendly services are ASRH programmes and ASRH interventions.

1.4.8 Gender-based violence and coercive sex

The terms gender-based violence (GBV) and violence against women are used interchangeably in the international literature (Rutherford et al. 2007). The most referred to definition of GBV is that stated in article 1 of the Declaration on the Elimination of Violence against Women (United Nations 1993), which defines violence against women as;

“any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

Article 2 of the same declaration goes further to state that this definition should encompass, but not be limited to, acts of physical, sexual, and psychological violence in the family, community, or perpetrated or condoned by the State, wherever it occurs. These acts include:

“spousal battery; sexual abuse, including of female children; dowry-related violence; rape, including marital rape; female genital mutilation/cutting and other traditional practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution.”
Sexual coercion has been defined as

“the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behaviour against his or her will.” (Heise et al. 1995)

In this context, women get involved in coerced sex due to “lack of choice to pursue other options without severe social or physical consequences.” (Heise et al. 1995).

The world report on violence and health defines sexual violence to be comprising of a wide range of acts such as coercive sex, date rape, and marital coercive sex, sexual favours in return for jobs or school grades, child sexual abuse, gang rape in armed conflict, child marriage, forced prostitution and sexual trafficking. Other harmful traditional practices include female genital mutilation, and obligatory virginity inspection (WHO 2002c).

Gender-based violence reinforces the social inequities between men and women and as a result compromises the health, dignity and autonomy of the victims and has therefore been recognised as a public health problem and a violation of the human rights. Adolescent girls are more prone to experiencing sexual coercion often from persons they know or trust such as male family members and other acquaintances (Pinheiro 2006). In addition young girls who have been sexually abused are more at risk of having unprotected sex as adolescents, experiencing unplanned pregnancies, HIV/AIDS infections and suffering severe injuries including mental illness and suicide (Heise, Moore, and Toubia 1995; Watts and Zimmerman 2002).

**1.4.9 VCT and HIV testing and counselling**

Client-initiated HIV testing and counselling (HCT) also referred to as voluntary counselling and testing (VCT) has been described as a process where an individual goes through the counselling process to enable him/her make an informed decision with regards to being tested for HIV (UNAIDS 2000). HIV testing and counselling is regarded as being an entry point to HIV care, treatment and support and is guided by the 3C’s principles which were described in 1985 when HIV testing first became available: confidentiality, counselling and consent (UNAIDS 2004). Client initiated HIV testing can be provided either at the health facility of in community settings.

Other forms of HTC that can occur in clinical settings include provider-initiated HIV testing and counselling (PITC). Previously health care providers only initiated HIV testing of clients who had signs and symptoms of HIV related illness but there has been a shift in policy where health care
providers are required to offer and conduct HIV testing and counselling as part of routine care to all clients who visit the health facilities (UNAIDS 2004).

1.4.10 Social Constructionism

Social constructionism is a theoretical orientation towards acquiring knowledge that aims at accounting for the way in which phenomena are socially constructed and understood. It focuses on gaining meaning and understanding of the way individuals and social groupings participate in the creation of their own reality (Gergen 1985).

In this study social constructionism has been used as a tool to gain a deeper understanding of the social and cultural context of young people’s sexual and reproductive health. Social constructionism helps understand local meanings and labeling placed on services and therefore enables one explain how, within this context, health service delivery approaches can either work or not work.

1.5 Thesis overview

In this thesis I present and discuss the findings of a research project on sexual and reproductive health (SRH) service provision to young people in Kenya. This thesis draws and reflects on SRH interventions which have targeted young people aged 10-24 years and have been implemented globally, particularly in developing countries. The effects of these interventions on young people’s SRH problems and related service delivery preferences and utilisation are examined. Globally the effectiveness of these interventions continues to draw mixed reactions in the literature with calls being made for the design and implementation of large scale and methodologically sound interventions particularly in sub-Saharan Africa, where limited rigorous evaluation of SRH programmes has been undertaken (Michielsen et al. 2010; Speizer, Magnani and Colvin 2003). Interventions to date have largely focused on HIV/AIDS awareness creation and prevention, leaving other STIs and SRH concerns conspicuously absent (Hindin and Fatusi 2009). There is therefore an urgent need for the design of evidence based comprehensive SRH interventions which go beyond addressing HIV/AIDS as a factor influencing sexual behaviour (Michielsen et al. 2010).

This study examines linkages between national policies, guidelines, and service delivery mechanisms with regards to SRH of young people in Kenya. Views and experiences of young people themselves, community members and health service providers are used to inform the development of an “ideal” SRH service delivery model for young people in Kenya.
1.6 Study aims and objectives

The research question

What is the best model for providing sexual and reproductive health services to young people aged 10-24 years within the Kenyan economic and socio-cultural setting?

Specific Objectives

1. To explore the SRH problems of young people and gain an understanding of their perceptions of the available SRH services
2. To explore community members’ views on the SRH problems of young people and their perceptions of available SRH services for young people
3. To explore health care providers’ perceptions and experiences of SRH service provision to young people
4. To explore the different models of SRH service provision and, through a stakeholder consultative process, develop an SRH service delivery model for young people in Kenya.

1.7 Structure of the thesis

Chapter 1 introduces the thesis and provides an overview of the general terms used throughout the thesis. It provides an explanation as to why efforts should be directed towards addressing the SRH problems of young people. It states the study aims and objectives and presents an outline of the thesis.

Chapter 2 provides a review of the international and national literature on the SRH problems of adolescents and youths. It presents the situation analysis of the magnitude of SRH problems which adolescents and young people experience. The section also gives a general account of the ASRH interventions that have been implemented across developing countries and in Kenya, including observations made about intervention effectiveness. Finally, the section gives a general account of the literature on the development of models of health service delivery.

Chapter 3 gives a detailed description of the Kenyan country background and the social, economic and health care system in Kenya. It gives an overview of the status of SRH of young people in Kenya and the current health policy framework.
Chapter 4 describes the study methodology. It outlines the study design, justification, and method of data analysis, study limitations, ethical consideration and reflexivity of the researcher.

Chapter 5 presents the study findings in three sections according to the categories of respondents interviewed: young people, community members and health service providers.

Section 5.1 presents the results of exploration of young people’s perspectives, their SRH problems and the available SRH services.

Section 5.2 describes community members’ views on the SRH problems of young people and their perspectives of the available SRH services.

Section 5.3 presents the perspectives and experiences of health service providers on provision of SRH services to young people.

Chapter 6 presents exploratory findings on the supportive elements for provision of SRH services and outlines the strengths and weaknesses of SRH service provision. The section also describes the process of developing the “ideal” SRH service delivery model and presents stakeholders’ views and opinions on the developed model.

Chapter 7 discusses the research findings

Chapter 8 gives the conclusions and recommendations

1.8 Summary of introduction chapter
This chapter introduces the concept of adolescence and young people and provides a justification for addressing the SRH problems of adolescents and young people. The chapter refers to the international instruments and declarations that have put adolescent sexual and reproductive health on the international agenda beginning with the International Conference for Population and Development (ICPD 1994). The chapter gives an overview of the thesis and introduces the research question and objectives.
Chapter 2: Literature review

2.0 Introduction:

This literature review is broadly organised into four main sections: section 2.1 provides a detailed global situation analysis of SRH of young people aged 10-24 with special emphasis on sub-Saharan Africa, section 2.2 reviews approaches to improving SRH of young people, section 2.3 gives an overview of published literature on ASRH interventions that have been conducted in Kenya and section 2.4 gives an overview of the effectiveness of SRH interventions. Section 2.5 describes the literature on components of health service delivery models and costs of RH service delivery.

Search strategy

The literature review was conducted using the following databases: Medline, PsycINFO, Scopus and Cochrane Database for Systematic Reviews. A broad search was undertaken using the following key words: adolescent sexual health, OR adolescent reproductive health, OR adolescent sexual health interventions OR youth friendly services AND developing countries OR Sub-Saharan Africa; details of which are shown in Table 2.

Titles and abstracts of articles retrieved were read and the full text of relevant articles retrieved from the University of Liverpool Library database. Articles which were not available electronically were obtained from the University of Liverpool Library. Reference lists of retrieved articles were also manually searched for any relevant articles. All the relevant electronically available articles were downloaded and organised using the Reference Manager Database.

A further search was conducted from websites of research organisations such as Guttmacher Institute, CDC, Population Reference Bureau (PRB), Macro DHS and International Planned Parenthood Federation (IPPF). Searches were also done on websites of donor agencies such as UNFPA, UNDP, WHO and the World Bank. Searches were also conducted on selected NGOs sites such as Population Council, Family Health International (FHI) and government ministries and departments in Kenya. Based on need, the Google search for specific reports was also conducted. The search was restricted to articles published between the years 1990-2011.
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<thead>
<tr>
<th>Literature review section</th>
<th>Questions guiding the literature review</th>
<th>Search words</th>
<th>Total number of articles retrieved</th>
<th>No of articles relevant</th>
<th>No of articles and reviewed</th>
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<td>What is the situation of SRH for young people at a global level, sub-Saharan Africa and Kenya?</td>
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<td></td>
<td>Search done on websites of research organisations</td>
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<td>100</td>
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<td>2.2. SRH interventions</td>
<td>What are some of the interventions that have been implemented in developing countries to address the SRH problems of young people, especially in sub-Saharan Africa?</td>
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<td>What are the SRH interventions for young people that have been implemented in Kenya?</td>
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<td>7</td>
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<td>2.4. Models of health service delivery</td>
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<td>169</td>
<td>18</td>
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</table>
2.1 Sexual and reproductive health problems of young people:
Situation analysis

Nearly half of the world’s population (more than 3 billion people) are persons less than 25 years of age, and over 88 percent of them live in less developed countries (UNFPA 2006). There are over 1.2 billion adolescents in the world today and their numbers are steadily increasing (United Nations 2011c). Current world population estimates (2010 revisions) indicate that adolescents aged 10-19 and young people aged 10-24 constitute 18 percent and 26 percent of the world population respectively (Table 3). In more developed countries young people constitute 18 percent of the population while in sub-Saharan Africa; they constitute 32 percent of the total population. Young adults aged 15-24 constitute 18 percent and 20 percent of the world and sub-Saharan Africa populations respectively (United Nations 2011c).

Although young people are often regarded as a healthy cohort, recent estimates show that a significant number of deaths are occurring in this population segment and that the number of deaths tend to increase between the ages 10-14 and 20-24. Mortality data estimate that globally 2.6 million deaths occurred in young people aged 10-24yrs in the year 2004 with almost two-thirds of these deaths occurring in sub-Saharan Africa. The leading causes of deaths among young people were maternal causes (15%) and HIV/AIDS and tuberculosis (11%) (Blum 2009; Patton et al. 2009). In sub-Saharan Africa WHO estimates show that among women aged 15-29, SRH problems account for 63% of Disability Adjusted Life Years (DALYS) of which 37% is due to AIDS (Robert 2007).

As previously discussed in section 1.4.2, adolescents are defined as young people aged 10-19 years (WHO 2002a). The adolescence stage of development is further categorised into early, middle and late stages by the age groups 10-14yrs, 15-17yrs and 18-19yrs respectively. This is in relation to their physical, social and psychosocial development during these years (WHO 2002a). During adolescence young girls and boys experience a period of rapid growth and development in their bodies, minds and social relationships (Patton and Viner 2007). The individual’s capacity for abstract and critical thought also develops, along with a heightened sense of self-awareness and emotional independence. As the attitudes, values and behaviours that determine the young person’s future begin to crystallize and take shape, society expects the adolescent to assume greater personal responsibility. This process is marked by increased exposure and experimentation and vulnerability to mental and psychosocial disorder (Patton and Viner 2007; WHO 2007b).

During this period of growth young people need accurate information, encouragement and support so as to understand the physical and psychological maturation process. They also need good
nutrition and information about consequences of unprotected sex and drug abuse. They also need information about physical body changes, the management of menstruation (for girls) (Koff and Rierdan 1995), protection from sexual abuse and harmful cultural practices such as female genital mutilation and early marriage (WHO 2002a). Research has shown that young people from developing countries, including those in school, face challenges during menstruation. Lack of water, proper sanitation facilities at the schools and sanitation supplies are major contributors to school absenteeism among girls (Kirk and Sommer 2004; McMahon et al. 2011; Sommer 2010). In a feasibility study conducted among school girls in urban slums in Nairobi, feelings of anxiety, embarrassment and discomfort during menstruation in addition to lack of proper sanitary wear were reported as having a negative effect on the girls’ concentration in school (APHRC 2010b). In rural Nyanza, fear, shame, distraction and confusion as a result of embarrassment, stigma and associating menstruation with girls’ sexual status were reported as some of the feelings associated with menstruation (McMahon et al. 2011). The commencement of menarche in girls and body changes in boys can cause either joy or distress depending on their understanding of this developmental process (Munthali and Zulu 2007). Girls need to be assured that menstruation is a normal and healthy process and that one need not feel ashamed of the experience (Koff and Rierdan 1995). Adolescents may also suffer from general health problems, eating disorders and may be prone to accidents and violence (WHO 2002a).

Though detected later in adult life, the manifestation of most mental disorders occur during the adolescent stage (12-14yrs). Young people who have poor mental health are more likely to achieve lower education status, be engaged in drug and substance abuse and have poor sexual and reproductive health (Vikram et al. 2007).

Young people are a demographic force and their sexual and reproductive health has become an area of focus for many national governments in both developed and developing countries. This is because their negative health is likely to result in both economic and social consequences which may, in turn, affect national development.

Table 3: Global and African Population Statistics

<table>
<thead>
<tr>
<th>Indicator</th>
<th>World</th>
<th>More developed</th>
<th>Less developed</th>
<th>Africa</th>
<th>Sub-Saharan Africa</th>
<th>North Africa</th>
<th>East Africa</th>
<th>Kenya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in Mid-2010 (millions)*</td>
<td>6,892</td>
<td>1,237</td>
<td>5,656</td>
<td>1,030</td>
<td>865</td>
<td>209</td>
<td>326</td>
<td>40</td>
</tr>
<tr>
<td>Births per 1000 population*</td>
<td>20</td>
<td>11</td>
<td>22</td>
<td>37</td>
<td>39</td>
<td>26</td>
<td>40</td>
<td>37</td>
</tr>
<tr>
<td>Gross National Income (GNI) $2008*</td>
<td>10,030</td>
<td>32,370</td>
<td>5,150</td>
<td>2,630</td>
<td>1,930</td>
<td>5,370</td>
<td>1,030</td>
<td>1,580</td>
</tr>
<tr>
<td>Projected population (millions) Mid-2025*</td>
<td>8,108</td>
<td>1,290</td>
<td>6,819</td>
<td>1,412</td>
<td>1,207</td>
<td>262</td>
<td>465</td>
<td>51.3</td>
</tr>
</tbody>
</table>
2.1.1 Sexual behaviour of young people

There is public health interest with regard to sexual behaviour of young people because of the potentially negative consequences, including the risks of unintended pregnancy and infection with sexually transmitted diseases including HIV/AIDS (Adams and Montemayor 1993). In low income countries, second to childhood malnutrition, unsafe sex has been documented as an important risk factor contributing to the global burden of disease, or lost years of healthy life (DALYs); unsafe sex contributes 10.2 percent of DALYs in developing regions (Ezzati et al. 2002).

Historically there are two paradigms in understanding adolescent sexual behaviour. One paradigm is represented by the work of Sigmund Freud (1933, 1959) who explains sexual behaviour as a biological phenomenon occurring during the adolescent stage, because of physical body development and maturation (Santrock 1990). The second paradigm explains sexual behaviour as a socially shaped phenomenon that is learned by observing and imitating what others do and that this behaviour can be regulated and controlled: the social learning theory (Bandura 1977).

a) Age at first sexual intercourse

There exists variation in sexual behaviour among adolescents between and within countries, as well as between different social and economic groups (Wellings et al. 2006). Young people are waiting longer before they get married and hence are exposed to a longer period of pre-marital sex. In most countries age at first sex occurs in the late teenage years, between age 15-19, with variations between men and women. For women, an earlier age of first sex is common in regions where early marriage is a custom such as sub-Saharan Africa and south Asia. Among young men age at first sex is independent of marriage (Wellings et al. 2006).

Teenagers who exhibit a longer period between the start of a relationship and initiation of sex activity, have greater chances of having discussions around contraception, using dual protection.
methods and always using contraceptives, nonetheless, consistent use decreases with increased relationship length (Manlove et al. 2008).

In developed countries there is little variation in the timing of first sex among young men and young women with the median age at first sex for both men and women aged 20-24 being between 17-18 years (Darroch et al. 2001b;Teitler 2002).

In sub-Saharan Africa the median age at first sex lies between 15.9-19.6 years among females and 16.3-19.6 years for males, with the average median age at first sex being 17.3 for females and 17.8 for males (Table 4); young women initiate sex at an earlier age often within or just before marriage (Khan and Vinod 2008;PRB 2001;Ringheim and Gribble 2010). In one district in Malawi a cross-sectional survey among women aged 15-59 found the age at first sex to be 17.5yrs and 18.8yrs for women and men respectively. Girls who began menarche at an earlier age (below 14yrs) were more likely to initiate sex at an earlier age than those whose menarche began at 14 or 15yrs. Girls who had not initiated menarche or were in school were less likely to have early sex (Glynn et al. 2010). Zeba et al (2004) in understanding recent trends of age at first sex in African demographic surveys for six countries using survival analysis techniques found that in Kenya and Uganda, 15-19 year old females report a later age at first sex than those aged 20-24 at each consecutive survey suggesting a rise in age at sexual debut over time, while the opposite was true for Tanzania. Male cohorts tended to report an older age at first sex when questioned at later ages while females reported a younger age. Secondary education and urban residence were associated with later ages at first sex for both males and females (Zaba et al. 2004). Systematic reviews have shown that boys who use drugs and alcohol are more at risk of engaging in premarital sex while girls especially those beginning sexual activity at an earlier age are more at risk of HIV/STIs and unwanted pregnancies (Mmari and Blum 2009).

Matters of sexual relationships are still regarded as a taboo in majority of African communities. For example among the Sukuma community in Tanzania, sexual matters are rarely discussed publicly and explicit discussion is regarded as obscene (Wight et al. 2006). In some cultures female fidelity before marriage especially for girls is highly valued but may be unlikely (Varga 2003). Because the society expects young people not to be involved in sex, there is a lot of secrecy and concealing of sexual relationships among young people (Mensch et al. 2003;Wight et al. 2006). Girls who get pregnant before marriage are perceived as having brought shame to the family. To avoid this, parents may employ different parenting control mechanisms for boys and girls (Wamoyi et al. 2011). Parents’ monitored girls’ whereabouts, mode of dressing and restricted them from going out freely while the same was not applied to the boys (Wamoyi et al 2011). However parental
protectiveness and good parent-youth relationships have been shown to be significant protective factors against risky sexual behaviour (Dimbuene and Defo 2011).

Table 4: Median age at first sex among youth aged 20-24, proportion who have had more than one partner in the last 12 months, proportion currently married and condom use at last high-risk sex

<table>
<thead>
<tr>
<th>Country and Year of DHS</th>
<th>Median age at first sex among 20-24</th>
<th>% &gt; one partner in past 12 months</th>
<th>% currently married 15-24</th>
<th>Condom use at last high-risk sex (15-24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benin 2001</td>
<td>17.2</td>
<td>17.3</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>Cameroon 2004</td>
<td>16.7</td>
<td>18.0</td>
<td>10</td>
<td>41</td>
</tr>
<tr>
<td>Congo (Brazzaville) 2005</td>
<td>16.2</td>
<td>16.3</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Senegal 2005</td>
<td>19.6</td>
<td>19.1</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Mali 2001</td>
<td>15.9</td>
<td>*</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Ghana 2003</td>
<td>18.4</td>
<td>19.6</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Guinea 2005</td>
<td>16.4</td>
<td>17.7</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Ethiopia 2005</td>
<td>18.2</td>
<td>*</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Kenya 2003</td>
<td>18.1</td>
<td>16.6</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Uganda 2004/05</td>
<td>17.1</td>
<td>18.3</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Tanzania 2004</td>
<td>17.1</td>
<td>18.3</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Malawi 2004</td>
<td>17.4</td>
<td>18.1</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Zambia 2001</td>
<td>17.0</td>
<td>17.0</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>17.3</strong></td>
<td><strong>17.8</strong></td>
<td><strong>4.5</strong></td>
<td><strong>25.5</strong></td>
</tr>
<tr>
<td>South East Asia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangladesh 2004</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Indonesia 2002/03</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Bolivia 2003</td>
<td>18.7</td>
<td>17.1</td>
<td>2</td>
<td>34</td>
</tr>
<tr>
<td>Dominican Republic 2002</td>
<td>18.2</td>
<td>16.5</td>
<td>5</td>
<td>38</td>
</tr>
</tbody>
</table>

Source (Khan & Vinod 2008)

b) Age at marriage

In less developed countries the interval between age at first sex and age at marriage or cohabiting with a partner is between 0-2 years for women and 3-6 years for men, while in developed countries this interval is approximately five years for both men and women (Wellings et al. 2006). Approximately four out of 10 young women aged 15-19 years living in low-income countries are married compared to one in 10 from high income countries. In sub-Saharan Africa this proportion is three out of 10. The majority of young women who get married at an earlier age are poor and un-
educated (Guttmacher Institute and IPPF 2010). Young married girls in developing countries are at a higher risk of HIV infections than their single counterparts partly, due to the lower rates of condom use within marriage and having older spouses (Clark 2004). The median spousal age difference in African countries ranges between 9.2 years in West Africa, 7.4 years in central and North Africa and 5.5 years in southern Africa (Wellings et al. 2006). Evidence shows that young women in sub-Saharan Africa are getting married at an older age than a decade before. This has been attributed to the higher educational attainment which keeps girls longer in school. However other factors such as the need for cash payment for bridal wealth may be a hindrance to men who want to marry young girls (Robert 2007).

c) Number of sexual partners

The proportion of young women and men who have more than one sexual partner, or who frequently change sexual partners, serves as an indicator to assess potential risks of adverse reproductive health outcomes such as unintended pregnancies and infection with STIs/HIV/AIDS (Darroch et al. 2001a). Globally, young men are more likely to have more than one sexual partner than young women, except for some industrialized countries where multiple sexual relationships are similar between the two sexes (Wellings et al 2006). In countries where data is available, more young men have had two or more sexual partners in the past one year than women the same age, as illustrated in Table 4. For example in Benin 35 percent of young men have had more than one sexual partner in the last 12 months compared to only three percent of young women (Khan and Vinod 2008;PRB 2001;Ringheim and Gribble 2010).

d) Gender-based violence, coercive sex and transactional sex among young people

Studies determining the prevalence of Gender Based Violence (GBV) at the international level are limited but according to the world report on violence and health, available data indicate that almost one in four 4 women report instances of intimate partner violence in some countries (IPV) (WHO 2002c). The most common form of violence against women is that perpetuated by their husbands or intimate partners, commonly known as “domestic violence” which can either be physical, sexual, psychological or emotional (Watts and Zimmerman 2002). The WHO multi-country study of 24,000 women from 10 countries found that among ever partnered women, between 15% to 71% had experienced physical or sexual violence or both at some point in their lifetime. The prevalence of sexual abuse by a partner among the women ranged from 6% in Japan, Serbia and Montenegro to 59% in Ethiopia. Sexual abuse for children below 15 years was reported to be between 1%-20%
(Garcia-Moreno et al. 2005). The same study also found that, adolescent girls aged 15-19 were at a higher risk of experiencing physical or sexual violence, or both than women aged 45-49 and that in more than half of the study settings, over 30% of women who reported first sex at age 15 described the experience as being forced (Garcia-Moreno et al 2005). WHO estimates also show that in the year 2002, 150 million girls and 73 million boys experienced forced sexual intercourse with 56% of girls and 25% of boys victims being abused by family members (Pinheiro 2006;United Nations 2006).

Health consequences of GBV range from non-fatal outcomes (physical and mental health) to fatal outcomes such as suicide or homicide. Reproductive health consequences include infection with STI/HIV, unwanted pregnancy, miscarriages, pain, depression and sexual dysfunction (Heise et al. 1994). In some countries societal norms and expectations further perpetuates this violence as it is seen as acceptable and the affected women often suffer in silence (Pinheiro 2006). DHS analytical reports show that young women are at risk of experiencing both physical and sexual violence including in situations where they are experiencing unintended pregnancy (Ringheim and Gribble 2010). Interestingly the DHS analytical reports show that young women (15-19) may agree that this violence is justifiable if the women have failed in meeting their domestic obligations such as cooking, being submissive, taking care of children, and refusing to have sex. For example almost 80% of women in Ethiopia agree that a husband is justified to beat his wife because of one or more reasons (Ringheim and Gribble 2010). A study conducted among 90 women from low-income areas of Kisumu in Kenya found that most women (47 out of 90) reported experiencing domestic violence. The most common forms of domestic violence experienced was verbal, physical or sexual mainly perpetuated by their husbands, with verbal violence (53%) being the most common type of violence experienced. Gender specific socialisation was ranked as the main cause of this violence (Mutiso et al. 2010).

Sexual coercion has been recognised as a risk factor for adverse reproductive health outcomes among both married and unmarried adolescents. The adverse reproductive health outcomes include unintended pregnancies, delivery of pre-term babies, unsafe abortion as well as STI/HIV infection (Watts and Zimmerman 2002). Research evidence shows that a significant proportion of both adolescent males (5-32 percent) and females (19-48 percent) report forced sexual initiation and that coerced sexual relations are not uncommon especially among females (WHO 2007a). In some African societies sexual coercion among girls is regarded as a normal occurrence in boy-girl relationships and not assumed to occur in marriage. In a study conducted in rural Uganda, Rakai district, 14 percent of women aged 15-19 reported coerced sexual initiation (Koenig et al. 2004). Young girls are most risk of experiencing sexual coercion because their sexual partners are often
older, commonly referred to as “sugar daddies” (Blum and Nelson-Mmari 2004). Young girls who experienced sexual coercion are more at risk of experiencing unwanted pregnancy, less likely to use contraception and condoms at last intercourse and more at risk of HIV/STI infections (Garcia-Moreno and Watts 2000; Koenig et al. 2004; Maharaj and Munthree 2007). In a qualitative study conducted in three districts in Kenya to explore the perceptions of sexual violence among men, women, boys and girls, rape was identified by all respondents as a risk factor for HIV infection (Kilonzo et al. 2008).

The exchange of gifts or money for sex, transactional sex, is a common occurrence among sexually active, unmarried young women in sub-Saharan Africa (Moore et al. 2007b; Nobelius et al. 2011). Analysis of DHS data from 12 sub-Saharan African countries has shown that almost all women reporting transactional sex are aged between 15-19 years, with young men being more likely to engage in transactional sex than older men. Being in school does not seem to have a significant effect on transactional sex. The reverse is true for married young women as marriage seems to be a strong predictor for not engaging in transactional sex (Chatterji et al. 2005). A multi-country household survey conducted in Burkina Faso, Ghana, Malawi and Uganda, among adolescent girls and boys aged 12-19 years, found that among unmarried adolescents who had sex in the previous 12 months, a higher proportion of girls than boys received gifts and money in exchange for sex (Moore, Biddlecom and Zulu 2007b).

**e) Structural drivers, vulnerability and gender in SRH**

Vulnerable populations have an increased risk of experiencing adverse health outcomes because of their low socio-economic status and lack of social connectedness within the society (Flaskerud and Winslow 1998). As stated in chapter 1 (section 1.2), young people, especially from sub-Saharan Africa are at risk of experiencing adverse reproductive health outcomes including early unprotected sexual activity which often involves multiple partners, infection with sexually transmitted infections including HIV/AIDS, sexual violence and unwanted teenage pregnancy often leading to unsafe abortion practices. In sub-Saharan Africa young women are almost five time more likely to be infected with HIV/AIDS than young men the same age group (Robert 2007). Several factors have been linked to the increased vulnerability of young people to the stated SRH problems including: their age, biological and emotional development and economic dependence. Young people’s lack of accurate information about their reproductive health problems, their own perception of low risk and limited access to health care services increases this vulnerability to experiencing the stated problems. Use of alcohol and drugs may also increase their vulnerability especially with regards to sexual experimentation and the likelihood of having unprotected sex (Page and Hall 2009; Summers
et al. 2002). Studies have also shown that there is no safe level of alcohol consumption among 15-16 year olds and often teenagers engage in regretted-sex after consuming alcohol (Bellis et al. 2009). The economic dependence on adults makes young girls engage in transactional sex and often this is with older multiple sexual partners who are able to meet their financial needs (Mabala 2008).

Research has shown that structural factors enhance adolescents’/young people’s vulnerability to the above stated adverse reproductive health outcomes (Gupta 2008). Current literature on structural factors mainly examines vulnerability in relation to HIV infection. Structural drivers of vulnerability with regard to other reproductive health outcomes is not well documented although vulnerability to HIV infection could also be extrapolated and applied to other reproductive health outcomes such as unintended pregnancy and sexual violence. Although there is no clear definition of what constitutes such structural factors, efforts have gone into outlining what they broadly entail; “physical, social, cultural, organisational, community, economic, legal and policy of the environment that either impede or facilitate efforts to avoid HIV infection” (Gupta et al. 2008). The low social status of women in society, their economic dependence and lack of power to negotiate for safer sex or monogamy underpins their vulnerability to STI/HIV, unwanted pregnancy and sexual violence. Lack of access to alternative means of protection like the female condom leaves them helpless. Young girls from poor families and orphans in need of finances to support their families may engage in transactional sex or commercial sex work where they may be exposed to unprotected sex (Kang et al. 2008;Mmari 2011).

The traditional hierarchical system and harmful traditional practices such as FGM and early marriage also makes girls and women more vulnerable to adverse RH outcomes (Rassjo and Kiwanuka 2010). For example in communities where female genital mutilation is practiced, young girls are married off immediately making them vulnerable to HIV infection, sexual violence, early pregnancy and complications related to pregnancy and delivery. In a qualitative study conducted in three districts in Kenya to determine adolescents and community members’ views about adolescents’ vulnerability to HIV infection; multiple sexual partners, transactional sex, cross-generational sex, poverty, sexual violence and use of alcohol were all mentioned as factors that increased girls’ vulnerability to HIV infection (Underwood et al. 2011).

Education has been shown to be an important contributor to the RH of adolescents as it reduces their vulnerability to unwanted pregnancy, STI/HIV infection and early marriages (Jukes et al. 2008). The World Bank Report (2007) makes reference to the fact that education is a “social vaccine” as it facilitates behaviour change and hence discourages young people from engaging in risky behaviours (The World Bank 2006). In addition, education increases optimism among young
people for a brighter future, hope for a better life and their ability to process health education information (The World Bank 2006). Some of the most important benefits of girls education, especially secondary education, are felt in the health sector in addition to the social and economic development of the nation (Rihani 2006). DHS analytical reports indicate that secondary education is consistently associated with delayed childbirth, increase in contraceptive use, reduced fertility and HIV/STI infections (Rihani 2006; Ringheim and Gribble 2010).

f) Validity of reported sexual behaviour by young people

Debate continues with regards to the validity of reported sexual behaviour among adolescents and young people especially in societies where young people are expected not to be sexually active. In most African communities sex among young people is prohibited and one is bound to undergo corporal punishment if found engaging in sex and hence they tend to keep their sexual relationships as guarded secrets (Wight et al 2006). This perception is bound to affect responses of sexual practices among individual young people during surveys and assessments. An evaluation of five methods of data collection in rural Tanzania: biological markers, face-face questionnaires (FFQ) interviews, self-completion questionnaire (SCQ), in-depth interviews and participant observation showed inconsistencies in self reported sexual behaviour data as only 58% of males and 29% of females with biological markers consistently reported sexual activity in both FFQ and SCQ. In-depth interviews seemed to be more effective in getting honest responses among females having STIs (Plummer et al. 2004).

Although face to face interviews illicit more positive responses with regards to sexual activity and Audio Computer-Assisted Survey Instruments (ACASI) illicit higher responses with regards to multiple lifetime sexual partners, in both modes the results are discouraging as young women who deny ever having sex end up with positive results for HIV/STIs. The benefit for use of ACASI in low resource settings is limited. The introduction of the computer element could create an unfamiliar and sometimes an unfriendly dynamic to the research process and therefore influence respondents participation and responses (Hewett et al. 2004; Mensch et al. 2008; Mensch, Hewett and Erulkar 2003). Nonetheless, a systematic review of literature has shown that a ACASI interview mode can significantly reduce reporting bias associated with self-reported sensitive sexual behaviours (Langhaug et al. 2010).

2.1.2 Young people and contraception

Since 1994, there has been a steady increase in global contraceptive use from 55 percent to the current 61 percent among married women of reproductive age; with 69 percent and 59 percent
prevalence in developed and developing countries respectively (UNFPA 2004). Female sterilization is the most common contraceptive method used by approximately 20 percent of married women worldwide and only two percent of women from sub-Saharan Africa, where the majority of married women (over 75 percent) do not use any contraceptive (PRB 2008).

Evidence from World Health Organisation case studies show that adolescents do not consistently and correctly use contraceptives at sexual debut, especially females. There is a large gap between knowledge, ever use and consistent contraceptive use, particularly with reference to condoms and the pill. In spite of the high level of awareness of the condom, there is little indication of its consistent and regular use (WHO 2001c).

Contraceptive use among sexually active adolescent women in developed countries ranges from 31 percent in Serbia and Montenegro to over 90 percent in the United Kingdom (Avery and Lazdane 2008). In low-income countries about 33 percent of adolescents who want to avoid pregnancy are using a modern contraceptive method, compared to 58 percent in high income countries (Guttmacher Institute and IPPF 2010). Several reasons have been suggested for this finding including lack of access to adequate and accurate information, fear of side effects, along with geographic, social, and economic barriers. Another reason could be that adolescents are less motivated to use contraception since they are entering into the childbearing period (PRB 2000).

Acceptability of the use of the term “family planning” or “contraception” varies across societies and unmarried young people often feel disconnected from the services if the term “family planning” is used due to the simple notion that they have not began child bearing.

**Figure 1: Current use of modern contraception by married and unmarried women aged 15-19: DHS 2003-2008**

Source: (Ringheim and Gribble 2010)
2.1.2.1 Condom use among young people

Worldwide, the proportion of sexually active young people who report using a condom during their last sexual encounter is higher for males than females, although for both sexes, there is an indication towards an increase in condom use (PRB 2001; Wellings et al. 2006). A review of DHS data from 18 countries from sub-Saharan Africa found a substantial increase in condom use among young sexually active single women, although its use was mainly linked to pregnancy prevention (Cleland and Ali 2006). With regards to high-risk sex, the proportion of young women who report condom use is still lower than that of young men with the exception of Uganda, where the proportions are almost similar (53 females and 55 males) (Table 4) (Khan and Vinod 2008). In 11 countries in sub-Saharan Africa where data is available, condom use at last high-risk sex has increased by over 10 percentage points between 2000 and 2007 (United Nations 2010).

Condom use among young people is greatly influenced by social norms, values and approval (Van Rossem and Meekers 2011). As stated in section 2.1.1 (d) and (e), the low status of women and girls in the society and their economic dependence inhibits their ability to negotiate for condom use. The community belief that condom use promotes promiscuity even among young people themselves has a negative effect on its use (Olugbenga-Bello et al. 2010). Even within the context of HIV young people who know their HIV positive status do not consistently use condoms (Birungi et al. 2009; Obare and Birungi 2010). Among adolescents attending prenatal clinics, condom use mostly occurs within the context of pregnancy prevention (Cherutich et al. 2008); also young people who have had an exposure to condom demonstration are likely to have a better knowledge of condom use (Bankole et al. 2007).

2.1.3 Pregnancy among young people

Worldwide approximately 16 million young women aged 15-19 give birth annually which constitutes 11 percent of all births. The majority of these births (95 percent) occur in low and middle income countries. In sub-Saharan Africa adolescent births constitute 50 percent of the total births, while in China they constitute two percent; in the Caribbean and Latin America, adolescent births constitute 18 percent (WHO 2008). The highest rates of adolescent pregnancy are seen in sub-Saharan Africa (115.25 births per 1,000 women) and the lowest in Europe (19.29 births per 1,000 women) (United Nations 2011c). Estimates show that fertility of young women in Africa is expected to remain above that of other adolescent women in other parts of the developing world, up to and beyond 2020 (US Bureau of the Census 1996). Asian countries form a good example where
increase in age at marriage and the reduction of the incidence of premarital childbearing have led to low levels of childbearing, among women aged 15-19 (United Nations 2004).

Annually, 2.2 million unintended pregnancies occur among adolescents in sub-Saharan Africa, 92 percent of which occur among adolescents who are not using any contraceptive methods (Guttmacher Institute and IPPF 2010).

2.1.4 Young people and sexually transmitted infections

WHO, on global estimates of the magnitude of STIs, indicate that approximately 340 million new cases of four commonly diagnosed STIs, syphilis, gonorrhea, chlamydia and trichomoniasis, occurred worldwide during the year 1999, among men and women of reproductive age. The prevalence tends to vary between regions, countries, rural and urban populations and even among sub-population groups (WHO 2001b). In sub-Saharan Africa, the incidence of STIs among men and women aged 15-49 was estimated at nine million new cases in the year 1999. Sub-Saharan Africa is estimated to have the highest prevalence of STIs in the world (119 per 1000 population) followed by South and South-East Asia with 50 per 1000 population (WHO 2001b). If untreated, STIs cause great harm to the health and well-being of the reproductive age population. Untreated STIs result in pelvic inflammatory disease in two out of five infections in women, while 33 percent of these infections may result in infertility (CDC and World Bank 2005). Treatment of STI is also essential for the prevention of both HIV infection and adverse pregnancy outcome (WHO 2007c). In the two community-based Randomised Control Trials in Tanzania and Uganda which examined the impact of STD prevention on HIV infection, there was a significant impact on the reduction of HIV transmission especially in the early stages of the HIV epidemic (Grosskurth et al. 1995; Hitchcock and Fransen 1999; Wawer et al. 1999). These results have implications for the sexual and reproductive health of adolescents because they are at the stage of sexual initiation and are prone to have multiple sexual partners in their lifetime (Hitchcock and Fransen 1999). Early screening and treatment of STIs in adolescents is therefore also essential to reduce the risk to HIV infection.

There is limited age and sex specific data on STIs, with the exception of HIV/AIDS where data is readily available. Adolescents are more susceptible to STI infection due to a variety of reasons including biological, socio-cultural and economic factors (CDC & World Bank 2005). Untreated STIs increase the risk of HIV infection by a factor of 10 and improvement in their management subsequently reduces the incidence of HIV infection by a factor of approximately 40 (WHO 2001b). The highest rates of STIs are seen among urban men and women between ages 15 and 35 while women generally become infected at a younger age, even below 15 years (WHO 2001b).
A rural population based study, carried out in Southeast Nigeria among adolescent girls aged 10-19, found an STI prevalence of 19.4 percent with sexually active girls aged 17-19 having the highest prevalence of Chlamydia (10.5 percent), while trichomoniasis was common in girls less than 17 years (11.1 percent) (Brabin and Kemp 1995). WHO classifies chlamydia as an adolescent infection while gonorrhoea normally occurs in sub-groups such as adolescent sex workers but it is less likely to be detected in the general population of adolescents (WHO 2004). A household survey conducted in rural Mwanza, Tanzania among 15-19 year olds found a chlamydia prevalence of 1.8 percent (one percent in males; 2.4 percent in females) with the majority (over 79 percent) of adolescents who tested positive being asymptomatic (Obasi et al. 2001).

### 2.1.5 Young people and HIV/AIDS

In the year 2009, approximately 2.6 million new cases of HIV infection were reported globally. This was a 19 percent reduction from the 3.1 million new cases that had been reported in 1999, a time when annual new HIV infections peaked. Reports also point towards a 25 percent decline in HIV incidence of 33 countries, 22 of which are in sub-Saharan Africa (UNAIDS 2010). In sub-Saharan Africa, 1.8 million people became infected with HIV in the year 2009. This is a much lower number than the 2001 estimate of 2.2 million, pointing to a positive impact of the HIV prevention efforts (UNAIDS 2010). In Europe (western, central, eastern), Central Asia and North America, the annual rate of HIV infections has been stable for the last five years (UNAIDS 2010).

HIV/AIDS infection has disproportionally affected women who constitute almost half (48%) of all persons infected with HIV/AIDS. HIV/AIDS is also the leading cause of mortality in women aged 15-44 years (Ribeiro et al. 2008). In sub-Saharan Africa, about three quarters of all young people living with HIV are females (Bearinger et al. 2007).

Young people constitute 40 percent of all new HIV infections and almost 5.4 million of young people worldwide are believed to be living with HIV (United Nations 2007). Their vulnerability to HIV infection is embedded in a multiplicity of factors stemming from socio-cultural, political, biological and economic factors (United Nations 2007). In sub-Saharan Africa young women are three times more likely to be infected with HIV than young men of the same age group (3.1 percent and 1.1 percent respectively) (Figure 2). Knowledge of the three preventive measures (abstinence, being faithful, and using condoms) among young people is inadequate especially among girls (Khan & Vinod 2008; Ringheim and Gribble 2010).

In sub-Saharan Africa DHS analytical reports have shown that young people believe that they are at low or no risk of being infected with HIV, especially young men. Women say they are at low risk since they abstain and have one sexual partner, while men report that they are at low risk because
they use condoms (PRB 2001). However, many young men and women do not know their HIV status, since only as few as four percent have ever been tested and received their results within the previous 12 months (Khan and Vinod 2008).

**Figure 2: HIV prevalence among women and men ages 15-24**

![HIV prevalence among women and men ages 15-24](image)

Source: (Ringheim and Gribble 2010)
2.2 Approaches to improving SRH of young people

This section of the literature review is presented in two parts. First, a summary of key findings from systematic reviews on SRH interventions targeting young people is presented. This is followed by a review of primary studies describing facility-based, school-based and community-based approaches.

2.2.1 SRH interventions targeting young people

Sixteen systematic reviews of SRH interventions targeting young people were identified; two were reviews from studies conducted in developed countries, three were reviews of studies conducted in both developed and developing countries, while the rest (11) were studies conducted in developing countries. A summary of these reviews is presented in Table 6.

The findings of these reviews suggest that most SRH interventions targeting young people which have undergone rigorous evaluation, especially those conducted in developing countries, have largely focused on HIV/AIDS prevention and control (Hindin and Fatusi 2009). Some interventions have included other aspects of reproductive health content, such as sexuality education and pregnancy prevention; however very few have focused on evaluating the “RH” component more broadly or have assessed how the intervention affects access to reproductive health services.

There is agreement, in the literature, on the lack of scientifically sound SRH interventions targeting young people in sub-Saharan Africa, in comparison to the magnitude of the SRH problems experienced in the region (Magnussen et al. 2004; Speizer, Magnani and Colvin 2003). This could be explained by skewed funding which tends to largely favour HIV/AIDS interventions.

Systematic reviews of SRH and HIV interventions, targeting young people, suggest that interventions tend to have significant positive effects on improving young peoples’ knowledge and some reported attitudes on sexual behaviour but are less effective in demonstrating change in sexual behaviour outcomes (Gallant and Maticka-Tyndale 2004; Paul-Ebbohimhen et al. 2008; Ross et al. 2006; Speizer, Magnani and Colvin 2003). There is some suggestion that most interventions may fail to produce impressive results because they lack sensitivity to existing community norms and beliefs. Therefore there may be need for a paradigm shift for interventions towards focusing activities on the community as a whole in order to influence social norms, as opposed to targeting individual young people for specific behaviour change (Harrison et al. 2010; Kristien et al. 2010). Another important finding across all systematic reviews is that sex education and condom promotion activities do not increase sexual activity among young people, as they neither encourage
early sexual initiation nor lead to an increase in the number of sexual partners (Kirby et al. 2006; Kirby et al. 2007; Michielsen et al. 2010).

It must be noted that the effectiveness of ASRH interventions cannot be ascertained, as most studies have had methodological deficiencies; many are uncontrolled studies, have a short implementation period, rely on self-reported responses and very few have measured intervention effects using biological outcomes such as HIV, STIs and pregnancy rates. Many studies lack adequate statistical power, making it difficult to measure intervention impact on sexual behaviour outcomes and hence are unable to make conclusions regarding “what interventions work” (Michielsen et al. 2010; Ross et al. 2007; Speizer et al. 2003). For example, a systematic review of HIV interventions conducted in South Africa to identify which interventions worked produced inconclusive results. A definite assessment of “what works” was not possible due to limitations in the effectiveness of most interventions and weakness of the study design. There were methodological variations in sampling (sample sizes), length of interventions, follow-up period and cluster versus individualised designs (Harrison et al. 2010).

Systematic reviews show that interventions having multiple components such as a combination of health service provider training, facility improvement initiatives and community wide health education activities often lead to increased service use, although there is need for careful monitoring, evaluation and operations research (Dick et al. 2006). With regard to unintended pregnancy among young people, one review showed a reduction among adolescents receiving multiple interventions (education, skills building, and contraceptive promotion) (Oringanje et al. 2009) while another review showed no effect on sexual behaviour outcomes and unintended pregnancies (DiCenso et al. 2002)

The systematic review conducted by Kirby, Laris and Rolleri 2007 identified 17 characteristics that were common to the majority of sex and HIV education programmes that had produced positive results (Table 5) and concluded that it was possible to achieve multiple outcome effects with the same intervention. On the other hand, the review by Poobalan et al. (2009) recommended the need to have multiple, step-wise health education sessions that were age specific and targeted specific behaviour, instead of multiple outcomes.
Table 5: Characteristics of effective curriculum-based programmes

<table>
<thead>
<tr>
<th>Category</th>
<th>17 Characteristics of effective curriculum based programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum development process</td>
<td>1. Involved a wide range of stakeholders with different background in theory, research and sex/HIV education 2. Assessed relevant target group needs 3. Developed the curriculum using a logical model approach – specified the health goals, behaviours affecting those health goals, risk and protective factors of those behaviours, and activities addressing those risk and protective factors 4. Designed activities consistent with community values and available resources (staff, staff skills, facility space, supplies) 5. Pilot-tested the programme</td>
</tr>
<tr>
<td>Curriculum content</td>
<td>Goals and objective of curriculum 6. Focused on clear health goals – the prevention of STD/HIV and/ or pregnancy 7. Focused narrowly on specific behaviours leading to these health goals such as abstaining from sex, using condoms, giving clear messages about these behaviours: 8. Addressed multiple sexual psychological risks and protective factors affecting sexual behaviours (knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy)</td>
</tr>
<tr>
<td></td>
<td>Teaching methods and activities 9. Created a conducive environment for youth to participate 10. Used multiple activities to address each of the targeted risk and protective factors 11. Employed sound teaching methods, with clear instructions, that actively involved the participants, to help them personalize the information, 12. Employed activities, instructional methods and behavioural messages that were culturally appropriate, age specific, and sensitive to sexual experience 13. Covered the topics in a logical sequence</td>
</tr>
<tr>
<td>Mode of content delivery</td>
<td>14. Secured minimal support from appropriate authorities e.g. Ministries of Education/ Health: district schools, community organisations, 15. Selected appropriate educators, trained them, provided monitoring and support supervision 16. Involved the youth in the implementation of activities 17. Implemented all activities with fidelity</td>
</tr>
</tbody>
</table>
## Table 6: List of systematic reviews of interventions targeting SRH of young people

<table>
<thead>
<tr>
<th>Author, year and country</th>
<th>Objective of systematic review</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| 1: (Shepherd et al. 2010) Developed countries 1985-2008 | Assesing the effectiveness and cost-effectiveness of school-based skills-building behavioural interventions | • Significant effects on knowledge and attitudes  
• No significant effect on sexual behaviour (sexual initiation and consistent condom use)  
• Implementation difficulties due to school culture, school administration flexibility  
• Peer led more expensive than teacher led at £15 and £4.30 per pupil respectively due to constant yearly training of peers |
| 2: DiCenso et al. 2002 Developed countries 1970-2000; (26 RCTs) | Reviewing effectiveness of primary prevention strategies aimed at delaying sexual intercourse, improving use of birth control and reducing incidence of unintended pregnancy in adolescents | • No significant effect on delaying sexual initiation, contraceptive use and reduction in pregnancy rates  
• A few programmes (abstinence and school-based) increased pregnancy rates for partners for young men in the intervention sites  
• Few pregnancies among young women receiving multi-faceted interventions |
| 3: Oringanje et al. 2010 Developed and developing countries Studies done till Dec. 2008: 41 RCTs | Assessing the effects of primary prevention interventions (school-based, community/home-based, clinic-based, and faith-based) on unintended pregnancies among adolescents | • Multiple interventions consisting of both education and contraceptive services reduced unwanted pregnancies among adolescents  
• Evidence on effect of sexual behaviour (sexual initiation, use of birth control) outcomes was inconclusive |
| 4: Kirby, Laris and Rolleri 2007 Developed and developing countries Studies done 1990 or thereafter: (83 studies; USA (53): 18 from developing countries | Examining the effect of curriculum based sex and HIV education programmes on sexual behaviour among young people below the age of 25 years | • Most studies had a significant effect on at least one or more sexual behaviour outcomes – initiation of sex, frequency of sex, number of sexual partners, use of condoms, use of contraceptives  
• No evidence for an increase in sexual activity due to intervention  
• Effects on STDs and pregnancy rates were insignificant  
• Half of studies lacked statistical power to detect meaningful programme effects |
| 5: Poo balloon et al. 2009 Developed and developing countries 1986-2006: 30 studies | Identifying characteristics of effective sex and relationship education (SRE) and identifying barriers and facilitators for implementation | • Most studies reported positive effects on knowledge and attitudes but inconsistencies in sexual behaviour changes (No. of sexual partners, contraceptive use)  
• Girls were more receptive to SRE interventions especially pregnancy prevention while boys were more receptive to HIV prevention  
• Effective interventions seem to  
  o Target younger age groups before sexual initiation  
  o Have content that is age specific  
  o Be theory based; culturally sensitive, sustained over a longer period with multiple booster sessions  
  o Delivered by properly trained personnel |
<table>
<thead>
<tr>
<th>Author, year and country</th>
<th>Objective of systematic review</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| 6: (Hindin and Fatusi 2009) Developing countries | Examining the overview of trends and interventions related to ASRH in developing countries | - Most community based interventions have focused on HIV rather than comprehensive RH, due to skewed funding  
- Despite interventions showing increased knowledge, the same does not translate into positive sexual behaviour |
| 7: (Ross, Dick and Ferguson 2006) Developing countries | Providing a systematic review of the evidence for policies and programmes to decrease HIV/AIDS prevalence among young people in developing countries | - Most interventions had weak designs hence evidence for effectiveness was weak  
- Interventions with positive results included those that  
  - Were curricular based, led by adults, for schools  
  - Included HSP training, facility improvement and community links  
  - Involved mass media: radio, TV and other print |
| 8: (Maticka-Tyndale and Brouillard-Coyle 2006) Developing countries 1990-2004: 22 interventions | Identifying successful HIV/AIDS prevention interventions targeting youths in developing countries | - Scale up is recommended for interventions delivered through existing youth centers but rigorous evaluation has to accompany the implementation  
- Results for other interventions were inconclusive as they were less rigorously evaluated |
| 9: Dick et al. 2006 Developing countries 1995-2002: 16 studies | Reviewing the evidence base for interventions that aim to increase young people's use of health services in developing countries | - Training of HSP is the most common intervention in addition to cost reduction, physical infrastructure improvement and community activities  
- Evidence for intervention effectiveness is weak.  
- Studies often poorly describe health service activities |
| 10: (Speizer, Magnani and Colvin 2003) Developing countries After 1990 with most studies 1995-2001: | Reviewing emerging literature and understanding "what works" in ARH programming | - Interventions improved adolescent knowledge but were less consistent in affecting sexual behaviour  
- Few programmes in developing countries have been evaluated with rigour  
- Evidence supporting effectiveness of YF health services and youth centres in developing countries is thin to non-existent  
- Most evaluated programmes have been small-scale and implemented over a short period of time.  
- Outcomes of studies were limited to self-reporting as opposed to biological markers |
| 11: (Kirby, Obasi and Laris 2006) Developing countries 1990-2005: 22 studies identified | Measuring the impact of sex and HIV education interventions in schools in developing countries | - Most interventions are effective in increasing knowledge and some reported sexual behaviour  
- Curricular based interventions led by adults and which included at least 4/5ths of previously indentified 17 characteristics, had a positive impact on reducing risky sexual behaviour |
<table>
<thead>
<tr>
<th>Author, year and country</th>
<th>Objective of systematic review</th>
<th>Key findings</th>
</tr>
</thead>
</table>
- Meta-analysis showed  
  - Condom use at last sex was 1.46 times more in intervention males than control males  
  - Little effect on condom use at last sex among pre-intervention virgin males and females  
- Interventions mainly focused on HIV/AIDS as a means of changing sexual behaviour. Reliance on self-reported data  
- Sex education and condom promotion do not increase sexual activity in young people |
| 13: (Paul-Ebhoimhen, Poobalan and Teijlingen 2008) Sub-Saharan Africa 1986-2006: 10 studies | Reviewing school-based sexual health interventions in SSA to prevent HIV/AIDS and STIs | - Published school-based interventions in SSA are scarce, relative to the magnitude of the HIV epidemic  
- Among sexually active adolescents, encouraging condom use seemed to be a more practical behaviour |
| 14: (Gallant and Maticka-Tyndale 2004) Sub-Saharan Africa 1994-2002: 11 studies | Critically reviewing 11 school-based HIV/AIDS risk reduction programmes for youth in Africa | - Significant improvement in SRH knowledge, improved communication with parents and peers about sexuality, and change in attitude towards people living with HIV.  
- No effect on perceptions of personal risks/susceptibility  
- Changes towards abstinence and condom use were inconsistent.  
- Some teachers show great reservations towards teaching condom use in schools  
- No evidence of increase in reported sexual activity |
| 15: Harrison et al. 2010. South Africa From 2000 or after: 8 RCTs identified | Assessing the evidence base for youth HIV prevention in south Africa | - Interventions led to reduced STI incidence and reported risky sexual behaviours or use of alcohol  
- School-based interventions experienced frequent implementation challenges such as absenteeism, rescheduling of activities |
| 16: (Bertrand and Anhang 2006) Developing countries (1990-2004): 15 programmes identified | Reviewing the effects of three mass media interventions (radio only, radio with supporting media, or radio and television with supporting media) on HIV/AIDS-related behaviour among young people in developing countries | - Mass media interventions may show some positive outcomes such as improved knowledge, condom self-efficacy, and interpersonal communication.  
- Campaigns that include television require the highest threshold of evidence, yet they also yield the strongest evidence of effects. |
2.2.2 SRH intervention programmes for young people in developing countries

A review of the literature shows that SRH intervention programmes targeting young people have taken one or a combination of the following approaches: a) facility-based, b) school-based, and c) community-based. Interventions comprising of a combination of approaches are often referred to as multi-component interventions (WHO 2009).

a) Studies evaluating facility-based SRH programmes

In essence most facility-based SRH programmes take a multi-component approach. Facility-based SRH interventions strive to increase access to SRH services through either training clinical and non-clinical staff to be sensitive to the sexual health problems young people experience, making facility improvements such as constructing or renovating specific service delivery areas and linking health activities with other sectors such as schools, communities and mass media networks (WHO 2009). The main challenge with multi-component interventions is that it is difficult to disentangle the effects of individual interventions on outcome measures (WHO 2009).

Ten studies reporting on multi-component programmes in sub-Saharan Africa were reviewed (Table 7) of which three were Randomised Control Trials (RCTs) while the rest were quasi-experimental or non-controlled studies. Four studies (3 RCTs and 1 quasi-experimental study) used biological markers to assess the effectiveness of SRH interventions: Mema kwa Vijana project implemented in rural Mwanza Tanzania (Hayes et al. 2005; Obasi et al. 2006; Ross et al. 2007), the Stepping Stones programme (Jewkes et al. 2006a; Jewkes et al. 2008) and Lovelife programmes (Pettifor et al. 2005) both implemented in South Africa, and the Regai Dzive Shiri Project implemented in Zimbabwe (Cowan et al. 2008; Cowan et al. 2010).

In all the four studies where biological markers were assessed, blood samples were taken from respondents for HIV and HSV-2 testing both at baseline and follow-up. Other tests conducted included those for STIs (gonorrhoea, chlamydia, syphilis) and pregnancy. In these four studies there were three main findings: i) a significant improvement in reported knowledge and attitude among both young men and women, ii) no effect on the incidence of HIV in both intervention and comparison sites, and iii) except in the Stepping Stones programme, no significant difference between trial arms on incidence of HSV-2. With regard to prevalence of pregnancy and other STIs (gonorrhoea, chlamydia, syphilis), the programmes were unable to demonstrate an effect.
Contrary to expectation, in the Mema kwa Vijana project, more young women in the intervention site became pregnant and had a higher prevalence of *N. gonorrhoea* during the three-year follow-up (Ross et al. 2007). An impact evaluation done eight years later produced similar results. However, the intervention was associated with a reduction in some high-risk reported sexual behaviour such as a reduction in the proportion of males reporting more than four sexual partners in their lifetime; and among females, an increase in reported condom use at last sex with non-regular partners. There was a significant and consistent impact on knowledge but no significant impact on reported attitudes to sexual risk, reported pregnancies and other sexual behaviours (Doyle et al. 2010). In addition, training of HSP in youth friendly services that were linked to other service components, such as schools and the community, significantly increased service use especially among younger males (15-19 yrs) seeking treatment for STI symptoms (Larke et al. 2010).

In the Stepping Stones programme, a 33 percent reduction in the incidence of HSV-2 was detected among the intervention group. In addition, there were significant improvements in the number of reported risk behaviours in males; fewer males reported perpetration of intimate partner violence (IPV) and there was evidence of less transactional sex and drinking problems at 12 months, although these effects were not sustained after 24 months. These changes were only noted in males and were not observed in females (Jewkes et al. 2008).

The Lovelife Youth Centre and Lovelife NAFCI programme evaluations found no significant difference in the prevalence of HIV, gonorrhoea and Chlamydia, among boys and girls, between the intervention and control groups (Pettifor et al. 2005). However, further evaluation of the NAFCI programme found that setting and implementing a set of adolescent friendly standards and criteria for ASRH service provision did improve the quality of services. The NAFCI sites scored higher on the standards and criterion (79.9%) than the control clinics (60.9%). Scores were likely to be higher at clinics where there was a quality assurance facilitator and the intervention had been implemented for a longer period. However, the evaluation did not assess whether there was an increase in service utilisation by adolescents, a reduction in the incidence of STI/HIV/AIDS or teenage pregnancies (Dickson et al. 2007).

The Regai Dzive Shiri Project showed an increase in knowledge with regards to transmission of STDs and pregnancy prevention, but no effect on reported condom self-efficacy (among men) and a moderate impact on reported condom use among women. The programmes had an impact on women’s attitudes to relationship control as well as gender empowerment. Overall, the intervention had no effect on behavioural outcomes such as age at first sex, pregnancy prevention and clinic attendance. It is important to note that the programme was affected by several factors; political
instability which led to high rates of school drop-out and almost 46 percent out-migration of most young people. The programme later became largely community-based and the original cohort was not followed during the final evaluation. Although it was not possible to determine whether this mobility had an effect on the intervention outcomes, this was likely to be the case (Cowan et al. 2010).

Other facility-based programmes interventions in sub-Saharan Africa have produced inconclusive results regarding their effect on SRH service utilization. Evaluation of three youth-friendly projects in Zambia produced mixed findings, as increase in service use by youth could not be linked to the intervention at the youth centres but rather; increase in service use was more associated with “levels of community acceptance of the reproductive health services” (Mmari and Magnani 2003). Evaluation of youth centres in Lome, Togo showed some positive findings; there was an increase in youth centre use by youth from 3.3 percent at baseline (1998) to 7.5 percent in 2000 and 10.3 percent at end line (2001). Visiting the youth centre was significantly associated with contact with a peer educator, media exposure or closer proximity to the youth centre. Contraceptive use was also significantly associated with peer educator contact and visiting the youth centre, although clients who used the youth centre were significantly younger, less likely to be married and never pregnant. The youth centre was used by most youths for recreational purposes. It is important to note that there was no comparison group in this intervention and hence it was not possible to determine whether the increase in youth centre utilisation was entirely due to the project (Speizer et al. 2004).

ASRH interventions implemented in Uganda, (Mbonye 2003) and Mozambique (Hainsworth and Zilhao 2009) through public health facilities have shown increased utilisation of SRH services especially among females. However, donor dependency, youth participation and constant stocks outs of supplies such as contraceptives were noted to pose a threat to the successful delivery of these interventions.

In developing countries, demand side financing such as use of competitive subsidised vouchers has been shown to increase utilisation of reproductive health and child health services by priority population groups as well as improve the quality of services provided (Bhatia and Gorter 2007). For example, voucher subsidies have shown success in increasing access to SRH by poor and underserved adolescent girls in Managua, Nicaragua. Girls receiving vouchers were more likely to access health facilities when in need of family planning services, treatment of reproductive tract infections, ANC, counselling and pregnancy testing. Girls receiving vouchers also had higher knowledge with regards to STI prevention and condom use (Meuwissen et al. 2006a;Meuwissen et al. 2006b). Three evaluation studies are currently underway to assess the impact of “voucher and
accreditation” interventions for improving the RH behaviour and status of women in three countries, Kenya, Bangladesh and Cambodia. The studies are being conducted by the Population Council with funding from the Bill and Melinda Gates Foundation (Bellows et al. 2011; Rob et al. 2011; Warren et al. 2011). Phase I of the Vouchers for Health programme implemented in Kenya has shown a steady increase in the purchase of the subsidised vouchers especially for women from the urban slums (Janisch et al. 2010).

There is emerging evidence that mobile phones can be used as a communication tool to improve service delivery and uptake especially in managing health information and communicating to clients from vulnerable and hard to reach areas. Studies have shown that providing health information using mobile text messages can improve communication with clients from underserved areas (Tezcan et al. 2011) as well as increase satisfaction with services among pregnant women (Jareethum et al. 2008). In South Africa, computerised mobile phone technologies are being used in research settings with pregnant women living with HIV/AIDS including for the quick identification of women who need psychological counselling and support (Rotheram-Borus et al. 2011).
### Table 7: Studies of multi-component SRH programmes including facility-based SRH programmes

<table>
<thead>
<tr>
<th>Author, year, programme name, country</th>
<th>Objectives of programme and type of evaluation</th>
<th>Programme components</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| 1: Hayes et al. 2005; Larke et al. 2010 (Obasi et al. 2006) **Mema Kwa Vijana (MvK)** **Mwanza, Tanzania** | To evaluate the impact of an ASRH intervention on sexual debut, number of sexual partners, condom use and uptake of FP and STI services | Implemented for 3 years (1999-2001) in Rural Mwanza Tanzania with three components: school-based, youth friendly services and community based  
- School-based: Teacher-led; peer education in primary schools, curricular-led, social learning theory based  
- Youth friendly services: Training HSP (Feb-March 1999) and refresher (June-July 2000): school-outreaches  
- Community activities: Established community advisory committees: involved parents, religious leaders, communities, government authorities, and women’s groups: Youth health weeks held annually, condom promotion and distribution. | Significant improvement in knowledge and attitudes  
Improved sexual behaviour among males  
No effect on incidence of HIV and HSV-2 |
| 2: Jewkes et al. 2006; Jewkes et al. 2008 **Stepping stones** **South Africa** | To assess the impact of Stepping Stones, an HIV prevention programme, on incidence of HIV and herpes simplex type 2 (HSV-2) and sexual behaviour | 50 hr participatory learning that ran for 6-8 weeks, same sex facilitator who were slightly older than participants: Uses adult education learners theory  
Health services arm not included in this study apart from nurse conducting the HIV counselling and testing  
Measurements taken at baseline, after 1 year and then after 2 years:  
One-off intervention. There was no contact with participants between the interviews. | No effect on incidence of HIV  
33% reduction in the incidence of HSV-2 in the interventions site |
Youth component: in-school programme and out of school: used Mema kwa Vijana curricular with adaptation:  
Clinic component: Training of HSP on YFS; refresher training after 2 years: on-site training for other staff: supervision and quality assurance.  
Community component: raising awareness of parents and other community members | No effect on behavioural outcomes  
No effect on clinic attendance  
No effect on prevalence of HIV, HSV-2, pregnancy tests |
<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Programme components</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| **4: Pettifor et al. 2005**  
*Lovelife Youth centre and Lovelife NAFCI*  
South Africa | ▪ Lovelife youth centre: multi-purpose youth centre: National media campaign, a toll-free help line, outreaches to community and schools, training in life-skills, sexuality, sports and recreational, computer training and limited range of RH and HIV clinical services  
▪ NAFCI: clinic-based services located within public health facilities: Quality improvement initiatives: limited recreational activities | No significant difference in HIV prevalence by intervention arm |
| **5: (Mmari and Magnani 2003)**  
  ○ Training of HSP and peer educators  
  ○ Sensitisation of community members  
  ○ 10 public clinics included in the assessment. | Mixed findings |
| **6: Speizer et al. 2004**  
*Lome, Togo* | ▪ A multi-purpose youth centre with four departments  
  ○ clinic with a laboratory except HIV testing  
  ○ library  
  ○ education (RH education, sewing, cooking and reading)  
  ○ recreation, peer education and outreaches to schools and community  
  ○ Used media (radio and television) to disseminate reproductive health education messages, as well as create awareness of the existence of the youth centre.  
  ▪ Data collected from youth using random sampling, and consecutive household surveys at three intervals, baseline (1998), 2000 and 2001. | Increase in youth centre use from 3.3% in 1998 to 10.3 percent in 2001  
Visiting YC was significantly associated with  
  ○ Contact with peer educator  
  ○ Media exposure  
  ○ Proximity to youth centre  
YC mainly used for recreational purposes |
| **7: Karim et al. 2009**  
*African Youth Alliance programme*  
Uganda | ▪ Policy and advocacy  
▪ Coordination and dissemination  
▪ Institutional and capacity building  
▪ BCC  
  ○ Life-planning skills training  
  ○ Enter-education (in-school; out-of-school)  
▪ YFS  
  ○ Establishing YFS  
  ○ Outreach, peer and provider services  
  ○ HSP training | Positive effect on sexual behaviour of young girls but not males with regards to condom and contraceptive use at last sex, and number of sexual partners |
<table>
<thead>
<tr>
<th>Author, year, programme name, country</th>
<th>Objectives of programme and type of evaluation</th>
<th>Programme components</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8: Agha 2002</td>
<td>To evaluate the impact of an adolescent sexual health intervention conducted by social marketing programmes in four SSA countries</td>
<td>To evaluate the impact of an adolescent sexual health intervention conducted by social marketing programmes in four SSA countries</td>
<td>Intervention exposure was as follows</td>
</tr>
<tr>
<td>Cameroon, Botswana, South Africa and Guinea</td>
<td>Quasi-experimental intervention</td>
<td>• Cameroon o 13 months intervention used: peer education, youth clubs, mass media (radio) for advertising and distribution of information and education materials o South Africa o 11 months intervention o Campaigns for promoting safe sex, use of radio, live weekly talk shows: Botswana o 8 months intervention o Demand creation of YFS, training of retailers: Providers at retail outlets referred adolescents to MOH clinics o Trained HSP on YFS o Mass media component – radio, messages directed at parents, teachers, young people, radio-call in show o Peer education o Guinea o Between 8-9 months intervention: relied on sponsored events such as soccer games, concerts o Peer education: YF retail outlets o Mass media not used</td>
<td>Intervention exposure was as follows o Cameroon - 91% of all adolescents o Botswana - Males (71%): females (68%) o South Africa – 25% of adolescents o Guinea- Men (38%): women (15%)</td>
</tr>
<tr>
<td>9: Mbonye 2003</td>
<td>To evaluate the impact of Adolescent Friendly Health Services in Jinja, Uganda</td>
<td>To evaluate the impact of Adolescent Friendly Health Services in Jinja, Uganda</td>
<td>Increased access and utilisation of RH services by adolescents</td>
</tr>
<tr>
<td>Uganda</td>
<td>Quasi-experimental non-equivalent control group design</td>
<td>• Training of HSP • Establishing recreational activities • Involving parents and young people</td>
<td>Implementation hindered by irregular supply of contraceptives and STD drugs</td>
</tr>
<tr>
<td>10: Hainsworth and Zilhao 2009</td>
<td>To improve ASRH, increase gender awareness, reduce incidence of unplanned pregnancies, decrease young people’s vulnerability to STIs, HIV and unsafe abortion</td>
<td>To improve ASRH, increase gender awareness, reduce incidence of unplanned pregnancies, decrease young people’s vulnerability to STIs, HIV and unsafe abortion</td>
<td>Increase in service use especially among females</td>
</tr>
<tr>
<td>The Geracao Biz Programme Mozambique</td>
<td>Retrospective evaluation</td>
<td>• A multi-sectoral ASRH intervention implemented by Government of Mozambique o Three main components: i) clinical youth-friendly health services (YFHS), ii) in-school interventions and iii) community-based outreach, implemented by Ministries of health, education and youths and sports respectively. o Programme was initially implemented in two sites, Maputo city and Zambeza province but has been scaled up nationally through integrating YFHS within the existing health facilities</td>
<td>Youth visits in Maputo city increased from 11,800 in 2000 to 24,000 in 2003</td>
</tr>
</tbody>
</table>
b) Studies evaluating school-based interventions

Eight school-based SRH intervention studies were indentified in this review (Table 8). All the studies reported positive outcomes in improved knowledge and changed attitudes but the effect on reported sexual behaviour was inconsistent (Agha and Rossem 2004; Alemayehu and Ahmed 2008; Cabezon et al. 2005; Gallegos et al. 2008; Jemmott, III et al. 2010; Mukoma et al. 2009; Rao et al. 2008). The interventions varied greatly with regard to duration (6 hrs to 4 years), number of sessions (single to multiple sessions) and content (abstinence, condom use, sexuality and skills building).

A school-based quasi-experimental study conducted in Zambia resulted in an increase in reported knowledge and attitudes towards abstinence, condoms use, HIV risk perception and reported sexual behaviours although the positive attitude towards condom use was not sustained for longer than six months (Agha and Rossem 2004). A school-based RCT implemented in South Africa showed an almost 50 percent reduction in the proportion of students reporting having either unprotected vaginal intercourse or multiple sexual partners; although the intervention had no significant effects on delaying sexual initiation (Jemmott, III et al. 2010). The 4-year abstinence-centred programme in Chile lead to a significant reduction in pregnancy rates in the intervention group (Cabezon et al. 2005) while an educational intervention among college students in India led to a significant increase in knowledge on RH and sexuality (Rao et al. 2008).

School-based programmes may be a good avenue to provide sex and HIV education but one need to be aware of the structural implementation challenges which the intervention may face, such as limited skills among the teachers, staffing inadequacies, high staff turnover, teacher-student relationships and availability of teaching resources (Mukoma et al. 2009; Paul-Ebbohimen, Poobalan and Teijlingen 2008; Plummer et al. 2007). In countries where majority of adolescents go to school, school-based interventions are likely to achieve high coverage and may benefit from national directives and inclusion of the intervention content into national examinations (Renju et al. 2010b; Renju et al. 2011). However, this may not be the case in some sub-Saharan African countries where the majority of young people are not in school. There may be need to target young people who are out-of-school through other interventions.

Another intervention, that has shown positive results is the programme in Nigerian secondary schools, with the aim of educating youth about STDs, increasing condom use, modifying treatment-seeking behaviour and improving partner notification of STD symptoms. The intervention consisted of three main components which included: formation of RH clubs in schools; training of teen peer
educators and training private health care providers in the diagnosis and treatment of STDs using sydromic management, condom promotion and encouragement of partner tracing and treatment. Young people from the schools involved in the programme reported a significant increase in the knowledge about signs and symptoms of STIs, a significant increase in the number of young people seeking STI treatment, a significant reduction in reported STD symptoms and increased partner notification among females (Okonofua et al. 2003).
Table 8: School-based SRH intervention studies

<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Objectives of programme and type of evaluation</th>
<th>Programme components</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| 1: Plummer et al. 2007 | To conduct a process evaluation of the school-component of the ASRH (MkV) in Mwanza, Tanzania | • School-based, teacher-led, peer-assisted ASRH education  
• Curriculum-based, social learning theory based, provide basic knowledge to RH, improve student’s risk perception, sign and symptoms of STIs, encouraging safer sex practices, sexual negotiation skills, discussing stereotypes | Intervention faced implementation challenges such as shortage of teachers, high turnover of teachers, lack of teaching resources, negative school policy towards condoms |
| Tanzania | Community-based RCT | | |
| 2: (Jemmott III et al. 2010) | To test the efficacy of a school-based HIV/STD risk-reduction intervention for South African adolescents | • Two interventions: HIV/STD risk-reduction and health-promotion:  
• HIV/STI risk reduction also included sexuality, sexual maturation, appropriate sex roles, rape myths and beliefs  
• Two-six session, for 6 consecutive days, interventions based on behaviour change theories- social cognitive theory, theory of reasoned action  
• Self-reported sexual behaviour taken at baseline, 3, 6 and 12 months | Fewer risk reduction intervention students reported having unprotected vaginal sex and multiple sexual partners |
| South Africa | Cluster RCT | | |
| 3: (Mukoma et al. 2009) | To evaluate a school-based SRH education programme, targeting adolescents aged 12–14 years. | • Theory based school intervention in 26 schools: Topic covered included self-esteem, reproduction, HIV/AIDS, sexuality, sexual health, safe sex, sexual coercion, decision making, substance abuse  
• Delivered by teachers, 26-55 lessons each lasting 45-55 minutes, over a 6 months period | Implementation facilitated by appropriate training materials, teacher training, teacher involvement in design, teacher monitoring, and student interest  
Barriers included: high turnover of teachers, larger classes, curriculum scope, many activities, teachers’ resistance to participatory methods, low value placed on the intervention |
| South Africa and Tanzania | Cluster RCT | | |
| 4: Agha and Rossem 2004 | To determine the effect of a peer sexual health education intervention on adolescents beliefs about condoms and abstinence | • Single session intervention lasting 1hr, 45 minutes implemented for one week in 3 intervention and 2 control secondary schools  
• Peer education through discussion and skirts on HIV transmission and prevention, abstinence, risk perception and condom use.  
• Data collected at baseline, 2 months and 6 months | Intervention students showed positive beliefs about abstinence 6 months after intervention  
Condom use positive beliefs improved immediately after intervention but were not retained for 6 months  
Students reported reduced multiple sexual partnerships |
| Zambia | Quasi-experimental design | | |
| 5: Alemayehu and Ahmed 2008 | To determine the effectiveness of IEC interventions | • One-off, IEC intervention among high school adolescents: 4 interventions implemented in 4 schools:  
  o Interpersonal communication  
  o Pamphlets  
  o Educational video  
  o Combination of all three interventions.  
• Data collected before, immediately after the intervention and two months after the intervention | All four interventions were effective in the reduction of HIV related stigma and discrimination among young people |
<p>| Ethiopia | | | |</p>
<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Objectives of programme and type of evaluation</th>
<th>Programme components</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| 6: Okonofua et al. 2003 | Evaluation of intervention impact on STD treatment, seeking behaviour and STD prevalence | - 12 schools in Eldo state: 4 intervention and 8 control schools.  
- Three intervention components:  
  - Establishing RH clubs in schools  
  - Peer education and counselling  
  - Training of providers in STD treatment including those with no formal training  
- Measurements before and after 10 months | Significant improvement in knowledge of STD, reported condom use and STD treatment seeking behaviour  
Significant increase in use of private providers for treatment of STD symptoms and partner notification  
Significant decrease in the proportion of YP reporting having an STI symptom |
| Nigeria | RCT | | |
| 7: Cabezon et al. 2005 | To evaluate the efficacy of an abstinence-only sex education programme on prevention of adolescent pregnancy | - High school students divided into three cohorts depending on year of enrolment: 1996, 1997, 1998; Intervention provided in 14 lessons spread over 1 year.  
  - 1997 – no intervention  
  - 1998: 210 students intervention: 213 control  
  - 1999: 328 students – intervention: 83 control  
- Included gender stereotypes, reproductive system, puberty, fertility, emotions and behaviour control, sexuality and the media, self assurance, decision making, value of human life, marriage and family, contraception, pregnancy, delivery, breastfeeding  
- Cohorts followed for 4 years | A significant reduction in the average number of pregnancies in the intervention groups  
  - 1996 cohort with no intervention had 3.36% pregnancies per year  
  - 1997 cohort: average of 0.87% and 4.87% pregnancies per year in intervention and control groups  
  - 1998 cohort: average of 1.16% and 5.88% pregnancies per year in intervention and cohort groups |
| Chile | RCT | | |
| 8: Rao et al. 2008 | To determine the effectiveness of an educational intervention programme on RH knowledge of adolescents  
Pre- and post test | - 5, 2hr-sessions conducted on 5 consecutive days:  
  - Health education programme covering menstruation, pregnancy, ANC, contraception  
- Post-test conducted immediately after education | There was a significant increase in overall knowledge after the intervention regarding contraception, ovulation, first sign of pregnancy, and fertilization |
c) Studies evaluating community-based interventions

Community-based programmes may be implemented through community initiatives such as youth development programmes, peer promotion programmes and educational programmes, and are able to reach young people both in-school and out-of-school. Community-based programmes often involve the use of mass media and other community education activities such as use of peer educators, volunteers, such as (WHO 2009). Three community-based mass media intervention studies were reviewed in this study (Table 9). Mass-media interventions have the potential of having a high coverage and positive influence on adolescent knowledge and attitudes, especially when the radio is used as a health education medium. However, the effect on sexual behaviour and contraceptive use has not been ascertained (Speizer, Magnani and Colvin 2003). The Zimbabwe mass media campaign reached over 90 percent of the target audience through posters (92%), launch days (87%), leaflets (70%) and drama (46%) with young people in the campaign sites reporting a higher intention to visit a health centre (2.5 times more) and a youth centre (14.0 times more) (Young 2001). Exposure to substantial levels of mass media and interpersonal communication where contraceptives are available (such as in social marketing) may lead to protective sexual behaviour (Agha 2002;Rossem and Meekers 2000), increased risk perception especially among males (Rossem & Meekers 2000) and a reduction in misconceptions about HIV and the associated stigma (Alemayehu and Ahmed 2008). Use of peer education in community-based programmes has been shown to result in increased reproductive health knowledge and contraceptive use (Speizer et al. 2001)
Table 9: Community-based SRH interventions

<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Objectives</th>
<th>Intervention components</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Meekers et al. 2005</td>
<td>To measure the reach of the “100% Jeune” social marketing campaign and assess its impact on condom use</td>
<td>Components included: peer education promotion- in schools, social places – football matches; Monthly magazine; Radio drama; Call-in weekly radio show; Radio, television, billboard campaign; Network of branded youth-friendly condom outlets</td>
<td>Through spontaneous recall knowledge of “100% Jeune” was 25.9% 11.9% youth had attended at least one peer-educator session 47.4% youth had heard about the call-in show but only 11.2% reported often listening to it 31.9% youth had heard about the YF condom outlets but only 5.5% reported visiting in the previous 3 months Intervention more effect among males than females. Repeated exposure is essential for behavior change</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Pre-post test 18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2: Speizer, Tambashe and Tegang 2001</td>
<td>To evaluate “Entre Nous Jeunes” a community-based peer education programme in Nkongsamba, Cameroon</td>
<td>Peer educators trained on reproductive anatomy, contraception, condom use negotiation skills Peer education using group discussions, one-on-one meetings, health and sport gatherings, referrals of peers to health centers, distribution of promotion materials</td>
<td>Contact with a peer educator was significantly associated with greater spontaneous knowledge of modern contraception, symptoms of STIs and modern contraceptive use, including the condom.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>A pre-post test quasi-experimental design for 18 months:</td>
<td></td>
<td></td>
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<tr>
<td>3: Rossem and Meekers 2000</td>
<td>To examine the effectiveness of the PSI/PMSC Horizon Jeunes, youth-targeted, social marketing programme for improving ARH in urban Cameroon</td>
<td>Components: peer education, establishing youth clubs, mass media promotion, and behaviour change communications</td>
<td>Programme knowledge was nearly universal (91%); majority of youths (67%) had direct contact with the program The intervention had a significant effect on determinants of preventive behaviour (awareness of sexual risks, knowledge of birth control methods, and discussion of sexuality and contraceptives). Increased proportion of female youths reporting use of oral contraceptives and condoms for birth control.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Quasi-experimental design pre-post test for 13 months</td>
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</table>
2.3 SRH interventions targeting young people in Kenya

Studies that have evaluated SRH interventions targeting young people in Kenya are limited. This literature review indentified seven intervention studies that aimed at improving the SRH of young people which were conducted in Kenya (Table 10). These studies investigated the following aspects of young people’s SRH: i) nurse-midwives attitudes to provision SRH services, ii) perceptions of young people on characteristics of ASRH services, iii) use of culturally appropriate practices SRH service provision, iv) use of social franchising in providing SRH services to young people, v) sex and HIV education in Kenyan primary schools, and vi) effectiveness of web-based education in schools.

2.3.1 Nurse-Midwives’ attitudes to provision of SRH services

This was a study that was carried out in Kenya and Zambia to investigate the attitudes of nurse-midwives towards adolescent sexuality and related reproductive health problems. The study reported that nurse-midwives regarded adolescent sexuality as a moral issue and disapproved of adolescent pre-marital sex, safe abortion, and safer sex practices, including contraceptive use and masturbation. In spite of this, the majority of the nurse-midwives were supportive of sexually active girls using contraception and counselling for boys on condom use (Warenius et al. 2006). Although over half of the providers did not agree with girls being allowed to undergo abortions, they were willing to treat girls who presented to their facilities with complications resulting from induced abortions. Moreover, providers who had received continuing medical education on ASRH showed more tolerance towards adolescent sexuality (Warenius et al. 2006).

2.3.2 Perceptions of young people on characteristics of ASRH services

This was a quasi-experimental community-based intervention conducted in Kenya and Zimbabwe that aimed at assessing young people’ perceptions of the importance of various aspects of youth-friendly service provision. Findings from the survey indicated that girls from both countries were more likely to rate a particular characteristic as “very important” than the boys. Both girls and boys from the two countries identified confidentiality (93% – only in Zimbabwe), short waiting time (90%), ability to obtain all services at one site (87%), low cost (84%), and health service provider attitude (82%) as the most important YFS characteristics. The least important characteristics identified were having a single sex facility (28%), being seen by adults going to the facility (31%), anonymity (32%), youth-only facility (51%), young staff (60%) and youth involvement (60%).

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Lack of information about available services, costly services, distance from the facility, being scared and being too busy were identified as some of the reasons that prevented young people from seeking health services. The conclusion drawn from this study was that it was possible to improve existing services, even in the most remote settings, so as to address the SRH problems of young people. However, these findings are to be interpreted with caution, as only end-line data were used in the above analysis and aspects of confidentiality were not evaluated in Kenya (Erulkar et al. 2005).

2.3.3 Use of culturally appropriate practices in ASRH service provision

This was a three-year quasi-experimental programme, implemented in Central Province in Kenya between the years 1998-2000. The intervention used respected and well known young parents from the local community as peer educators or adult counsellors. This programme was methodologically adapted from the local traditional educational system known as *atiri* where respected adults are used to educate young people in the community. These adult counsellors were referred to as friends of the youths (FOY) and were paid a monthly honorarium of $25 per month by funds from the programme. No cases of dropouts were reported from these adult counsellors. The project also trained health care providers from the private sector in youth-friendly service provision. Young people from the community with SRH problems were referred by FOY to the private sector with a voucher but were expected to pay a contribution of $0.50-1.50 for services they received. The programme had a fairly good coverage; reaching 47 percent of parents and 66 percent of young people aged 10-24yrs. FOY conducted at least one session with 19 percent of the parents and 33 percent of the young people. The results also showed that being in school was a protective factor to sexual initiation among both girls and boys. There was a more significant improvement in discussion of RH with parents among females than males. There was also increased reported condom use among boys as opposed to girls. Generally the intervention demonstrated that indigenous African traditions can be adapted to help improve the reproductive health status of young people. However, the project evaluation did not report on the effects the intervention had on SRH service uptake and utilisation (Erulkar et al. 2004).
2.3.4 Use of social franchising to provide SRH services to young people

This was study conducted in the western part of Kenya, to evaluate the ability of social franchise programmes to offer SRH services within the private sector, by comparing reproductive health attitudes and practices of youth attending Kisumu Medical and Education Trust (KMET) site (a private social franchise), with youth at neighbouring health sites (non-member sites) and households. The results showed that youth attending KMET sites were more likely, than youth from non-member clinics, to use a modern method of contraceptive, especially injectables, the pill and condoms (52% vs 39%). More health care providers from KMET managed facilities offered reproductive health services to adolescents (40% vs 30%). In addition, KMET youths reported health care providers spending more time counselling them on contraceptive choices, than youths from non-member sites (14% vs 3%). KMET youth also reported knowing friends who used contraception and obtaining supplies easily. Some youths from both sites reported having difficulty in obtaining family planning supplies and related services, due to barriers related to social unacceptability and local unavailability. Young people identified adequate provider skills, ensuring privacy and respectful treatment of clients as important traits a health care provider should have. However, cost, accessibility and provider’s age were said not to be important. The above results are to be interpreted with caution due to methodological inadequacies; this was a small sample size, interviews were restricted to youths who were 18 years and above, and, in the household survey, married women (Decker and Montagu 2007).

2.3.5 Primary school-based HIV prevention intervention

This was a teacher-led and peer-supported 18 months quasi-experimental programme that targeted students in class 6 and 7 (median age14) in public schools in Nyanza province. The project was conceived after the Ministry of Education gave a directive that all schools should integrate HIV/AIDS education into their curriculum. The objectives were to deliver participatory HIV/AIDS education to upper primary school pupils so as to enable them enhance their knowledge of HIV/AIDS, promote communication with parents and teachers and increase self-efficacy towards abstinence and condom use. The mode of delivery was use of regular classroom time and co-curricular activities. Programme evaluation results showed that with regard to knowledge, only boys who were not sexually active prior to the intervention showed positive results; there was lack of knowledge gain in girls and boys who were already sexually active. The programme had a positive effect on adolescents’ communication with both parents and teachers, although this was not
reflected among girls who were already sexually active. Gains in self-efficacy on condom use were positive among boys who were already sexually active, although this did not translate into change in sexual behaviour. For girls there was no evidence of self efficacy on condom use. This led to the conclusion that the programme, in its current state, was not meeting the HIV prevention concerns of sexually active upper primary school girls. However, the current infrastructure was reported to be adequate for a national scale-up. A national roll-out of the programme in Kenyan primary schools was thereafter undertaken (Maticka-Tyndale et al. 2007).

A subsequent evaluation, done three years later, gave more positive results and demonstrated the feasibility as well as sustainability of the programme. Overall knowledge scores among both boys and girls increased; self-efficacy related to “say no to sex” significantly increased among both sexes and delaying sexual debut was found to be positive among girls only. There was no change in condom use among boys but positive gains in condom use were reported among girls (Maticka-Tyndale et al. 2010). These positive outcomes may have been contributed by better implementation, for example, increased confidence among teachers and use of health care workers in teaching about condom use.

Another two-year randomised evaluation which compared three school-based HIV interventions in Western Kenya: i) training teachers on HIV education, ii) encouraging students to conduct debates on condoms as well as write essays on HIV/AIDS, and iii) reducing the education costs through provision of school uniforms. All the three interventions reported minimum impact on students’ knowledge, attitudes and behaviour as well as incidence of teen pregnancy. The cost reduction intervention led to a reduction in school dropouts, teen marriages and teen pregnancies (Duflo et al. 2007).

2.3.6 Effectiveness of web-based education

This was a quasi-experimental, school-based, internet-based, intervention that was conducted in Nairobi, Kenya and Rio, Brazil with the aim of assessing whether web access would improve RH knowledge among boys and girls. The intervention duration was 6-8 weeks. The evaluation produced mixed findings in both countries on perceptions of condoms use and knowledge of effectiveness of EC, with differences between girls and boys reported. In both study sites, all web students were less likely to disagree that “condoms are embarrassing to talk about / use”. In Nairobi, web-girls were less likely to perceive condoms as being effective against HIV/AIDS, while web-boys were twice as likely to perceive the same. Web-boys in Nairobi were twice as likely to know effectiveness of EC, while web-girls were less likely to know the effectiveness of EC than
their comparison counterparts. In Rio, intervention boys were twice more likely to know EC than comparison boys, while girls reported no difference in knowledge between web girls and comparison girls. Differences in web-intervention effectiveness was attributed to limited exposure to the web-based information, as students were said to spend less time at the project site compared with entertainment sites or accessing the e-mail (Halpern et al. 2008).

2.3.7 One2one Youth programme

This is a youth programme hosted by Liverpool VCT (LVCT) and aims to increase access to SRH information and services for young people in Kenya through three strategies: the one2one hotline, provision of youth friendly services and provision of treatment and support for HIV positive youth. The one2one hotline is a toll free counselling hotline that aims at giving sexuality, reproductive health and HIV/AIDS information to young people in Kenya and East Africa through tele-counselling, bulk short message service (SMS), emails, problem questions and face-book wall discussion. The One2one youth hotline is operated by five youth counsellors and operates seven days a week (8.00am-8.00pm weekdays and 10.00am-4.00pm weekends). In 2008, it was voted the most innovative youth program in Kenya during the National Organisation of Peer educators Conference. The hotline responds to approximately 16,000 calls and 5,000 SMS annually (LVCT 2009)
<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Objective</th>
<th>Methodology</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| **Kenya and Zambia**  | To investigate the attitudes of Kenyan and Zambian nurse-midwives towards ASRH problems | A cross-sectional survey Kenya N=322 and Zambia N=385 | - Nurse-midwives first option is to recommend unmarried YP to abstain when they ask for contraceptives (Kenya-77% and Zambia-81%)  
- Nurse-midwives agree that sexually active girls should be allowed to use condoms: (Kenya-55%: Zambia-67%)  
- Majority disagreed that abortion should be allowed for adolescent girls with unwanted pregnancies (Kenya-80%: Zambia-94%)  
- Nurse-midwives trained in YFS had more friendly attitudes than untrained staff. |
| **Kenya and Zimbabwe** | To explore the relative importance of various aspects of YFS | Quasi-experimental design with no control: Population-based survey in Kenya N=1,344 and Zimbabwe N=539 | - Not all YFS characteristics are important  
- Most important include staff attitude, confidentiality, short waiting time, low cost, obtaining services at one site  
- YP do not seek health care, due to lack of knowledge on where to go. |
| **Kenya** | To measure behavioural changes associated with a culturally consistent RH programme for young people | Quasi-experimental design with control: 1997-2001: N=3,409  
Training of young parents as friends of youths (FOY)  
FOY worked with young people, community adults, and teachers in schools to encourage better communication with youth on sexual issues  
Training private providers on YFSRH services | - Females reported  
  - Improved communication with parents and adults  
  - Increased secondary abstinence  
  - Reduction in number of sexual partners  
- Males reported  
  - Delayed sexual initiation |
| **Kenya** | Evaluation of youth services offered by KMET consisting of 204 RH providers | Cross-sectional study comparing young people visiting 102 randomly selected KMET sites and 50 non-KMET sites  
N=256-young people and 152 health providers | - KMET youth report higher rates of FP counselling by providers  
- Youth reported social unacceptability as a barrier to contraceptive use  
- Important features of services identified by YP include: skills of staff, privacy, respect  
- Cost, accessibility, provider age were not important |
| **Kenya** | To examine the impact of HIV education on the knowledge, self-efficacy, and condom use among upper primary school pupils in Kenya | Quasi-experimental design with control, using 40 intervention and 40 control schools: N=7,392 | - Programme most beneficial to sexually inexperienced young people  
- Results are gender specific – boys report increased condom use while girls report delay in sexual initiation  
- Programme not effective for sexually active girls |
<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Objective</th>
<th>Methodology</th>
<th>Main outcomes</th>
</tr>
</thead>
</table>
| 6: Duflo et al. 2007 | To compare comparing three school-based HIV/AIDS interventions in Kenya | Randomised evaluation of three school-based interventions  
- Teacher training on HIV/AIDS  
- Student debates, essay writing on condoms and HIV prevention  
- Education cost reduction- provision of school uniform  
N= 382 schools; 74,000 students and 3,000 teachers | - Cost reduction intervention resulted in reduced dropout rates, teen marriages and childbearing |
| Kenya                |           |             |               |
| 7: Halpern et al. 2008 | To determine if easy access to web-based RH topics would result in improved knowledge and attitudes on condoms, HIV testing, EC and abortion laws. | Quasi-experimental study with control: school-based conducted in Nairobi, Kenya N=1178 and Rio de Janeiro, Brazil, N=714 | - There were gender differences in the reported knowledge  
- Only half of knowledge differences were in the hypothesised direction  
- Students spent less time at the project web-sites compared to entertainment sites and accessing e-mail |
| Kenya                |           |             |               |
2.4 Effectiveness of SRH intervention programmes

A review of the literature has shown that ASRH interventions have been successful in improving the SRH knowledge and attitudes of young people; however, this has not translated to the reduction in pregnancy rates and the incidence of HIV/AIDs. A few reasons have been suggested for these negative outcomes. Firstly, improvements in SRH knowledge and attitudes may not necessarily lead to change in sexual behaviour, secondly, sexual behaviour changes observed may be below the threshold level required to result in the desired significant change on the biological measures. Thirdly, interventions may require a longer implementation period so as to achieve a positive effect, and fourthly, social, cultural and religious factors around adolescent sexuality play a major role in the sexual behaviour of young people and these have not been well articulated in the design of these interventions (Harrison et al. 2010; Mema Kwa Vijana 2008; Michielsen et al. 2010; Ross et al. 2007). The Stepping Stones programme may have produced some positive results because it addressed some of the social and cultural factors driving HIV/AIDs transmission such as gender, motivations for sexual behaviour and alcohol risk (Harrison et al. 2010). There is an argument that implementing SRH in their current state; “skills-based, in-school education, linked to YFHS and limited supportive community activities” may be insufficient to result in significant improvements in biological outcome measures (Doyle et al. 2010; Ross et al. 2007).

Moreover, SRH programmes have largely designed their interventions based on insufficient HIV/AIDS risk reduction assumptions. Most programmes use HIV/AIDS prevention as a precursor to change in sexual behaviour without taking into consideration other interrelating social, cultural and economic factors that influence sexual behaviour (Michielsen et al. 2010). It might therefore not be realistic to expect significant behaviour change and positive biological outcomes from SRH educational programmes. At best, these programmes should strive to increase service utilization; for example, picking up more cases of unrecognised STIs and treating them, rather than expecting to reduce the prevalence. Unfortunately most SRH interventions have not evaluated the effect on utilization of SRH services.

Another line of argument has been that long-term concurrency or overlapping sexual relationships may be contributing significantly to the negative outcomes of sex and HIV interventions and that lack of programme focus on concurrency may contribute to the ineffectiveness of SRH interventions (Epstein 2010). However, it has been reported that focusing on long-term concurrency alone may not produce the expected positive changes in biological outcomes of SRH interventions. Furthermore, indicators measuring concurrency are not standardized, making comparison across interventions difficult (Kristien et al. 2010). Sexual behaviour is a complex issue, which is prone to influence by young people’s social and economic environment. Focusing sexual behaviour change interventions to individual young persons’ behaviour change may not result in significant positive outcomes if community norms and values young
people conform to remain the same. Furthermore, the proportion of HIV transmitted through long-term concurrency is uncertain (Kristein et al. 2010). Suggestions have been made for a paradigm shift to the design of interventions that try to change social norms and values, for the whole community, rather than change individual behaviour of the young person (Kristein et al. 2010). More efforts have to be geared towards addressing the underlying causes of young people’s risky sexual behaviour, through the inclusion of structural interventions in the design of SRH programmes (Blankenship et al. 2000). The purpose of structural interventions would be to address the underlying causes of risky sexual behaviour among young people such as social norms, economic empowerment and the political and policy environment (Parker et al. 2000; Sumartojo 2000). Some of the societal factors that are known to negatively affect the sexual behaviour of young people and may need to be considered during the design of structural interventions include peer pressure, negative attitudes towards condoms, financial and material gain for sex and intergeneration sex between young girls and older men (Doyle et al. 2010).

It has also been reported that ineffectiveness of some programmes could have occurred because of implementation challenges experienced by both school-based and facility-based programmes (Kriesten et al. 2010). Implementation challenges faced by ASRH programmes in schools, which may have a negative effect on the expected outcomes, include: lack of teachers, lack of teaching resource materials, the values and beliefs teachers possess, as they may omit discussions on condom use during sex education sessions and the low priority accorded to sex education by the education system (Jemmott, III et al. 2010; Renju et al. 2010c; Renju et al. 2011). Implementation challenges, faced by facility-based interventions, include aspects of staffing such as inadequate staffing levels and a high turnover of trained staff at the health facilities. An example of this would be in the MkV project, where the effect of trained prescribing staff disappeared one year after the initial training due to the high turnover of staff. In addition facilities did not have adequate privacy during consultation as there was constant interruption by other staff, consultation rooms were open and other patients could over-hear the consultations (Larke et al. 2010).

Evaluation of SRH programmes has also had methodological design challenges. Systematic reviews have shown that the majority of evaluations of SRH programmes are derived from uncontrolled and non-randomised studies which heavily rely on reported sexual behaviours, a process that is prone to bias (Cowan 2002; Oakley et al. 1995; Speizer, Magnani and Colvin 2003). Sex is a private issue and young people tend to under-report or over-report their sexual activity in accordance with existing norms and practices. Research on ASRH programmes are few and often linked to a few NGO institutions, who may only report what they consider to work best according to practice, but not as a result of scientific evaluation (Taffa et al. 1999). The available evidence is therefore insufficient to ascertain the effectiveness of youth-friendly initiatives (Tylee et al. 2007).
Multi-component interventions often comprise of a combination of facility-based, school-based or/and community-based programmes (WHO 2009). Use of multi-component intervention in improving the SRH of young people have been shown to produce positive outcomes, however, it is difficult to disentangle interventions effects and link them to specific programmes (WHO 2009).

2.5 Development of health care delivery models

Literature on the development of health service delivery models is limited. The literature review search identified 15 studies with a focus on development of health service delivery models (Table 11). The literature gives suggestions on some of the essential elements that need to be considered during the planning phase of any health service model. To date, this has largely been informed by literature on the development of nursing care delivery models in high income countries (Armstrong and Stetler 1991; Girard 1993; Walter and Robinson 1994) and primary health care models in developed countries (Abelson and Hutchison 1994; Lomas 1986; Wakerman et al. 2008). The phrases “health service delivery models” and “health service delivery systems” are sometimes used interchangeably in the literature to describe the provision of health care (Walter and Robinson 1994). Articles with titles reading “health service delivery models” more often discuss health service delivery systems and organisational changes that have occurred within the health system. An example of such an article is that by Lomas 1986 “Health care delivery models: emerging trends in the delivery of health services” which discusses organisational changes that have occurred in developed countries in the delivery of health services. The article discusses the emergence of cost-consciousness and the different regulatory approaches that have been put in place by developed governments (USA, Britain and Canada) to reduce the cost of health care, while ensuring equity of both funding and access to services. It is observed that cost containment regulatory activities have targeted institutions as opposed to health care providers and that cost has become the primary motivator for most health policies and health reforms (Lomas 1986). The focus has also been shifting to health promotion and prevention rather than the traditional illness and curative models (Bendell 1997).

2.5.1 Key components of a health care delivery model

A model is a schematic description or presentation of phenomenon (system or theory). It depicts how the phenomenon works and clearly shows the interrelationships and inter-linkages between different components (Girard 1993). Girard (1993) outlines essential features which need to be considered during the development of new nursing care models. These include understanding the social, political, organisational culture, financial and technical system of the institution. Other aspects of significance which need to be considered during health service model development include: the identification of assistive factors, barriers and boundaries as illustrated in Figure 3 below. Assistive factors are those
elements that contribute to the planning, development and implementation of the model, while barriers are elements that affect the ability of one to provide good quality care and should be removed or negotiated upon. Boundaries are factors present that may or may not be changed (Girard 1993). Health care delivery models can also be described within the context of primary health care (PHC).

Figure 3: Development of model of health care delivery: factors for consideration

A systematic review of innovative models of comprehensive primary health care services in rural and remote areas of Australia identified five models of PHC which were categorised as: i) discrete primary care service models, ii) integrated service models, iii) comprehensive primary health care service models, iv) outreach models, and v) telemedicine or tele-health models (Walkerman 2008). In addition to this, the review identified essential elements necessary for the success and sustainability of each model which included the following: a supportive policy environment conducive to change, community involvement and participation, supportive and adequate workforce, consistent funding, good governance, management and leadership, proper infrastructure and information and communication (Walkerman et al 2008). All of these form the building blocks of an effective health system (WHO 2007d). Literature review on primary health care delivery models in Canada does point to an “ideal model” but identifies appropriate
mechanisms that may improve service delivery such as the use of multidisciplinary group practices, reforms to the payment of provider schemes and increased accountability (Abelson and Hutchison 1994).

Other health service delivery models are defined on the basis of whether or not they are patient driven services. In patient-centred services, health care services are organised and executed at the convenience of the client, rather than the convenience of the health service provider. Such a set-up underscores the importance of involving users in the management of their own illness, the “expert-client” concept, as well as involving the users in the decision making process of health service organisation (Clarke 2004). Health social networks are other patient-driven models of health care that are emerging. Through such networks, patients use the internet to get and share information about their condition, receive emotional support and have questions answered through “question-answer” sessions with physicians. Health social networks are primarily designed for patients but other consumers also have access to the information (Swan 2009)

2.5.2 Sexual reproductive health care delivery models

According to the WHO guidelines, adolescent friendly services can be provided in health facilities, schools and the community (WHO 2002a). This includes having services offered in already existing hospitals or health centres, youth specific health centres (for example in urban areas or shopping centres), already existing youth centres which have other youth development programmes, health centres linked to schools and outreach services using mobile services to rural and remote areas (WHO 2002a). Tylee et al (2007) outlines six service models for providing SRH services to young people depending on the setting: i) centres specialising in adolescent health located in hospitals and providing inpatient, drop-in services also acting as referral points; ii) community-based health facilities that provides general health care to the whole community including adolescents; iii) school-based or college-based health services; iv) community-based centres which provide health services, education services and recreational services to young people only; v) pharmacies and shops which also sell condoms and contraceptives; and vi) mobile outreach services (Tylee et al 2007). Three key health prevention and promotion strategies have been documented as being essential elements in adolescent health service provision. These include: i) ensuring access to quality clinical reproductive health services including contraception, ANC/PNC, and STI prevention, diagnostic and treatment services; ii) the development of evidence-based and curricular-grounded sex education programmes which include training in life-skills, interpersonal communication and decision making; and iii) youth development programmes which also enhance youth education, their economic capacities and participation in their own health promotion (Bearinger, Sieving, Ferguson, & Sharma 2007). The 2009 FIGO/WHO pre-conference workshop gave recommendations to stakeholders to ensure that both boys and girls have access to a full range of SRH information and confidential services,
and that adolescent girls were protected from all forms of sexual violence. In addition, the conference put emphasis on ensuring the integration of the age-specific problems of adolescents in the training curricular of health care providers, the service delivery process, including monitoring, supervision and quality assessment (Mbizvo and Zaidi 2010).

The WHO guidelines (WHO 2002a) also outline essential elements that need to be in place in order to regard a health facility “adolescent-friendly”. These include:

- friendly policies that respect adolescents rights and take into account adolescents special needs while guaranteeing privacy and confidentiality and also ensuring services are either free or affordable
- adolescent friendly procedures including client registration and record keeping, short waiting time and drop-in services
- adolescent friendly health care providers who are technically competent, are non-judgemental, respectful, motivated and have good interpersonal skills; and support staff who are friendly
- adolescent friendly facilities that have a welcoming and safe environment, offer comprehensive services, have appropriate guidelines, have friendly working hours, offer appropriate information and education
- Other components include: having adolescent involvement, community participation, and an effective monitoring and evaluation system (WHO 2002a).

2.5.3 Costs of reproductive health service delivery

Evidence shows that the benefits of investing in family planning (FP), maternal and newborn health (MNH) are enormous and essential to the achievement of the Millennium Development Goals. For example in sub-Saharan Africa, it has been estimated that meeting the FP and MNH service needs of women would result in a 70% reduction in maternal deaths, 57% reduction in new born deaths and 75% reduction in unintended pregnancies. In addition, significant savings (of $1.5 billion) would be made if investments were made in both FP and MNH compared to investing in only MNH services (Guttmacher Institute 2010; Susheela et al. 2009). Another estimate, using WHO clinical guidelines, shows that annual resources needed to either moderately or rapidly scale up MNH interventions, within the MDG context, are US$3.9 billion and US$5.6 billion respectively. Annual increments gives a figure of US$39.3 billion and US$55.7 billion for the interventions to be implemented either moderately or on a rapid scale, respectively, over a ten year period (2006-2015) (Johns et al. 2007). While advocating for the scaling up of effective health interventions, attention should be paid to improving the health system in general. A functioning close-to-client health system is essential for the scaling up of any health intervention and this
needs important consideration during any intervention design (Jha et al. 2002). Inadequate financial resources have been a major barrier to the scaling up of effective health interventions in developing countries and there is evidence suggesting that more resources than currently available are needed (Morel et al. 2005). Having a strong health system ensures that there are adequate resources for infrastructural expansion, inputs, distribution, health workforce, awareness and demand creation, human resource development, actual programme costs including monitoring and supervision (Jha et al. 2002; Morel et al. 2005). For developing countries, government spending on all reproductive health services and commodities currently falls below the internationally standard of US$16 per person needed to ensure availability of modern contraception only (Ha et al. 2011). Public-private partnerships (PPPs) and donor funding are initiatives that aim to narrow this resource gap, however, evidence supporting where to invest in PPPs is lacking (Fryatt et al. 2010) and the sustainability of donor funding is questionable. On the other hand evidence has shown an association between high government expenditure and increased utilization of maternal health services such as skilled birth attendance and caesarean section (Kruk et al. 2007). The taskforce on innovative international financing for health systems (Fryatt and Mills 2010) set up in September 2008 to identify ways of strengthening the health system in 49 poor countries to enable them attain MDGs 4 and 5 recommended innovative ways in which funds could be raised to address health systems challenges. This included using airline tax revenue to reduce market prices of drugs in LMICs, linking tobacco taxes to specific health activities, use of De-tax initiatives (governments forgoing some VAT and businesses forgoing some profit for a health course), expansion of the already existing financing mechanisms to include maternal and child health services such as the International Finance Facility for Immunisation (IFFIm), Global Fund’s Debt2Health Initiative and the Millennium Foundation (Fryatt, Mills and Nordstrom 2010).

Studies assessing the cost of providing specific components of RH health services show variation between countries and continents with regards to cost to the health sector. For example estimates show that the cost of providing post-abortion care lies between US$83 and US$94 per patient and US$159 million and US$333 million to the health system, per year in Africa and Latin America respectively (Vlassoff et al. 2009). In a study comparing the cost of providing RH services in Zimbabwe and Mexico, the cost of providing RH services was found to be higher in Mexico compared to Zimbabwe especially with regards to surgical procedures. The cost of providing tubal ligation and treatment for STI was found to be $70 and $19 in Zimbabwe and $269 and $29 in Mexico respectively. With regards to providing adolescents with routine examination and iron supplementation, the cost was almost similar, $5 and $4 for Zimbabwe and Mexico respectively (Mitchell et al. 1999). A cost analysis of the three year multi-component ASRH RCT trial implemented in Tanzania (also discussed in section 2.2.2a) estimated the
intervention cost to be US$879,032 with 70% of the total cost being utilised in the school-based component. The annual costs per pupil dropped from $16 in 1999 to $10 in 2001, while after full scale up, only an additional $1.54 was needed per pupil per year for continuation of the intervention; although all costs related to research activities and strengthened STI treatment services were excluded from the cost analysis (Terris-Prestholt et al. 2006). Studies costing SRH services for young people are limited and hence there is need to undertake cost evaluation studies so as to ascertain the cost and cost-effectiveness of these interventions.
<table>
<thead>
<tr>
<th>No.</th>
<th>Author, year, country</th>
<th>Objectives</th>
<th>Essential elements for health service models</th>
</tr>
</thead>
</table>
| 1   | Girard 1993           | Article introduces readers to the concept of nursing models | Assistive factors:  
- Staff motivation  
- Supportive administration  
- Credible leadership/ planning  
- Staff knowledge and skills  
Boundaries identification:  
- Target population  
- Financial source  
- Institutional infrastructure  
- Management type (private for profit, non-profit)  
- Decision making  
Understanding the social, political, organizational policy of the institution |
| 2   | Manthey 1991 A review of health delivery systems and practice models | A delivery system has to answer five basic questions  
- Who is responsible for making decisions about patient care? (decision making)  
- How long does that person's decision remain in effect?  
- How work distribution among staff members? By task or by patient? (task distribution)  
- How is patient care communication handled? (communication channels and referral mechanism)  
- How is the whole unit managed? (management)  
Staffing levels should be determined by acuteness of patients and not the delivery system  
Any delivery system can be implemented with any level and skill-mix of staff and hence there is no need to change the staff levels in order to change the delivery system. |
| 3   | Armstrong and Stetler 1991 Strategic considerations in developing a health service delivery model | Staff make up  
- Cadre  
- Competencies  
- Skills-mix  
Tasks  
- Specific tasks  
- Task delegation  
- Routine work  
- Comprehensive of services  
- Reporting of communication linkages  
- Model cost-effectiveness  
Evaluation criteria  
- Administrative efficiency  
- Patient satisfaction  
- Staff satisfaction  
- Cost of services  
Other essential features  
- Scientific soundness of the model  
Desirability and Feasibility |
| 4   | Vacek et al. 1978 Paper presents a conceptual model with which functions of health service personnel can be organized | Problem solving concepts of assessment, diagnosis, intervention and evaluation  
- Concepts of  
  o Goal of health care  
  o Nature of patient-provider relationship  
  o Organizational structure of the health care system  
All directed towards individual patients and communities of patients  
Other non-professional activities involve organizing patients records, clerical tasks, ordering supplies |
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<th>No.</th>
<th>Author, year, country</th>
<th>Objectives</th>
<th>Essential elements for health service models</th>
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</table>
| 5   | Fennell 2001          | Article aims at defining and elaborating dimensions of health care delivery services | Components or actors of health care delivery systems  
  - Health workforce  
  - Organization structure and coordination  
  - Financial source- public or private  
Types of health care delivery system:  
  - Primary, secondary, tertiary and rehabilitative | Structural features  
  - Size, ownership, profit orientation, range of service provision, governance structure  
Process characteristics  
  - Service delivery mechanism  
  - Coordination mechanism  
  - Information flow  
  - Decision making processes  
  - Quality control  
  - Provider-client communication flow |
| 6   | Stevens and van der Zee 2008 | Article describes health-care systems from a comparative perspective | Typical characteristics of a health system  
  - Functional specificity – systems have shared operational goals  
  - Structural differentiation - division of labour between elements (persons & organizations)  
  - Elements coherence - coordination, planning and organization |  
  - Autonomy – self-regulating  
Four models of health care systems  
  - Free market  
  - Social insurance  
  - NHS  
  - Socialist |
| 7   | O'Donnell et al. 2010 | Developing a framework for reporting health service models for managing rheumatoid arthritis | Components and Dimensions  
  - Goals of the model  
    o Why was the health service model founded?  
    o Role of provider(s) and user(s)  
    o Who is involved and what are their roles?  
    - Setting, country, level of care (community, primary, secondary, tertiary)  
    - Method(s) in which the interventions are delivered  
    o How are the services or interventions implemented? |  
  - Duration of the intervention  
    o How long is the intervention?  
  - Referral process  
    o How will patients access the services or interventions?  
  - Mode(s) of communication between individuals  
  - Sustainability of the model |
| 8   | Wakerman et al. 2008  | Literature review of innovative models of comprehensive primary health care in rural and remote Australia to identify primary health care models that work well. | Five models identified  
  - Discrete primary care services  
  - Integrated services  
  - Comprehensive Primary Health Care services  
  - Outreach models  
  - Tele-health and telemedicine  
Enablers of sustainable PHC  
  - Supportive policy  
  - Sustained service funding  
  - Community participation in planning and delivery of services | Essential requirements  
  - Workforce – numbers and skills mix  
  - Funding  
  - Governance  
  - Management and leadership  
  - Linkages- service integration within, linkages with other key organizations  
  - Infrastructural – physical, information, communication technology |
| 9   | Abelson and Hutchison 1994 | A review of the international literature on primary health care | Evaluation of PHC delivery models are scarce  
  - Research evidence does not point to one ideal model | Features to consider in model design  
  - Multi-disciplinary group practice  
  - Payments of providers as opposed to exclusive |
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<th>No.</th>
<th>Author, year, country</th>
<th>Objectives</th>
<th>Essential elements for health service models</th>
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<tr>
<td>10</td>
<td>Wakerman 2009</td>
<td>Paper examines literature on ‘innovative’ primary health care (PHC) models in rural and remote areas of Australia</td>
<td>Key features of PHC models&lt;br&gt;▪ Financial system- sustainable&lt;br&gt;▪ Community participation&lt;br&gt;▪ Health information system&lt;br&gt;▪ Multi-disciplinary practice&lt;br&gt;▪ Credible leadership / clear vision</td>
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<td>11</td>
<td>Anderson and Lowen 2010</td>
<td>To identify models of health care delivery that support youth access to health and mental services</td>
<td>Models identified included&lt;br&gt;▪ Primary support from parents and family&lt;br&gt;▪ Family physicians – youth may not use them for birth control or suspected pregnancy&lt;br&gt;▪ School-based services- may be a key setting for delivery of health care to youth&lt;br&gt;▪ Community based health centres – linked with hospitals, churches, business, community centres&lt;br&gt;▪ Other access points – arts, music, internet, telephone counselling, services, pharmacies</td>
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<td>12</td>
<td>Swan 2009</td>
<td>Paper examines three categories of novel health services: health social networks, consumer personalized medicine, quantified self-tracking</td>
<td>Health social networks&lt;br&gt;▪ Website for health resources ranging from information, emotional support, information sharing, physicians questions and answers</td>
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<td>13</td>
<td>Craig et al. 2008</td>
<td>Article describes complex interventions as interventions containing several interacting components</td>
<td>Steps taken in the development of a complex interventions&lt;br&gt;▪ Identifying existing evidence: what is known about similar interventions and what methods were used to evaluate them?&lt;br&gt;▪ Identifying and developing theory</td>
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<td>14</td>
<td>Clarke 2004</td>
<td>Studying the organization and delivery of health services</td>
<td>Patient- and carer- centred services:&lt;br&gt;▪ The need to organize health services to meet the health problems of the user, instead of the provider’s convenience&lt;br&gt;▪ User involvement in service organization and making decisions about their care</td>
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<td>15</td>
<td>Bendell 1997</td>
<td>Health care in the 1990’s and changes in health care delivery models</td>
<td>Due to the increasing costs of health care, there is need to shift the focus from the traditional illness model to a more current health promotion and prevention model</td>
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7 principles for better practices in youth health include:<br>▪ Access facilitation, evidence-based practice, youth participation, collaboration, professional development, sustainability, evaluation.
The above literature review on health service delivery models brings out the following 12 commonality features as essential elements that require consideration during the development of a health service delivery model (Table 12).

**Table 12: Essential elements needed for development of a health service delivery model**

<table>
<thead>
<tr>
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<th>1. Service goal or purpose</th>
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<td></td>
<td>o target population</td>
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<td>2.</td>
<td>Services delivery mechanism</td>
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<td>o range of services to be provided or comprehensiveness</td>
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<td></td>
<td>o integrated services</td>
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<td></td>
<td>o client satisfaction</td>
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<td>o multi-disciplinary workforce</td>
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<td>o outreach services</td>
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<td>o telemedicine</td>
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<td>o service cost</td>
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<td>3.</td>
<td>Staffing</td>
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<td></td>
<td>o Cadre and numbers</td>
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<td></td>
<td>o Incentives and motivation to change</td>
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<td></td>
<td>o skills mix, tasks and competencies</td>
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<td></td>
<td>o job satisfaction</td>
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<td>4.</td>
<td>Supplies and equipment availability</td>
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<td>5.</td>
<td>Institutional infrastructure</td>
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<td>6.</td>
<td>Financial sustainability</td>
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<tr>
<td></td>
<td>o source of finances</td>
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<td></td>
<td>o management type – public, private for profit</td>
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<td>7.</td>
<td>Organisational structure</td>
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<td></td>
<td>o leadership credibility and capacity</td>
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<td></td>
<td>o administrative support</td>
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<td></td>
<td>o policies and procedures</td>
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<td></td>
<td>o coordination</td>
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<td></td>
<td>o accountability</td>
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<td>8.</td>
<td>Networking</td>
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<td></td>
<td>o linkages within and with other organisations</td>
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<td>9.</td>
<td>Communication channels</td>
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<td></td>
<td>o information flow</td>
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<td></td>
<td>o reporting process</td>
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<td></td>
<td>o health information system</td>
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<td>10.</td>
<td>Evaluation</td>
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<td></td>
<td>o rigorous evaluation</td>
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<td></td>
<td>o scientific soundness</td>
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<td></td>
<td>o feasibility</td>
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<td>11.</td>
<td>Community participation</td>
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<td>12.</td>
<td>Political environment</td>
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### 2.6 Summary of literature review chapter

The first part of the literature review gives a detailed description of the situation of SRH among adolescents and young people globally with a special emphasis on countries in sub-Saharan Africa. It gives the current trend in sexual behaviour and reproductive practices among young people. The second part of the literature review provides findings from systematic reviews and primary interventions implemented mainly in developing countries and the effectiveness of these interventions. The literature review mainly focuses on examining the effectiveness of facility-based and/or multi-component interventions (section 2.2.2 a), school-based interventions (section 2.2.2 b) and community-based (2.2.2.c) interventions for young people. The review also examines components of health service delivery models, models for SRH service delivery and health system cost as an essential component of effective health intervention design. The conclusion drawn from this review is that SRH interventions have been successful in improving SRH knowledge and
attitudes but this has not translated to change in sexual behaviour. The review identifies 12 essential elements needed for the development of a health care delivery model.
Chapter 3: Background to the study area

3.0 Introduction

Chapter 3 provides background information on Kenya. Section 3.1 gives information on the demographic, political and socio-economic context of Kenya. Section 3.2 describes the situation of SRH of young people in Kenya, while section 3.3 gives an overview of health services in Kenya. Section 3.4 describes the policy environment for provision of youth-friendly services in Kenya; section 3.5 describes the availability of youth friendly SRH services in Kenya, while section 3.6 explores the impact of scaling up VCT and post-rape care services in Kenya. Section 3.7 gives a brief description of health services at the study sites.

3.1 Demographic, political and socio-economic context

Kenya’s population is estimated at 38.6 million (KNBS 2010) and is projected to reach 56.5 million by the year 2025 (PRB 2009). The majority of the population, over 68 percent, live in the rural areas while 32 percent live in the urban areas. Young people aged 15-24 comprise of almost 21 percent of the total population, out of which 51 percent and 49 percent are females and males respectively (KNBS 2010). The annual population growth rate declined from 3.4 to 2.9 percent between the years 1979-1989 and 1989-1999 (KNBS and ICF 2010). Currently the annual population growth rate is 2.6 percent. The country has experienced a significant decline in the total fertility rate (TFR) from 8.1 births per woman in the late 1970s, to 4.6 births per woman in 2008-09.

Agriculture and tourism are the main economic drivers in Kenya, contributing over 20 percent and ten percent of the GDP respectively. The Kenyan economy grew in the year 2006 by 6.3 percent, but due to political instability experienced in 2007/8, the Gross Domestic Product (GDP) growth rate has declined to levels below 1.0 percent. In the year 2008, the GDP growth rate was 1.8 percent (KNBS 2009). Demographic and socio-economic indicators for Kenya are summarised in Table 13.
Table 13: Demographic, health and socio-economic indicators for Kenya

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (in millions) (census 2009)</td>
<td>38.6*</td>
</tr>
<tr>
<td>Percentage urban / rural (census 2009)</td>
<td>32% / 68%</td>
</tr>
<tr>
<td>Gross National Income per capita *</td>
<td>$ 760*</td>
</tr>
<tr>
<td>GDP</td>
<td>$29,375,775,194*</td>
</tr>
<tr>
<td>GDP Growth rate (2009)</td>
<td>1.8</td>
</tr>
<tr>
<td>Education: School enrolment, Primary (% gross)</td>
<td>112.7%*</td>
</tr>
<tr>
<td>Literacy rate, adult, total (% of people ages 15 and above)</td>
<td>89%*</td>
</tr>
<tr>
<td>Life expectancy at birth, both sexes combined (yrs)</td>
<td>58.1**</td>
</tr>
<tr>
<td>National Poverty Rate (% population living below national poverty line)*</td>
<td>45.9%*</td>
</tr>
<tr>
<td>Improved water source, rural (% of rural population with access to water)</td>
<td>(World Bank 2008)</td>
</tr>
<tr>
<td>(World Bank 2008)</td>
<td>52.0%*</td>
</tr>
<tr>
<td>Improved sanitation facilities, urban (% of urban population with access)</td>
<td>(World Bank 2008)</td>
</tr>
<tr>
<td>Under 5 Mortality rate (per 1,000) (KDHS 2008-09)</td>
<td>74</td>
</tr>
<tr>
<td>Maternal Mortality rate (per 100,000) (KDHS 2008-09)</td>
<td>488</td>
</tr>
<tr>
<td>Total Fertility Rate (KDHS 2008-09)</td>
<td>4.6</td>
</tr>
<tr>
<td>Illiteracy levels females aged 15-19 (%)</td>
<td>7.3%</td>
</tr>
<tr>
<td>Among females aged 20-24, proportion who had sex by age 15 (KDHS 2008-09)</td>
<td>10.0</td>
</tr>
<tr>
<td>Age specific fertility rate (median 2005-2010) 15-19</td>
<td>100.22**</td>
</tr>
<tr>
<td>Age specific fertility rate (median 2005-2010) 20-24</td>
<td>234.45**</td>
</tr>
<tr>
<td>Proportion 15-19 already began childbearing (KDHS 2008-09)</td>
<td>18%</td>
</tr>
<tr>
<td>HIV Prevalence rate (15-49) (KDHS 2008-09)</td>
<td>6.3%</td>
</tr>
<tr>
<td>HIV prevalence rate 15-24 (Total) (KAIS 2007)</td>
<td>3.8%</td>
</tr>
<tr>
<td>HIV Prevalence rate 15-24: Male / Female (KAIS 2007)</td>
<td>1.4% / 5.6%</td>
</tr>
<tr>
<td>Proportion ever tested for HIV and received results (15-19) (KAIS 2007)</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

* Source: (World Bank 2011); ** (United Nations 2011c)

Kenya has 42 ethnic communities out of which the Kikuyu, Luo, Kalenjin, Luhya, Kamba, Kisii, Mijikenda, Somali, and Meru are the major tribes. The official language is English, while the national language is Kiswahili. Almost 80 percent of Kenyans are Christians, with Muslims and other religions being a minority (KNBS 2010).

On August 4th 2010, the country held a national constitutional referendum where citizens endorsed a new constitution. With the enactment of a new constitutional dispensation, the country’s governance structures have changed. The country has been subdivided into 47 devolved units of governance (counties) which will commence their functions after the next general election due to be held in August 2012 (GOK 2010). Currently Kenya is divided into eight administrative provinces, 210 parliamentary constituencies, and 72 districts. The district is the lowest government administrative and planning unit.
3.2  SRH of young people in Kenya: a situation analysis

3.2.1 Age at first sex

There has been a steady increase in the age at first sex among boys and girls in Kenya. Comparative DHS data indicate that between years 2003 and 2008-09, the median age at first sex among women age 20-49 increased slightly from 17.8 years to 18.2 years, while that of men age 20-54 increased from 17.1 to 17.6 years (KNBS and ICF 2010). Rural women initiate sex two years earlier than their urban counterparts. There are also regional variations, with women from Nyanza province on average initiating sexual activity earliest (16.5 years) while those from Nairobi initiate sexual activity latest (20.3 years). Women with secondary level education initiate sexual activity three years later than women with no education (KNBS and ICF 2010).

3.2.2 Young people and childbearing

Early onset of childbearing lengthens the reproductive period and subsequently increases the overall total fertility levels. There has been a reduction in the percentage of teenagers aged 15-19 who have begun childbearing, from 23 percent (KDHS 2003) to 18 percent (KDHS 2008-09), with no difference between the urban and rural population. Teenage motherhood increases with age and shows significant regional variations, with education and wealth being important determining factors (Figure 4). Adolescent fertility in Kenya has steadily declined from 138 per 1000 live births in KDHS 1993 to 106 per 1000 live births in 2008-09 (KNBS and ICF 2010).

Figure 4: Percentage of teenage girls who have began childbearing by age
3.2.3 Young people and contraceptive use

Kenya has shown a steady increase in modern method contraceptive use since the 1980s. Among sexually active girls aged 15-19, contraceptive use (any modern method) has increased from 20 percent in 2003 to almost 25 percent in 2008-09; for those aged 20-24 this has increased from 29 percent to 37 percent during the same period. Table 14 shows that currently married women aged 15-19 mostly use the injectable contraceptive (14.4%), while unmarried women the same age group commonly use the male condom (19.6%). Any modern contraceptive method use among unmarried girls aged 15-19 is slightly higher than among currently married women the same age (23.2% vs 19.6%). Implants, IUD, female sterilization and female condoms are rarely used by adolescent girls. Among currently married women, the unmet need for FP for women aged 15-19 is almost 30 percent while the unmet need for women 15-49 is almost 26 percent (KNBS and ICF 2010).

Table 14: Percentage of current contraceptive use among women aged 15-24

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Sexually active unmarried women</th>
<th>Currently married women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any modern method</td>
<td>26.8</td>
<td>63.2</td>
</tr>
<tr>
<td>Pill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectables</td>
<td>1.6</td>
<td>16.0</td>
</tr>
<tr>
<td>Implants</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>IUD</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Male condom</td>
<td>19.6</td>
<td>31.2</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total demand for FP</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Met need for FP – currently using</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Unmet need for FP</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

3.2.4 Condom use

Condom use at last high-risk sex has been identified as one the indicators to assess progress towards combating the spread of HIV/AIDS (United Nations 2008). According to the KDHS 2008-09 national survey statistics, condom use among young people aged (15-24) at first sex has increased two-fold in the previous five years, between 2005 and 2008-08. Among young women, condom use at first sex has increased from 11 percent in 2003 to 24 percent in 2008-09; while for men the increment has been from 14 percent to 26 percent over the same period. In addition, condom use at last sex is higher among young men (64 percent) than among young women (40 percent) who report
partner condom use (KNBS and ICF 2010). This positive result on condom use at first sex has been attributed to the current HIV/AIDS education and prevention efforts targeting young people.

### 3.2.5 HIV and young people in Kenya

The 2008-9 KDHS indicate that the prevalence of HIV among young people aged 15-24 is three percent, with women (4.5 percent) being four times more likely to be infected than young men (1.1 percent). As shown in Figure 5, the prevalence of HIV increases with age, from 1.7 percent (15-17yrs) to 5.7 percent (20-24yrs) with small rural-urban differences of 4.5 percent and 4.8 percent respectively, and major regional variations. The Kenya AIDS Indicator Survey (KAIS) 2007 reports that among young adults aged 15-24, women aged 24 are the most affected (KAIS 2009).

**Figure 5: HIV prevalence by age for young people aged 15-24 (%)**

![HIV prevalence by age for young people aged 15-24 (%)](image)

Source: KAIS 2007

Although the majority of young people aged 15-24 (nine out of ten) know where to receive an HIV test, less than five out of ten have ever gone for an HIV test and received a result, while half of them have never gone for an HIV test as shown in Figure 6 below,
3.2.6 Young people and sexually transmitted infections

Studies on STIs among young people in Kenya are rare but from the KDHS 2008-09 data, the proportion of young women aged 15-24 who reported having had an STI or having experienced STI symptoms (genital discharge, sore or ulcer) was five percent, while that for men of the same age group was two percent (KNBS and ICF 2010). The KAIS report (2007) indicate that 12.6 percent of girls and 5.5 percent of boys aged 15-19 are infected with HSV-2, while 0.6 percent of young people aged 15-24 are infected with syphilis (KAIS 2009).

3.2.7 Age at first marriage

Among women aged 25-49 the median age at first marriage has increased marginally from 19.7 years (KDHS 2003) to 20 years (KDHS 2008-09) while that for men aged 30 and above has remained at 25.1 years over the same period. Overall 12 percent of girls aged 15-19 and 56 percent of women aged 20-24 are either married or with a partner, compared to 0.4 percent of men and 16 percent of men in the same age group respectively (KNBS and ICF 2010).
3.2.8 Young people and education

In Kenya almost all (over 95%) adolescents aged 10-14 are in school, with no variation between urban and rural areas. On the other hand almost three out of ten girls and two out of ten boys aged 15-19 are not in school (UNFPA and Population Council 2010). Census estimates also show that only 23 percent of adolescents (15-19 yrs) have completed primary education, while 41 percent have some primary education (KNBS and ICF 2010); half of the boys aged 20-24 have completed either primary (8 years) or secondary (12 years) education, while 47 percent of girls have completed the same (see Figure 7). At the national level over seven percent of young girls aged 15-19 and four percent of boys the same age are illiterate (KNBS 2009;KNBS and ICF 2010).

Figure 7: Education level of young people aged 15-24

<table>
<thead>
<tr>
<th></th>
<th>Complete secondary</th>
<th>Some secondary</th>
<th>Complete primary</th>
<th>No education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.9</td>
<td>3.1</td>
<td></td>
<td>25.2</td>
</tr>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>8.9</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Girls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.6</td>
<td>7.2</td>
<td></td>
<td>29.4</td>
</tr>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td>8.2</td>
<td></td>
<td>22.9</td>
</tr>
</tbody>
</table>
3.2.9 Young people and gender-based violence in Kenya

According to the KDHS 2008-09 report, 39 percent of women aged 15-49 in Kenya report having been physically or sexually abused by their husbands or partners during their lifetime (KNBS and ICF 2010). This suggests that GBV is not uncommon in Kenya. Among young women aged 15-24 years, 12.9 percent report having experienced first time coerced sex with a slightly higher proportion being from urban (15.3%) than rural (12.1%) areas. There are in-country variations with the highest proportion of young people reporting experiencing first time forced sex being from Nyanza province (19%) and the lowest from Nairobi province (6.2%). In addition, over half (56%) of females 15-24 years reported that a husband would be justified to beat his wife in at least one of the following situations: if the wife went out without telling the husband, neglects children, argues with husband, refuses to have sex, and burns food. Nonetheless 23.9 percent of 15-24 year old females in Kenya report experiencing physical violence since age 15 years (UNFPA and Population Council 2010). A study conducted to determine the prevalence, context and consequences of sexual coercion among young women and men in central Kenya revealed that among sexually experienced, 11 percent males and 21 percent females, reported experiencing some form of sexual coercion (Erulkar 2004). Girls reported experiencing sexual coercion through “deception/tricks” or “insistence/not taking no for an answer” by boys with regards to sexual advances with most perpetrators being people known to them such as boyfriends, husbands and acquaintances (Erulkar 2004). In a qualitative study conducted in Kenya to understand the experience of the sexuality of young people and the associated socio-cultural context Maticka-Tyndale et al (2005) found that girls in Kenya are not expected by the society to immediately consent to having or “playing” sex. Boys were expected to use tricks and sometimes force to have sexual contact with the girls. In addition, boys’ expression of “love” to a girl often meant having sex, although there was no emotional attachment or intimacy in the relationship (Maticka - Tyndale et al. 2005). The secrecy around which sexual relations occur among young girls and boys exposes them to poor reproductive health as they are not able to freely talk about boy-girl sexual relationships, negotiate safe sex and contraceptive use when the need arise. Young girls talk of having coercive sex in bushes by the roadside, on the way to fetch water and that boys only aim at having penetrative sex with young girls they regard to “love” (Forde 2009).
3.3 Overview of health services in Kenya

The Annual Health Sector Statistics Report (2008) indicates that there are a total of 6,190 health facilities in Kenya, of which 48 percent are managed by the government and 43 percent are privately owned. Other providers are faith-based organisations (13%), NGOs (2%) and local authorities (1%) (HMIS 2009).

Out of pocket household expenditure (36%) is the major financing source of contribution to health care funding, followed by donors (31%) and then government (29%). Most of the funds are consumed by curative services (69%), followed by preventive and public health programmes (11.8%) and 14.5 percent for public health administration. HIV/AIDS and RH services consume 38 percent of the total health resources (MOH 2008b).

HIV/AIDS, maternal health and child health are government priority areas in Kenya. The HIV/AIDS epidemic in Kenya has had a negative impact on all development sectors. According to the 2007 Kenya HIV/AIDS indicator survey, 7.1 percent of the Kenyan population aged 15-64 are HIV positive, with women (8.4%) more likely to be affected than males (5.4%). There are distinctive regional variations in HIV prevalence, ranging from 15 percent in Nyanza province to 0.8 percent in North Eastern province; although 84 percent of the population does not, in fact, know their HIV status (KAIS 2009).

Maternal and child health mortality rates still remain high, although both are showing a declining trend. The infant mortality rate is 52 per 1000 live births, which is a reduction from 67 per 1000 live births for the year 2003. The under-five mortality rate is 74 per 1000 live births, a reduction from the 95 per 1000 rate in 2003. The maternal mortality ratio has increased from 414 per 100,000 live births recorded in 2003, to 488 per 100,000 live births in 2009-09 (KNBS and ICF 2010).

3.3.1. The National Health Sector Strategic Plan II (2005-2010)

Within the 1994 Kenya health policy framework, the National Health Sector Strategic Plan II (NHSSPII) (2005-2010) currently provides the framework for health service delivery, as well as health sector reforms in Kenya. It shifts the focus from strategic planning, based on the disease burden, to disease prevention. NHSSP II aims at reducing inequalities in health as well as reversing the downward trend in outcome and impact indicators of health, through the introduction of the Kenya Essential Package for Health (KEPH). The KEPH addresses individual health problems through six stages of the human life cycle: i) pregnancy, delivery and the newborn child up to 2 weeks of age, ii) early childhood (3 weeks to 5 years), iii) late childhood (6-12 years), iv)
adolescence (13-24 years), v) adulthood (25-59 years), and vi) elderly (60 years and over). The KEPH has four main objectives:

- To increase access to health services by targeting part of its interventions at the community level and at poor deprived areas and groups (poor districts and sub-districts, pastoralists).
- To integrate the different programmes towards the client.
- To enhance the promotion of individual and community health.
- To improve quality of service delivery by improving the responsiveness of health workers and changing their attitudes towards clients.

KEPH related indicators are prioritized towards achieving health-related MDGs and the essential services are delivered through six defined levels of health care (Levels 1-6) with a strengthened interface between the community and rural health facilities, as shown in Figure 8 (MOH 2005).

NHHSP II has recognised adolescence as one of the priority areas. The plan aims at improving access of young people to services such as: reproductive health counselling, provision of contraceptives, HIV counselling and testing, promotion of anti-tobacco and anti-alcohol habits, and establishment of youth-friendly services within existing health facilities. The target was to set up, by the year 2010, at least 60 health facilities where adolescents and youth could receive comprehensive services, as well as accurate health information specific to their health problems (MOH 2005).

**Figure 8: KEPH levels of health care**

![KEPH levels of health care diagram](source: MOH 2005)
3.3.2. Management and governance of health services in Kenya

Health care provision has always been the mandate of the Ministry of Health but from the year 2008, (due to the country’s political instability), the Ministry of Health was split into two: Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS). Currently MOMS is mandated to provide curative and rehabilitative services within KEPH levels 4, 5 and 6, while MOPHS oversees the provision of preventive and promotive health services within the rural health facility networks (KEPH levels 1, 2 and 3). It is anticipated that, after the general election in August 2012, the two ministries will be merged hence re-creating only one Ministry of Health. Since 2008 the two ministries have developed their respective strategic plans (MOMS 2008; MOPHS 2008) which are to run till 2012.

The MOPHS has eight administrative departments which report to the Director of Public Health and Sanitation. This includes the department of disease control, family health, sanitation and environmental, health promotion, primary health services, technical planning, disaster management and international health (see Figure 9). Divisions of Reproductive Health (DRH) and Child and Adolescent Health (CAH) under which ASRH services fall are managed by the Department of Family Health (MOH 2006). It is worth noting that STI/HIV/AIDS are managed under the department of disease control. Often DRH and CAH work in close collaboration but there is limited collaboration with the department of disease control. Functions of each of these divisions include the following:

**Division of Reproductive Health:** Develop policies, strategies and interventions that are responsive to sexual and reproductive health problems of individuals, adolescents, families and communities.

**Division of Child and Adolescent Health:** Develop policies, strategies and interventions for the promotion of child health, prevention of diseases affecting children and adolescents, and effective treatment and care for children and adolescents.

**Division of AIDS/STI control:** Develop policies, strategies and interventions that are responsive to the prevention and treatment of HIV/AIDS and other sexually transmitted infections. Facilitate development of policies that can mitigate the effect of HIV/AIDS.

There is currently in Kenya a verticalisation of the RH and national AIDS/STI control programmes (NASCOP). Although it is apparent that their joint collaboration and co-ordination would have a synergistic effect, these linkages are quite weak. Each of the divisions has technical working groups
or taskforces which oversee the implementation of RH and HIV/AIDS/STI related services but often these departments may not be aware of each other’s activities. For example while the adolescent sexual reproductive health (ASRH) programme, within the DRH, has a technical working group that meets on a quarterly basis, there may be no representation from the AIDS/STI department and vice versa. Similarly, the National Guidelines for HIV testing and counselling (2010) may have been developed without the technical input of the DRH in spite of the fact that HIV testing and counselling services are an essential component of ASRH service provision. This same verticalisation and lack of proper coordination is likely to trickle down to the district level and the service delivery points. The coordination between the MOPHS and Ministry of Youth Affairs is similarly weak. This is despite the fact that the MOYA is setting up Youth Empowerment Centres (YEC) which would be an ideal opportunity for integration with services offered by the ASRH programme and NASCOP. Proper co-ordination could be strengthened through the creation of an inter-ministerial committee, ensuring representation at each of these technical working groups and organising joint consultative meetings between the stakeholders involved. These consultations would provide an opportunity for leveraging of resources and eliminate duplication of activities.
Figure 9: Ministry of Public Health and Sanitation (MOPHS) National Level Structure

Source: (MOH 2005)
3.4 Policy framework for SRH services for young people in Kenya

There exists an explicit policy framework for the implementation of ASRH programmes in Kenya. This includes the following:

- National reproductive health policy (MOH and DRH 2007)
- National reproductive health strategy 2009-2015, (DRH 2009)
- Adolescent reproductive health and development policy (NCAPD and MOH 2003)
- National guidelines for provision of youth friendly services in Kenya (MOH and DRH 2005)
- Adolescent sexual and reproductive health: Trainers manual for health service providers (MOH and DRH 2006)
- Reproductive health communication strategy 2010-2012, (MOPHS and MOMS 2010)
- National school health policy and guidelines (MOPHS and MOE 2008)
- Kenya National Youth Policy for Youth Development, Sessional Paper No.3 (MOYA 2007a)
- National guidelines on management of sexual violence in Kenya (MOPHS and MOMS 2009)
- Guidelines for HIV testing and counselling in Kenya (NASCOP and MOPHS 2010)

The National Reproductive Health Policy (MOH and DRH 2007) and Strategy (DRH 2009) identifies adolescent / youth sexual and reproductive health as one of its key priority components and outlines four key priority actions to be instituted in addressing the SRH problems of adolescents/youths. These include: ensuring that young people have access to SRH information and services, establishing of YFS, promoting multi-sector collaboration and strengthening partnerships between stakeholders. Similarly these actions are highlighted in the ARH&D policy and plan of action (MOH and NCAPD 2005;NCAPD and MOH 2003). The plan outlines eight ASRH related indicators which target women and men aged 15-24; these include: unplanned pregnancies, HIV prevalence, STI prevalence, proportion undergone Female Genital Cutting (FGC), proportion marrying before age 18, prevalence of fistulae among women 15-24 and ratio of girls to boys in primary, secondary and tertiary level of education (MOH and NCAPD 2005).

The national guidelines for provision of YFS services aim to standardizing youth-friendly service provision, as well as provide a minimum service package. The guidelines broadly identify two
approaches to be used in the delivery of SRH services to young people: the targeted and the integrated approaches (MOH and DRH 2005). The targeted (youth-only) approach is where services are designed and planned for youth alone and can either be facility-based, school-based or community-based. In the integrated approach, young people receive SRH services together with the general public but special arrangements are put in place to make the services more acceptable to young people, such as training of health care providers and facility improvement.

Three models of youth-friendly service provision, each with an essential service package, are recommended by the guidelines: youth centre based model, clinic based model and school based model. Figure 10 gives details of the essential services to be provided in each model set up as stated in the national guidelines. The essential services needed for the provision of clinic-based and youth centre-based services are similar and include SRH counselling, STI screening and treatment, VCT, ANC/PNC, provision of post-rape care services, contraceptives, information and education materials, outreach activities to schools and the community. The school-based model essential services outlined by the guidelines include SRH counselling, life skills training, school health talks, and referral for medical treatment to either the youth centre or clinic-based models.

According to the HIV/AIDS prevention and control act (2006), all persons must give an informed consent before undergoing an HIV test. For children below 18 years consent should be provided by a parent or legal guardian. Situations where the act allows for children below 18yrs giving consent for HIV testing include when the child has HIV/AIDS related illness/ symptoms, is pregnant, married, a parent or engaged in risky behaviours that makes them vulnerable to HIV infection (GOK 2006a). These guidelines also inform the basis for provision of SRH services to adolescents below 18 years.

The Kenya National Youth Policy for Youth Development (2007) recognises the fact that young people in Kenya have social, economic, and developmental health concerns which need to be addressed in order to achieve sustainable economic development (MOYA 2007a). Establishment of Youth Empowerment Centres (YEC) is an initiative the Ministry of Youth Affairs (MOYA) has developed with the purpose of providing a “one-stop-shop” youth friendly facility where young people can have access to information and services essential for youth development such as entrepreneurship, innovation, unemployment, career development, health education and recreation (MOYA 2007b). The objective is to set up at least one multi-purpose YEC per constituency so that young people countrywide can have access to these services.
The guidelines also stipulate that YFS should address and encompass three key components of health care: service facility components, health provider and staff requirements and supportive elements.

**Service facility components**
- Convenient hours and special times set aside
- Acceptable costs
- Adequate or separate space and sufficient privacy
- Comfortable secure surroundings

**Health provider requirements**
- Specially trained staff
- Respect for young people
- Privacy and confidentiality honoured

**Supportive elements**
- Youth involvement
- Young men and women welcome and served
- Group discussions available
- Necessary referral mechanism available
- Delay of pelvic examination and blood tests possible
- Affordable fees
- Wide range of services available: one-stop-shop
- Drop-in-clients welcomed and appointments arranged quickly
- Educational materials available on-site and to take away
- Publicity, awareness and recruitment that informs and

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**Figure 10: Models for provision of YFS in Kenya - Essential Service Package**

Models for provision of youth-friendly services in Kenya – recommended essential service package

- **Youth-centre based model**
  - Essential service package
    - SRH Counselling (sexuality, growing up, relationships, pregnancy, abstinence, unsafe abortion, STI/HIV/AIDS, substance and drug abuse, contraception, careers, rape prevention, nutrition, male involvement, parenting, ANC/PNC, skilled attendance)
    - Screening and treatment of STIs
    - VCT, ANC/PNC
    - Provision of information and education on RH
    - Availability of IEC, audio/visual materials
    - Comprehensive post-rape care
    - Provision of contraceptives
    - Promoting community based and school based outreach activities
    - Recreational activities
    - Linkages to school-based model

- **Clinic-based model**
  - Essential service package
    - SRH counselling (sexuality, growing up, relationships, pregnancy, abstinence, STI/HIV, VCT, drug abuse, contraception, unsafe abortion, rape prevention, male involvement, parenting, ANC/PNC, skilled attendance)
    - Life skills training (goal-setting, decision making, negotiation, moral values, assertiveness, careers, self-esteem)
    - School health talks (personal hygiene, sexuality & growing up, RH, STI prevention, HIV prevention, rape prevention, communication skills)
    - Refer for treatment and management to clinic-based and youth-centre based

- **School-based model**
  - Essential service package
    - SRH counselling (sexuality, growing up, relationships, pregnancy, abstinence, contraception, careers, rape prevention, nutrition, male involvement, parenting, ANC/PNC, skilled attendance)
    - Life skills training (goal-setting, decision making, negotiation, moral values, assertiveness, careers, self-esteem)
    - School health talks (personal hygiene, sexuality & growing up, RH, STI prevention, HIV prevention, rape prevention, communication skills)
    - Refer for treatment and management to clinic-based and youth-centre based
3.5 Availability of youth-friendly SRH services in Kenya

The provision of SRH services to young people in Kenya is mainly done by three types of service providers: public, NGOs/FBOs and private. Availability of youth-friendly services has been assessed at national level using three main indicators: i) proportion of facilities with at least one HSP trained in YFS, ii) proportion of facilities with observed policy/guidelines on YFS and iii) proportion of facilities offering YF HIV testing services (NCAPD et al. 2011). Current estimates from KSPA 2010 show that only 7 percent of facilities are able to provide youth friendly HIV counselling and testing (HCT) services, a decline from the 12 percent proportion of facilities reported in KSPA 2004 (Figure 11). There are regional variations with Western province having the highest number of facilities providing YF HCT services (24%) followed by Nairobi province (17%) and North Eastern province having no facilities providing YF HCT services. KSPA 2010 report also indicate that there has been an increase in the proportion of facilities with at least one health provider trained in YFS from 12 percent in 2004 to 34 percent in 2010 (Figure 12) (NCAPD and MOPHS 2010).

Figure 11: Percentage of facilities that provided youth friendly HIV counselling and testing in years 2004 and 2010
SRH services for young people in Kenya are commonly provided in two settings: Youth centres and integrated services. Youth centres only serve young people and can either be facility-based or community-based, while in the integrated services young people receive services within the general health system as part of the general public.

**Facility-based youth centres** are youth-only facilities which are based within the compound of a main hospital. The centres provide SRH information, education and clinical services to adolescents. The centre may be located within a hospital or other health facility setting such as provincial referral hospital, district hospital or health centre. Clinical services provided to adolescents may include: contraception, screening and treatment of STI/HIV, post rape care, pregnancy testing, curative services for minor illnesses and other counselling services. The facility staff may also be involved in limited outreach activities to schools and the community in general.

**Community-based youth centres** are youth-only facilities, often located within the community or major shopping centres. Most community-based youth centres provide SRH information through education, recreational facilities, youth development programmes, career counselling, counselling on drug and substance abuse and community and school outreach activities. If competent staff are available, the facility may in addition provide limited clinical services such as pregnancy testing, counselling and testing for HIV, and provision of condoms. Community-based youth centres are popular among Non-Governmental Organisations (NGOs) and mostly rely on donor funding. Most of the centres are multipurpose and also offer other facilities such as vocational training of young
people. Depending on the level of funding and cadre of staff available, the centre may provide clinical services (similar to KEPH level 2).

**Integrated health services** are services which are provided within the general health system and young people receive SRH services, together with the general public. Special arrangements are put in place to make the services friendlier to young people, such as training of facility staffs in youth-friendly service provision and facility infrastructure improvement to enhance privacy. In most cases, health care providers receive training on youth-friendly service provision where they are informed on how to be sensitive to the problems of young people. SRH services are provided within separate clinical areas such as outpatient departments, maternal and child health clinics and VCT clinics.

NGOs have been known to supplement government efforts in the design, implementation, financing, monitoring and evaluation of reproductive health programmes (DRH 2009; MOH and DRH 2007). NGOs play a crucial role in expanding coverage and improving access to SRH services by young people through conducting outreach activities in schools and the community. NGOs have also been proven to be successful in evaluating SRH interventions and comparing lessons learnt between countries and continents. An example is the African Youth Alliance project which was implemented in four African countries: Ghana, Botswana, Tanzania and Uganda (Senderowitz 2004). NGOs spearhead the initiation of research projects which often informs the shaping of national policies and guidelines. Most youth development programmes present in sub-Saharan African countries are run by NGOs through the support of donors and other development partners.

### 3.6 Exploring the impact of the scale up of VCT and post-rape care services in Kenya on youth friendly services

The Kenya Service Provision Assessment Report (2010) indicate that almost three quarters (74%) of health facilities in Kenya are able to offer HIV testing and counselling services, a significant increase from the 37 percent of facilities reported in 2004 (NCAPD et al 2011). Use of targeted and professionally designed mass media campaigns has been documented as one of the success stories to increase utilisation of HIV testing and counselling services in Kenya (Marum et al 2008). A combination of mass media campaign strategies such as increasing knowledge and confidence in VCT services among the general population, using a VCT logo, creating linkages between clients and VCT facilities, using popular locally designed phrases such as “chanuka”, and putting emphasis on couple counselling using celebrity couples as role models have shown a positive impact on this scale up (Marum et al. 2008). The scale up of VCT services has also been facilitated
through the standardization of service delivery processes, quality assurance mechanisms and task shifting in national policy allowing lay and professional counsellors to conduct HIV testing and counselling (Taegtmeyer et al. 2011). The development of national guidelines through a consultative process, standardization of training materials, counselling protocols, reporting tools, VCT site registration and provision of free HIV tests kits to the VCT centres, use of mobile VCT and integration of VCT services in community-based organisation activities have all facilitated acceleration of this scale up (Marum et al. 2006). Use of mobile VCT as an additional service to an already existing stand-alone HIV testing and counselling service has been shown to be cost effective with regards to increasing coverage and reaching population groups such as young people and first time clients (Grabbe et al. 2010).

Until the year 2000, availability of post-rape care services (PRC) in Kenya was scarce. With the implementation of a post-rape care services pilot project in Kenya’s three districts between the years 2002-2007, lessons learnt informed the development of a national policy framework and scaling up of PRC services to other health facilities countrywide (Kilonzo et al. 2009a; Kilonzo 2007). There are now national guidelines for the management of sexual violence in Kenya which provide a framework for medical and psychological management of victims of sexual violence including the collection and storage of evidence for legal purposes. Children are also recognised as constituting a significant proportion of sexual violence victims (MOPHS and MOMS 2009). One of the major challenges experienced during the scaling up of post-rape care services in Kenya has been the verticalisation of STI/HIV/AIDS and SRH programmes which results in a weakened coordination mechanism (Kilonzo et al 2009). Healthcare providers’ incompetency with regards to counselling, shared confidentiality and not wanting to give evidence in court have also been mentioned as draw backs to the provision of a comprehensive high quality service. Police officers also report feeling uncomfortable about asking sexual violence victims personal questions (Kilonzo et al 2008).

Despite young girls and women being more vulnerable to HIV infection in Kenya, evidence suggests that fewer women visit VCT sites for HIV testing especially the standalone sites. Women are also less likely to use condoms or carry condoms home after counselling due to their lack of negotiating power with regards to sex; women also less aware of the benefits of visiting a VCT site after rape (Taegtmeyer et al. 2006). The limited studies available on post-rape care services show that majority of clients visiting the facilities after sexual violence are children below 15 years (Speight et al. 2006). In Kilonzo et al (2009) study, out of the 784 survivors of sexual violence 43 percent were young people (predominantly girls) aged less than 15. This could be attributed to the fact that sexually abused children are often seen as victims and it’s therefore socially “acceptable”
for them to seek health care. Since majority of clients accessing post-rape care services are also girls below 15 years, integrating post-rape care services in youth friendly service provision and vice versa would provide an opportunity of also reaching out to younger adolescents with information and services relating to sexual violence.

3.7 Description of health services at study sites

The study took place in four areas: Nairobi city and three districts namely Meru central, Laikipia and Kirinyaga districts. In Nairobi, the study was conducted at five health facilities which included three health centres, one clinic and one youth centre which was community-based. The community-based youth centre was offering both clinical and non-clinical services to young people. At the district the study was conducted at the district hospitals. Two of the district hospitals had youth centres within the facility compound.

3.7.1 Nairobi

Nairobi is the capital city of Kenya with a population of over 3 million people (KNBS 2010). It has a cosmopolitan population with a significant proportion of the population (20%) living in informal settlements (slums). Nairobi province is divided into three district administrative units namely Nairobi West, Nairobi North and Nairobi East. Health services within Nairobi city are managed by two arms of government: the Ministry of Local Government through the City Council of Nairobi (NCC), and the two ministries responsible for health service delivery (MOMS and MOPHS). The Provincial Health Management Team is the governance structure which oversees the running of health facilities in Nairobi province. Most public health facilities in Nairobi are health centres managed by Nairobi City Council (NCC). The facilities mainly serve the population living in the slums and offer integrated SRH to young people. Health centres in Nairobi have previously had youth programmes supported by donor agencies such as UNFPA and Pathfinder International.

Through the department of public health, the City Council of Nairobi provides preventive, promotive, curative and rehabilitative health services to city residents (NCC 2010b). However, according to the National Health Information system report, the City Council of Nairobi manages only 10 percent of the facilities in Nairobi province. Almost half (49%) of the facilities are privately managed, while 23 percent are managed by either FBOs or NGOs. The central government manages 18 percent of the facilities (HMIS 2009). According to the 2007 NCC statistics from the public health department, the leading three causes of morbidity within Nairobi NCC facilities were diseases of the respiratory system (42%), malaria (19%) and diseases of the skin (including ulcers 8%) (NCC 2010a).
Within Nairobi province 51 percent of the facilities have at least one health service provider trained in YFS provision, while 17 percent of facilities are able to offer youth friendly VCT services (NCAPD and MOPHS 2010).

### 3.7.2 Study sites at the district level

The district is the lowest planning unit in Kenya and the level at which decentralisation of services takes place. Decentralization of governance and the management of health services in Kenya has been on-going over the last two decades. This began with the introduction of user-fees or cost-sharing within health facilities in the early 1990s. However, decentralisation has experienced challenges such as lack of political will, laxity of relinquishing management by the central level, coupled with lack of proper knowledge of the operation guidelines, by the governance structures at the district level (Ndavi et al. 2009; Owino and Munga 1997).

**Meru central district**

Meru central district is located in the Eastern province of Kenya. It covers a total area of 2 982 sq. km of which Mt Kenya and Imenti forests covers 1,030 sq. Kms, leaving only 1 952 sq. Km for human settlement. Meru central is divided into 10 administrative divisions. Forty one percent of the population in Meru central live in absolute poverty (NCAPD 2005b). By the year 2008, the population of Meru Central was projected to be 569,992 with 26 percent being young people aged 15-25 years. The district has 160 health facilities, with the average distance to a facility being 7 Km and the doctor patient ratio being 1:33 259. The current HIV prevalence of persons aged 15-49 is 38 percent with young people being most affected (NCAPD 2005b).

With regards to youth-friendly SRH services the district faces several challenges which include lack of appropriate YFS, lack of a proper networking system especially for referral, and hostility of health care providers towards young people. There are a lot of cases of drug abuse among young people as khatt (miraa) is the major cash crop and driver of the district’s economy. Many young people chew miraa and subsequently drop out of school to work on the miraa farms. However, in the financial year 2008/09 the district health management team had planned to undertake the following activities to improve the health of young people in the district: initiate youth-friendly services, train health care providers, enhance advocacy activities, and promote the school health programme (MOH 2008a).
Meru youth centre

Meru youth centre is a facility-based youth centre located within the compound of Meru central district hospital. The youth centre was established in the year 2000 with support from an NGO known as Save the Children Canada (SCC). The youth centre is managed by a nurse/psychological counsellor and offers SRH services to young people aged 10-24 at no cost. At the time of the study the facility staff included 2 nurses (1 male, 1 female), 2 VCT counsellors (1 male, 1 female), one male receptionist who doubled up as a cleaner and 10 youth peer educators. The two VCT counsellors were employed by a German-based NGO known as DSW. The receptionist was previously a youth peer educator at the youth centre. The youth peer educators only come to the youth centre upon prior arrangement. All the staff at the youth centre have received training in youth-friendly service provision. The centre provides general counselling to young people in the following areas: contraception, condom use, STI/HIV prevention, pregnancy crisis, sexual violence prevention. The youth centre provides the following services: pregnancy testing, VCT, treatment of STIs, provision of contraceptives (pills, depo, EC, condoms). The youth centre also has a resource centre with a TV, video players, indoor games (chess, darts) and IEC materials. However, the youth centre does not have a supply of STI drugs; clients are given a prescription to go and buy or get from the main hospital pharmacy. The youth centre attends to an average over 200 young people per month.

Laikipia District

Laikipia district is located on the slopes of Mount Kenya, a major tourist attraction site in Kenya. Its capital town is Nanyuki and it is located within the Rift valley province. The district has a population of 157 039 of which 19 percent are young people aged 15-24. Laikipia district is one of the vast districts in Kenya with poor terrain and poor road and communication networks. In some of the areas, the distance from one facility to another can be as far as 300 km. There is a total of 40 health facilities in the district: 4 hospitals (1 GOK, and 3 private), 3 health centres (2 GoK and 1 FBO) 13 dispensaries (11 GoK and 2 FBO), and 20 FBO clinics) (MOH 2009).

Some of the key health issues faced by youth in the district include poor reproductive health services, high prevalence of HIV/AIDS and STIs, and increased psychiatric cases. Other specific problems include: FGM, unsafe abortion, early marriage, lack of skilled health personnel, and drug abuse. In the financial year 2008/09, the district health management planned to address these challenges through improving health education, setting up youth friendly services and mental health outreaches.
Laikipia youth centre.

Laikipia youth centre opened its doors to young people in the year 2004 after being constructed with the support of Save the Children Canada (SCC). The youth centre is located within the Laikipia district hospital compound. The youth centre is spacious with several consultation rooms, a space located for a laboratory, pharmacy, reception area and a resource centre. The youth centre is managed by 2 nurses, a volunteer VCT counsellor and a receptionist (on a voluntary basis). The youth centre provides the following services: VCT, pregnancy testing, contraceptives (EC, pills, and condoms). Only one of the nurses has received training in YFS. The youth centre attends to on average over 140 young people per month.

Kirinyaga District

Kirinyaga district is located in the central province and its capital town is Kerugoya. It covers an area of 1.437 sq. Km; 21 percent of which is covered by Mt. Kenya Forest. The district is divided into four divisions and four constituencies. The population density as at 2008 was estimated at 557 persons per sq. Km. It is estimated that 42 percent of the population live in absolute poverty (NCAPD 2005a). The total population of Kirinyaga district, in 2008, was estimated at 492,072 with 27 percent being young people aged 15-24 years. In 2001 Kirinyaga district had a total of 201 health facilities: 7 hospitals, 5 health centres, 42 dispensaries and 147 private clinics. The majority of health facilities (63%) are managed by the government. Of these facilities, 40 provided MCH/FP services. The doctor/population ratio was estimated at 1:79,690 and the average distance to a health facility was 6.32 Km. Approximately 6 out of 10 households had access to a health centre. The most prevalent diseases in the district are malaria, respiratory system diseases and skin diseases (NCAPD 2005a). Kirinyaga district hospital does not have a youth centre at present.

Table 15: Comparative indicators for the study sites

<table>
<thead>
<tr>
<th></th>
<th>Nairobi</th>
<th>Meru</th>
<th>Laikipia</th>
<th>Kirinyaga</th>
<th>Kenya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of population aged 15-24 (NCAPD 2005-06)</td>
<td>*</td>
<td>26</td>
<td>19</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Percentage of population living in absolute poverty (NCAPD 2005-2006)</td>
<td>22***</td>
<td>41</td>
<td>50.5</td>
<td>42</td>
<td>45.9</td>
</tr>
<tr>
<td>Illiteracy levels (Females aged 15-19): KDHS 2008-09</td>
<td>3.9</td>
<td>5.0</td>
<td>8.9</td>
<td>3.4</td>
<td>7.3</td>
</tr>
<tr>
<td>Among females aged 20-24, proportion who had sex by age 15: – KDHS 2008-09</td>
<td>1.7</td>
<td>5.5</td>
<td>11.6</td>
<td>5.1</td>
<td>10.0</td>
</tr>
<tr>
<td>Proportion began childbearing (15-19)</td>
<td>13.9</td>
<td>13.5</td>
<td>16.5</td>
<td>10.9</td>
<td>18.1</td>
</tr>
<tr>
<td>HIV prevalence (15-24) (females and males) - KAIS 2007</td>
<td>3.9</td>
<td>2.6</td>
<td>2.1</td>
<td>1.3</td>
<td>3.8</td>
</tr>
<tr>
<td>% boys and girls ever tested for HIV and received results (15-19) - KAIS 2007</td>
<td>39.6</td>
<td>17.1</td>
<td>27.7</td>
<td>25.5</td>
<td>28.1</td>
</tr>
</tbody>
</table>

***Kenya open data: * data not available
3.8  **Summary of the background to study area**

This chapter presents the background information on the situation of SRH of young people in Kenya. The chapter describes the social, economic and political context of Kenya, the sexual behaviour practices of young people in Kenya. The chapter also describes the situation of health services in Kenya, the availability of youth friendly services in Kenya, the practical consideration of scaling up HIV counselling and testing services and how this could impact on youth friendly service provision. The section also introduces the study sites.
Chapter 4: Methodology

4.0 Introduction

This chapter provides a detailed description of the methodology used in this study. Section 4.1 describes the study design; section 4.2 provides the theoretical considerations that have informed this study, section 4.3 states the study aims and objectives, while sections 4.4 to 4.6 describe the study area, study respondents and data collection methods and tools. Section 4.7 describes the process of developing a comprehensive SRH service delivery model for young people in Kenya. Section 4.8 provides information about ethical considerations for the research. Section 4.9 gives a chronology of the data management and analysis process while 4.10 provides information about precautions undertaken by the study to ensure trustworthiness. Reflexivity or the researcher’s position with respect to this research process is described in section 4.11.

4.1 Study Design

This is a qualitative study, whose purpose is to gain a deeper understanding of the SRH problems of young people and perceptions of available SRH services, from the perspectives of young people themselves, community members and health service providers. Qualitative research is mainly concerned with inductive generation of ideas and providing in-depth and rich explanations of individual’s views and experiences (Jones 1995; Patton 2002b; Pope and Mays 1995). Data collection takes place in real-world settings and people are interviewed with open-ended questions, under conditions that are comfortable and familiar to them (Patton 2002a). Its main emphasis is in providing explanations and meanings to individuals’ responses and experiences (Pope and Mays 1995) and giving a voice to participants voices rather than imposing a story or perspective on them. The qualitative research methodology has gained importance in health research, especially in the areas of developing, evaluating and refining health interventions (Power 2002).

This study uses a naturalistic approach to answer the question on how best SRH services can be provided to young people within the Kenyan social and economic context. Adolescent sexuality has been construed to be a social creation and for it to be well understood, there is need for examination on how it is influenced by local socio-cultural norms and values (Weeks et al. 2003). This can be achieved through understanding how persons interact, the language they use and the meanings they attach to certain sexual and health practices. Understanding the meaning young people and the community place on SRH services may determine whether the stated services are seen as beneficial and socially acceptable, both to the target audience and the society at large. An intervention can only work if it meets the concerns of the target audience who, in turn, feel comfortable in using the
services. A naturalistic inquiry approach helps to understand SRH services, by exploring experiences and values placed on them by the users, providers and community members (Patton 2002b).

4.2 Theoretical underpinnings of the study

4.2.1 Social constructionism

This study takes a social constructionism approach. Social constructionism (SC) is an epistemological approach to acquiring knowledge, which provides a lens through which phenomena can be viewed and socially constructed (Gergen 1985). Berger and Luckmann (1966) are the key developers of social constructionism, an aspect of the sociology of knowledge which asserts the notion that “reality and knowledge are socially constructed”. They suggest that language provides the order for making sense of everyday life and that the reality of everyday life presents itself as something that is comprehensible and can be shared with others. The reality of everyday life takes place in time and is shared with others, especially through face-to-face conversation. This interaction with other people is shaped by the meaning we put into our lived experiences and what we perceive to be happening (Berger and Luckmann 1966). Social constructionism therefore involves the total sum of these interactions, interpretations and meaning the society attaches to these lived experiences and how it is shared among individuals (Berger and Luckmann 1966).

Social constructionists are therefore not concerned with uncovering the “truth” about “reality” and the validity of the knowledge generated rather, it is concerned with seeking explanations, meanings and gaining a deeper understanding of how people make sense of the world in which they live and how any body of knowledge becomes socially acceptable (Berger and Luckmann 1966).

“the sociology of knowledge has to deal not only with the empirical variety of knowledge in human societies, but also with the processes by which any body of knowledge comes to be socially accepted as ‘reality’........regardless of the ultimate validity or invalidity of such knowledge” pg 15 (Berger and Luckmann 1966).

Sexuality has been described as a social construct, as opposed to only being regarded as a biological phenomenon and as such, the meanings attached to it are strongly reflective of societal and cultural values present within different cultural groupings (Burr 2003). This study makes the assumption that the sexual behaviour of young people is created and enhanced through existing social processes and institutions and that, through social interaction, young people learn the social norms, cultural
values and beliefs and ultimately exhibit behaviour that conforms to these beliefs and practices (Burr 2003).

Critics have argued that social constructionism assigns a passive role to the individual’s psychology, creativity, and personal values while putting more emphasis on socialisation, language and values within given social settings or groupings; it also fails to recognise the effect of biology on an individual’s mind and behaviour (Bury 1986; DeLamater and Hyde 1998). It is also argued that since social relations show great variability across different societies, theories derived using a social constructionist approach often reflect lived experiences of the persons under study and may not be reflective of views that can be generalised within a given social spectrum (Turnbull 2002). Nonetheless social constructionism provides an avenue of gaining an understanding of how people place meanings on their everyday experiences and interaction with other members of the society (Cunliffe 2008).

The social construction approach of acquiring knowledge has been used in other research processes such as understanding human sexuality and discourses around sex (DeLamater and Hyde 1998; Foucault 1978), the creation and change of sexual meanings within social groupings (Villaneuva 1997) and exploring the role of metaphors in understanding sexual violence (Vernon 1998). Through narratives of HIV positive persons, the social constructionism approach has been applied to make ‘sense’ of what ‘safe-sex’ means within the Kenyan social and cultural context and the implications for policy formulation (Nzioka 1996). In South Africa, Shefer et al. (2002) applied the social construction approach to understand perceptions of STI, sexual behaviour and health seeking behaviour for STIs among community members (Shefer et al. 2002).

4.2.2 Why a social constructionism approach?

Adolescence has been referred to as a socially defined stage in the lifecycle of human development and the social reality of adolescence, its boundaries, duration and experiences are variables which are socially constructed and constantly changing (Dragastin 1975b).

In this study, social construction is used as a tool to help tease out and gain a deeper understanding of the social and cultural factors that have an influence on access to and utilisation of SRH services by young people. It enables one put meaning to young people’s understanding of the world around them and how these views and opinions facilitate, or hinder, SRH service utilisation. Social constructionism helps to understand local meanings placed on services and therefore enables one to explain how, within a local context, health service delivery approaches can either work or not work.
It also helps to explain local labelling and bring out background meaning placed on events, actions and occurrences that are likely to have a direct effect on SRH service provision and utilisation. By taking a social constructionism stance, the different contradictions, tensions and meanings placed on statements obtained during the interviews and group discussions can be understood. During the interview process, a social constructionism stance is concerned with understanding how interviewing participants actively create meaning to events and occurrences around them (Silverman 2001), what they consider real and how this reality is construed. It is important to note that people’s experiences are never “raw” but are entrenched in the social web of interpretation and re-interpretation. The social constructionism perspective, during interviews and focus group discussions, is concerned with uncovering local meanings, tensions and points of agreement present within a given social system (Legard et al. 2003).

Social constructionism therefore provides a lens through which an understanding can be developed on the following key questions:

*How does the society define the SRH problems of young people? How are SRH services being described by different respondents: young people (users), providers and community members?*

*What are the respondents’ opinions and views about the available services and what meanings and explanation(s) can be drawn from these views?*

*What are the commonalities in the responses among the different respondents? What are the points of agreement and contradictions?*

Social constructionism therefore helps one in taking a critical view on how SRH services are organised, the meaning SRH services have to adolescents, youths and other members of the society, the language and labelling placed on the SRH, acceptable and unacceptable services, and how the stated factors may either facilitate or hinder service provision and use. It is only after we understand the social meaning placed on the SRH problems of young people, that we can understand how access, service provision and service utilisation can be improved.
4.2.3 The conceptual framework for the research

This study has been conducted in four stages as shown in Figure 13.

1. A literature review was undertaken to understand the SRH problems of young people from the national and international literature. The review also examined the effectiveness of SRH interventions that have been implemented in developing countries, especially in sub-Saharan Africa. The review also examined the SRH interventions that have been implemented in Kenya. The literature review also examined essential elements required for the development of health care delivery models.

2. The second stage of this research involved collecting primary data through in-depth interviews and focus group discussions with young people who are the service users, community members and health service providers. Key informant interviews (KII) with facility managers and programme managers were also conducted to identify strengths and weaknesses of SRH service provision. Respondents also provided their perspective and meaning of SRH services.

3. The third stage of the research involved using the findings of both the literature review and the primary data to develop an “ideal” SRH service delivery model for young people in Kenya.

4. The last stage of the research involved presenting the developed model to stakeholders through a series of stakeholders’ workshops, in order to obtain their opinions and views about the developed SRH service delivery model.
Figure 13: Conceptual framework for the research

1: Literature review

- SRH problems of young people: situation analysis
  - Global, sub-Saharan Africa, Kenya
- SRH intervention effectiveness
  - Facility-based
  - School-based
  - Community-based
- SRH interventions implemented in Kenya

Components of health care delivery models / and SRH service models

2: Primary data collection methods

- In-depth interviews
- Focus group discussions
- Key informant interviews
- Participatory stakeholders’ workshops

Identification of SRH problems of young people

AND

Perceptions of available SRH services through interviews with:
- young people
- community members
- health service providers
- facility managers and programme managers

AND

Social constructionism approach

3: Development of SRH service delivery model for young people

- Explore the different models of SRH service provision for young people in Kenya.

4: Review of the proposed SRH service model through stakeholders’ workshops
4.3 Study aims and objectives

4.3.1 The research question

What is the best model for providing SRH services to young people aged 10-24 years within the Kenyan economic and socio-cultural setting?

4.3.2 Specific objectives

1. To explore the SRH problems young people experience and gain an understanding of their perceptions of the available SRH services
2. To explore community members views on the SRH problems of young people and their perceptions of available SRH services targeting young people
3. To explore health care providers’ perceptions and experiences of SRH service provision to young people
4. To explore the different models of SRH service provision and, through a stakeholder consultative process, develop an SRH service delivery model for young people in Kenya.

4.4 Sampling methods

Three non-probability sampling techniques were used in the selection of health facilities and study respondents. They included purposive sampling, convenience sampling and snowball sampling.

**Purposive sampling** is mainly used in qualitative research and primarily aims at selecting “information rich” respondents, who are able to provide an in-depth understanding of the area under study (Devers and Frankel 2000; Patton 2002b). A respondent may be regarded as “information rich” if they have extensive knowledge about a particular behaviour, experience or phenomenon of interest. While employing a purposive sampling technique it is important to take note of participants or cases which are typical, deviant and negative (Devers and Frankel 2000; Patton 2002b). Purposive sampling was used in the selection of study health facilities (section 4.4.2), young people (section 4.5.1), community members (section 4.5.2), health service providers (section 4.5.3) and key informants who were health facility managers and programme managers (section 4.5.4).

**Convenience sampling** involves selecting the most accessible respondents taking into consideration the convenience element of distance, time and cost (Marshall 1996) with the disadvantage being a lack of a clear sampling strategy (Ritchie et al. 2003b). Convenience sampling was used in the selection of the study area (section 4.4.1).
**Snowball sampling** involves using already sampled respondents to select other respondents whom they know and who fit the selection criteria (Ritchie, Lewis and Elam 2003b). Snowball sampling was used to supplement the selection of young people interviewed at the health centers in Nairobi, especially boys, because the number of boys seen at the health facilities was low. The initial points of contact were young people who were either youth church leaders or leaders of youth groups that had links with the health facilities (section 4.5.1).

### 4.4.1 Study area

The study took place in four areas: the capital city of Nairobi and three districts namely Laikipia, Meru Central and Kirinyaga (map in Figure 14). A detailed description of study area is provided in section 3.7 of this thesis. Two methods of sampling were used to select the study area: purposeful sampling and convenience sampling (page 103). During purposeful sampling, two factors were taken into consideration:

- The availability of health facilities providing SRH services to young people for at least three years
- Previous history of youth SRH programmes within the study area

Other factors that informed the selection of the study area included: poverty levels, the proportion of teenage pregnancy and the prevalence HIV among young people from the catchment population (see Table 15 in section 3.7.2). With regards to convenience sampling availability of financial resources and logistical reasons influenced the selection of the study sites. Nairobi area was chosen because it was logistically convenient for the researcher to undertake the research taking into consideration the financial limitations of the study. In addition, the three districts included in this study were part of an on-going maternal and new-born health study, conducted by the Division of Reproductive Health (DRH), with financial support from the WHO-Kenya country office (WHO-KCO). Two of the districts (Laikipia and Meru) had facility-based youth centres at the district hospitals. Kirinyaga was included to give a contrast as it did not have youth-only services but offered integrated SRH services to young people.

### 4.4.2 Selection of study health facilities

The study health facilities were purposefully selected taking into consideration availability of SRH services for young people for at least three years, the level of health care (health centres, clinics or youth centres) and health facility management authority (public or NGO managed). Selection of facilities in Nairobi involved consultations with the Medical officer of Health of Nairobi City
Council due to lack of a specific listing of facilities offering YFS. The aim was to include in the study sample facilities offering youth-only services and those offering integrated SRH services. Health facilities selected in Nairobi comprised of five facilities offering integrated services (four health centres and one clinic) and one community-based youth centre.

At the district level the sample included two district hospitals which had facility-based youth centres and for comparative purposes one district hospital that did not have youth-specific services, but where SRH services for young people were integrated in the overall health services. A total of 8 health facilities were included in the study, of which details are shown in the Table 16.

**Figure 14: Geographical location of the study sites**
### 4.5 Primary data study respondents

Four categories of primary data study respondents were included in this study as described in the objectives:

- Service users who were young people aged between 10-24 years
- Community members
- Health service providers providing SRH services to young people
- Key Informants - health facility managers and programme managers

#### 4.5.1 Selection of young people

Two methods were used in the selection of young people who took part in this study: Purposive sampling and snowball sampling. At the health facilities, the selection criteria for young people included: boys and girls aged between 10-24 accessing SRH services at the health facilities on the day the research team visited the health facility. Young people at the health facilities were drawn from the following clinical areas: maternal and child health and family planning (MCH/FP) clinic, VCT and youth centres. Young people were requested to participate in the study, by the research team, after consultation with the health service provider. Most boys who took part in the study were selected from the VCT clinic and the youth centre. Young people were excluded from the study if they had a child who was restless, had other engagements or were aged 25 years and above.

<table>
<thead>
<tr>
<th>Study site</th>
<th>Facility name and type</th>
<th>Model of service provision</th>
<th>Managing authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>1. Mathare North health centre</td>
<td>Integrated</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>2. Langata health centre</td>
<td>Integrated</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>3. Woodley clinic</td>
<td>Integrated</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>4. Kibera community health centre</td>
<td>Integrated</td>
<td>Public/NGO</td>
</tr>
<tr>
<td></td>
<td>5. Nairobi youth centre</td>
<td>Youth centre - (Community-based)</td>
<td>NGO</td>
</tr>
<tr>
<td>District</td>
<td>6. Meru district hospital</td>
<td>Youth centre (Facility-based)</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>7. Laikipia district hospital</td>
<td>Youth centre (Facility-based)</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>8. Kirinyaga district hospital</td>
<td>Integrated</td>
<td>Public</td>
</tr>
</tbody>
</table>
Snowball sampling was used in the selection of young people from the community within the catchment area of the selected facilities. The initial reference points for snowball sampling were leaders of existing youth social networks such as youth groups and church leaders, within the facility catchment area. The aim of selecting young people from the community was to allow for inclusion in the study, of young people who may not easily come to the health facility for services. This was particularly important for boys as their numbers at the health facilities were low. Church youth leaders and leaders of youth groups linked to health facilities helped identify young people who later on identified other young people between the ages 10-24. Young people identified were requested to either assemble at a local church hall or the health facilities from where the FGDs took place. This process identified 40 young people, 10 girls and 30 boys, who then took part in five FGDs (1 FGD for girls and 3 FGDs for boys).

4.5.2 Selection of community members

Community members were selected by taking into consideration the existing diversity within the community social structures, gatekeepers and opinion leaders. This included members of the facility management committee, religious leaders or pastors, village elders, chiefs, community health workers (CHWs), community-based distributors of contraceptives (CBDs) and members of women’s groups. Community members also represented the views of parents as it was assumed that they were or had previously been parents of teenagers.

In Nairobi, community members were selected based on the above criteria with the assistance of a church elder from a local church. This approach was used to minimize bias associated with the health provider preferences. The elder contacted members of his church and requested them to assemble at the church hall on a particular day and time for the FGD. The FGDs for men and women were held separately on different days. A total of 16 community members (9 men and 7 women) were selected using this approach. At the district level community members were also selected using the above criteria with the assistance of the district health management teams, particularly the District Public Health Nurse (DPHN). The identified community members were asked to assemble at a local hotel where the FGDs took place. Some community members who had travelled long distances and could not travel back to their homes the same day were accommodated overnight at the same hotel. A total of 67 community members (37 males and 30 females) were included in the study from the three districts. Community members were excluded from the study if they did not have adequate time to participate in the study or came in late while the FGDs were almost halfway completed.
4.5.3 Selection of health service providers

Health service providers (HSP), from all the facilities, were selected based on their firsthand experience in providing SRH services to young people and their willingness to participate in the study. Preference was given to HSP who had provided SRH services to young people for at least 2 years. HSPs were drawn from the following service delivery areas: MCH/FP clinics, VCT clinics, youth-friendly centres, maternity units, out-patient departments, comprehensive care centres (CCC), and obstetrics/gynaecology wards. With the assistance of the facility managers or in-charges a list of names of HSP to be included in the study was put forward per health facility. The manager then introduced the research team to the HSPs, who were then later approached individually by the research team and consent for participation requested. In Nairobi, for HSPs who were not able to have the interview done on the day the research team visited the facility, interview appointments were made at the HSP’s convenience. Only two HSPs from Nairobi declined to be interviewed, even on appointment, because they felt the interview would interfere with their working schedule and other commitments. At the district hospital level, prior arrangements were made with the health facility management to invite health service providers, based on the above criteria to participate in the study. Health service providers who were busy or declined to give consent to participate were excluded from the study.

4.5.4 Selection of key informants- health facility managers and programme managers

Key informants included two categories of respondents: health facility managers or in-charges and programme managers/officers involved in the implementation of ASRH programmes at the national and district levels. The inclusion criteria of key informants included: health facility managers or youth centre managers of health facilities that had been selected to take part in the study; programme managers or officers involved in the implementation of ASRH services at both national and district levels and members of the technical working groups (RH training and ASRH) hosted by the Division of Reproductive Health (DRH), MOPHS. The key informants were identified in consultation with the programme managers at the DRH and were selected so as to have representation from different organisations including relevant line ministries, NGOs and development partners. Once identified, key informants were requested by telephone to participate in the interviews at their offices at a time and day that was convenient for them. Key informants were excluded from the study if they were too busy or gave three consecutive appointments which were not honoured.
4.6 Data collection methods and tools

4.6.1 Data collection methods

In this study four data collection methods were used: focus group discussions (FGD), semi-structured in-depth interviews (IDI), key informant interviews (KII) and stakeholder workshops.

A combination of FGDs and semi-structured in-depth interviews were used as prime methods of data collection for young people and health care providers. This is because both methods complement one another in terms of generating ideas and understanding respondents’ views, perceptions, experiences, values, beliefs and expectations about a phenomenon (Patton 2002b; Robinson 1999). FGDs and IDIs provide a good social context of gaining a deeper understanding and putting meaning to young people’s sexual health experiences (Finch and Lewis 2003). They also provide an opportunity for issues to be explored in detail, as the interviewer has the opportunity and time to ask questions and seek clarification of issues raised (Watts and Ebbutt 1987). FGDs and semi-structured interviews were used to gain an understanding of perceptions of young people, health service providers and community members on available SRH services, as well as identify mechanisms of improving these services.

4.6.2 Focus group discussions

A focus group is a homogenous detailed group discussion, which aims at exploring a given issue, usually lasting between 1-2 hrs, under the guidance of a moderator. Between six to eight research participants, with similar backgrounds, are brought together to participate in a discussion that is well organised and directed towards understanding people’s feelings and thoughts with regards to a particular issue, product or service (Krueger and Casey 2000; Robinson 1999). Focus groups can also take the form of a workshop, where there is a structured agenda with specific group activities accompanied by plenary sessions (Finch and Lewis 2003).

Focus groups have been used widely in market research and the political field since the 1920’s, but have now gained importance in health research (Pope and Mays 1995). They are a great asset in feminist research and in exploring people’s own meaning and understanding of health and illness (Wilkinson 1998a);(Wilkinson 1998b). They have the capacity to bring out the multiplicity of views, areas of consensus and voices of dissent in relation to the socio-cultural environment, thereby providing an opportunity for collection of data on social norms and the discussion of issues generally considered taboo within the society (Kitzinger 1994; Kitzinger 1995; Mitchell and
Branigan 2000). FGDs have gained significance in sexual health studies and have been found to be of great value in exploring discourses involving sexual health (Hyde et al. 2005; Mkandawire-Valhmu and Stevens 2010), assessing knowledge, attitudes and practices with regards to SRH services such as contraception (Aneblom et al. 2000); (Zimmerman et al. 1990), adolescent childbearing (Barker and Rich 1992) and parent-child communication on sexuality (Wilson et al. 2010).

In this study, FGDs were conducted among young people, community members and health service providers with the aim of understanding their perceptions of and experiences with regards to available SRH services. The FGDs were conducted with two researchers, a moderator and a note taker. The moderator was responsible for guiding the discussion and began by welcoming the participants, leading the introductions and obtaining consent for both participation and tape-recording. The moderator also followed up the discussion with appropriate probes for depth and clarification of issues. The note taker was responsible for taking notes, noting down non-verbal responses and ensuring that tape-recording was on-going. The moderator guided the discussion through the phases of small group behaviour dynamics which included the forming, storming, norming, performing and adjourning phases (Finch and Lewis 2003). Each FGD took approximately between 1hr 30 minutes and 2hrs and consisted of between 6-10 participants.

For young people FGDs were held separately for girls and boys to avoid gender dynamics within the groups and allow for free expression of views during the discussion of potentially sensitive issues (Morgan 2005). FGDs with young people explored the following aspects of SRH service provision: SRH problems of young people, health seeking behaviour, views and perceptions of available SRH services, reasons for not seeking health care and suggestions on improving access and utilisation of SRH services. At health facilities in Nairobi, FGDs with young people took place in a room that had specifically been allocated to the research team. At the district level, young people were invited to assemble at a nearby hotel where the FGDs took place. A total of 18 FGDs were held with young people aged between 10-24 years, 10 FGDs with girls and 8 FGDs with boys.

Community FGDs aimed at exploring the community members’ views on the SRH problems of young people, their perceptions of available SRH services and suggestions of SRH service improvement. A total of 10 community FGDs were conducted; 2 in Nairobi and 8 at the district level.

FGDs with health service providers explored the following aspects of SRH service provision: knowledge of the available policies and guidelines, availability of SRH services at the health facility, perceptions of and experiences with SRH service provision, barriers to providing SRH
services to young people and suggestions on SRH service improvement. The two FGDs with HSP took place in one of the rooms at the health facilities.

4.6.3 Semi-structured in-depth interviews

An interview can be defined as “a conversation initiated by an interviewer for the specific purpose of obtaining research relevant information and focused on content specified by research objectives” (Watts and Ebbutt 1987). Semi-structured interviews are guided by a loose structure consisting of open-ended questions that outline the area of research to be studied. Probing on specific issues is done by the interviewer to gain depth and clarity of participants’ responses and construction of meanings (Britten 1995; Legard, Keegan and Ward 2003). In-depth interviews mainly focus on the individual personal perspective and understanding of the phenomena under investigations and provides an opportunity of giving personal opinions, history and experiences in discussing sensitive issues (Lewis 2003). Semi-structured individual interviews have been used in various aspects of health and development research such as: assessing women’s perspectives on social and health concerns (Avotri and Walters 1999), assessing the quality of reproductive health services (Becker et al. 2009) and examining sexual coercion among adolescents (Moore et al. 2007a).

Semi-structured individual interviews (IDI) were conducted among young people and health service providers. The interviews took between 30-45 minutes and were conducted with individual researchers. The researcher also made sure the interview was tape-recorded, if consent was given, and took notes as the interview progressed.

Although the data collection tool for young people’s IDIs and FGDs was similar, during IDIs young people were probed more about their personal experiences such as if they had previously visited a health facility, the reason for the visit, whether they received the services they needed and in what ways the health facility or youth centre had been useful to either themselves or their friends. A total of 39 IDIs were conducted with young people and 19 with health service providers.

4.6.4 Key Informant Interviews

Patton (2002b) describes Key Informants as “persons who are particularly knowledgeable about the inquiry setting” and whose insights can help gain an understanding of the subject under study (Patton 2002b). Key Informants provide an important source of information by virtue of their position, role in society and personal skills (Houston and Sudman 1975; Marshall 1996). Two categories of Key Informants were interviewed in this study:
• Nine health facility managers of the 8 health facilities that were visited in this study. In one of the health facilities, Laikipia district hospital, two KII were interviewed; the youth-centre manager and the DASCO. The DASCO was included because he had worked longer at the health facility and knew more about the progression of youth-friendly services at the facility. A total of 9 KII consisting of facility managers were interviewed.

• Two programme managers and/or officers involved in the implementation of ASRH services at both the national and district levels.

KII conducted with health facility managers aimed at assessing youth-friendliness of the facilities, identifying strengths and weaknesses of the different SRH service delivery models, as well as identifying factors that may hinder or facilitate the delivery of SRH services for young people (see Appendix I for the data collection tool)

KII conducted with programme managers aimed at getting their views on the proposed SRH service delivery model in the following aspects: purpose of YFS provision, how and where such services could be provided, overall reaction to the model proposed, identification of enabling factors and barriers to model implementation, how the identified barriers could be addressed, the proposed SRH service model acceptability and sustainability.

4.6.5 Participatory workshops

Participatory stakeholders’ workshops have the potential for producing results that are contextually relevant with regards to identification of health priorities and solving local health problems (Madi et al. 2007). They deepen collective knowledge and enhance the capacities for individuals to take informed action in solving their problems (Sutton and Kemp 2006). Participatory workshops also enable participants to learn new ideas and concepts from the consultative and interactive process (Baron-Epel et al. 2004) and have effectively been used in the generation of data needed for the planning of future health activities, health needs assessment and lifestyle issues (Griffin and Gray 2007).

Three participatory workshops were held to elicit stakeholders’ views, opinions and suggestions on the developed SRH service model. Workshop participants were drawn from a wide range of stakeholders and included policy makers, programme managers and programme officers from the health sector; government departments, NGOs and development partners involved in funding SRH programmes for adolescents or youth. Workshop participants also included the health management teams from the provincial and district levels of health care of the respective study health facilities.
In this study stakeholder participatory workshops were considered an appropriate way of pulling together views from different participants engaged in providing SRH services targeting young people. The forums were seen to provide an environment where tensions, disagreements and agreements could be freely expressed, resulting in the generation of useful and rich information on the proposed SRH service delivery model.

The objectives of the workshops included the following:

1. To share the research findings from interviews with young people, community members, health service providers, facility and programme managers
2. To explore stakeholders views on the model of SRH service provision.
3. To identify structural and contextual factors that may influence implementation of the model.

The first two workshops were pegged to routine monthly departmental meeting at MOPHS and quarterly working group meeting at the DRH. This was due to the busy schedules of national level officers and the difficulty in bringing together a significant number of stakeholders, to discuss the research findings of this study. Pegging onto these routine national level meetings enabled results of study findings to be discussed by a significant number of stakeholders.

**Workshop I:** The first workshop was pegged to the quarterly meeting of the national level RH training technical working group and consisted of 22 policy makers and programme managers, involved in the implementation of RH activities, based at the national level. The representation of stakeholders was as follows: NGOs and development partners (13); teaching institutions (2) and programme managers and officers from MOPHS (7).

**Workshop II:** in the second workshop presentation of the research findings of this study formed one of the agenda items of the monthly departmental meeting at the MOPHS. The meeting comprised of a total of 23 senior managers and policy makers.

In these two workshops key research findings of this study and the proposed model were presented to stakeholders and a plenary discussion was held for at least twenty minutes. However, participants who were willing to provide more information and did not get a chance to do so during the plenary session were asked to voluntarily get in-touch with the principal researcher after the workshops. The principal researcher remained behind after the workshops to identify participants who were willing to take part in subsequent key-informant interviews. Other participants who did not come forward but had important information to share, by virtue of their experience and involvement in implementation of youth SRH programmes were identified from the list of workshop participants.
and contacted by telephone for their consent to participate in the key informant interviews of the study.

**Workshop III:** The third workshop was a one-day workshop which was more participatory and task oriented than the previous two. In addition to having stakeholders from the national level, participants were also drawn from the district study sites and the provincial level. The number of participants was as follows: MOPHS (2); NGOs/development partners (10); training institutions (2); provincial managers (4) and district reproductive health managers (10). The workshop was facilitated by the principal researcher with assistance from two programme managers from the Ministry of Public Health and Sanitation using the topic guide in text box 1 below. The workshop tasks involved discussing the following aspects: purpose of YFS, getting stakeholders’ views on the proposed model, identification of enabling factors and barriers, model acceptability and sustainability.

A total of 28 participants took part in Workshop III (see Appendix II for workshop schedule). In order to have focused and in-depth discussions of the different topic areas and provide ample time for participants to discuss the questions provided, participants were divided into four smaller working groups and given written tasks in the form of questions. All the groups discussed questions on the purpose of YFS provision, how and where such services should be provided, overall reaction to the model presented, and how to sustain the model (questions, 1, 2, 3 and 8). In addition groups I and III discussed the question on enabling factors and model acceptability (questions 4 and 7) while groups II and IV discussed implementation barriers and how they can be addressed (questions 5 and 6). Members of each working group were asked to choose, from among themselves, a moderator and a note taker. The moderator led the discussion using the key questions provided while the note taker wrote on the flip chart the salient points of agreement and disagreement that came out of the discussion. Participants were given two hours of discussion after which each group made a presentation in plenary.
4.6.6 Strengths and weaknesses of FGDs, IDIs and KIIs

FGDs and IDIs are complementary to each other as each method yields a somewhat different kind of information (Patton, 2002 pp 389). It is also assumed in both methods that participants give the true value of information (Lincoln and Guba 1985). Table 17 below outlines the strengths and weaknesses of the two data collection methods,

**Table 17: Strengths and weaknesses of FGDs, IDIs and KII**

<table>
<thead>
<tr>
<th>Study method</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus group discussions (FGDs)</td>
<td>▪ Data are generated through interaction between group participants; participants influence and are influenced by others (Finch &amp; Lewis 2003; Kitzinger 1994)</td>
<td>▪ Are least useful in bringing out intensely personal or sensitive matters (Finch &amp; Lewis 2003; Watts &amp; Ebbutt 1987)</td>
</tr>
<tr>
<td></td>
<td>▪ Responses are spontaneous and less influenced by researcher who is more of a listener (Finch &amp; Lewis 2003)</td>
<td>▪ It requires skilled moderation (Patton 2002; Watts &amp; Ebbutt 1987)</td>
</tr>
<tr>
<td></td>
<td>▪ Provide a good social context in understanding use of language and explaining social meanings attached to occurrences or events (Finch &amp; Lewis 2003).</td>
<td>▪ Confidentiality may not be totally assured as one may not have control over what participants discuss outside the research environment (Patton 2002)</td>
</tr>
<tr>
<td></td>
<td>▪ FGDs are less expensive, one can collect a lot of data within a short period of time (Rabiee 2004; Watts &amp; Ebbutt 1987)</td>
<td>▪ Participants with very negative views may shy away from expressing them, due to fear of rebuke by other group members (Patton 2002)</td>
</tr>
<tr>
<td></td>
<td>▪ Provides information about experiences and attitudes, though not generalisable to a given population – leads to the collection of a wide range of broad responses (Rabiee 2004; Watts &amp; Ebbutt 1987)</td>
<td>▪ Consensus arrived at during focus groups may not be a true reflection of individual respondents views (Stokes &amp; Bergin 2006)</td>
</tr>
<tr>
<td></td>
<td>▪ Presence of a tape-recorder may not be an inhibiting factor in the group discussion (Krueger &amp; Casey 2000, Watts &amp; Ebbutt 1987)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Interaction among the participants makes the discussions lively and enjoyable (Patton 2002 pp 386)</td>
<td></td>
</tr>
<tr>
<td>In-depth Interviews (IDIs)</td>
<td>▪ Interview brings out socially sensitive issues, including personal experiences (Patton 2002 pp 389)</td>
<td>▪ Some respondents find one-on-one interviews intimidating and may be unable to share some issues (individual vulnerability) (Patton 2002 pp 389)</td>
</tr>
<tr>
<td></td>
<td>▪ Allows greater possibility for the interviewer to be task-oriented and for the interviewee to be brought back to answer the questions at hand (Watts &amp; Ebbutt 1987)</td>
<td>▪ In-depth interviews offer less breadth of both the range of issues generated and contextual information (Stokes and Richard 2006)</td>
</tr>
<tr>
<td></td>
<td>▪ The interview covers issues in great depth and detail as the interviewer has an opportunity and time to ask questions and seek clarification of issues raised (Bitten 1995; Stokes &amp; Bergin 2006)</td>
<td>▪ Presence of a tape recorder may be inhibiting to the interviewee.</td>
</tr>
<tr>
<td>Key informant interviews (KII)</td>
<td>▪ Great deal of data is collected over a relatively short time period (Marshall 1996a)</td>
<td>▪ Some key informants may not represent the majority views of the study population. Some key informants may only divulge information that is politically or socially acceptable (Marshall 1996a)</td>
</tr>
<tr>
<td></td>
<td>▪ Key informants may be useful in learning about subgroups which may be inaccessible to the researcher (Patton 2002b)</td>
<td>▪ Key informants perspectives may be limited, selective and biased (Patton 2002b)</td>
</tr>
</tbody>
</table>
4.6.7 Data collection tools

Semi-structured In-depth Interview (IDI) guides and FGD topic guides were used as for data collection, details of which are found in Appendix I. The data collection tools for young people were adapted from the data collection instruments of a previous qualitative study on ASRH conducted in four sub-Saharan African countries (Burkina Faso, Ghana Malawi and Uganda) by the Guttmacher Institute (Amuyumzu-Nyamongo et al. 2005; Kumi-Kyereme et al. 2007; Munthali et al. 2006). Questions were adapted from these studies with some modifications to suit the research objectives. The IDI guide for health facility managers and programme managers was adapted from the tools for assessing and improving reproductive health services for youth, published by Pathfinder International (Senderowitz et al. 2002). For health service providers and community members, data collection tools were developed by the principal researcher in line with the stated research aims and objectives. Adapting of the research tools was also informed by literature review on of SRH interventions targeting young people.

The development of the research tool used during the stakeholders’ workshop was informed by the literature on components of health care delivery models (section 2.5.1) and essential elements needed for development of a health service delivery model as shown in Table 12 of the literature review section. The (Girrard 1993) framework highlights the importance of identifying enabling or assistive factors, barriers and boundaries as important elements of health service models.

Research findings from the primary data as summarised in Figure 23 - section 6.3.1.2 of the results section and the key components of the model for SRH health services presented in Figure 24 also informed the development of the tool for reviewing the proposed SRH service model with stakeholders and KII.

4.6.8 The research team

The research team was comprised of the principal researcher and three research assistants who were all females of less than 29 years. One research assistant was a Kenya Registered Community Health Nurse (KRCHN), while the other two were social scientists with previous experience in social health research. The research assistants were chosen on the basis of having previously participated in other social health research and having good experience and understanding in planning, organising and conducting FGDs and semi-structured interviews.

Before the commencement of the research, the research team underwent training for two days where they were informed about the study aims, objectives and the research methodology. The research assistants were trained on how to conduct IDIs and how to moderate FGDs. Emphasis was placed on the key tasks of data collection such as planning for the interviews and FGDs,
taking notes, tape-recording of interviews and FGDs, labelling of tapes, transcription of the recorded tapes and data storage. There was also a discussion on the data collection tools so as to have a similar understanding of the given topic guides. This opportunity was also used to translate the questions into the local language which is Kiswahili.

The principal researcher oversaw the research process which included training the research assistants, organising and conducting the pre-testing of data collection tools, getting the necessary permission from the key organisations which included the MOPHS, Nairobi City Council - Public Health Department, making the initial contact to the district health management, and facility managers, conducting interviews and group discussions as shown in Table 18.

Table 18: Summary of the research teams roles and responsibilities in data collection

<table>
<thead>
<tr>
<th>Data set</th>
<th>Nairobi sites</th>
<th>District sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 FGDs conducted with young people</td>
<td>Principal researcher (12)</td>
<td>Principal researcher (4)</td>
</tr>
<tr>
<td></td>
<td>Research assistant (1)</td>
<td>Research assistant (1)</td>
</tr>
<tr>
<td>39 IDIs conducted with young people</td>
<td>Principal researcher (20)</td>
<td>Principal researcher (4)</td>
</tr>
<tr>
<td></td>
<td>Research assistant (4)</td>
<td>Research assistant (11)</td>
</tr>
<tr>
<td>19 IDIs conducted with health service providers</td>
<td>Principal researcher (13)</td>
<td>Principal researcher (1)</td>
</tr>
<tr>
<td></td>
<td>Research assistants (1)</td>
<td>Research assistants (4)</td>
</tr>
<tr>
<td>2 FGDs conducted with health service providers</td>
<td>-</td>
<td>Principal researcher (2)</td>
</tr>
<tr>
<td>10 FGDs conducted with community members</td>
<td>Principal researcher (2)</td>
<td>Principal researcher (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Research assistants (3)</td>
</tr>
<tr>
<td>26 Key informant interviews conducted with health facility managers (9) and programme managers (17)</td>
<td>Principal researcher (20)</td>
<td>Principal researcher (4)</td>
</tr>
</tbody>
</table>

4.6.9 Pre-testing of the data collection tools

All the study tools were pre-tested in one of the health facilities in Nairobi, Westlands Health Centre. The pre-test aimed at assessing the following: the relevance, clarity, accuracy and flow of questions asked, the approximate time needed for each tool, the accuracy of the translation to the Kiswahili language, the clarity of the instructions to the interviewee and the tape-recording process. The pre-test mainly resulted in changes being made to the tools in the translation of the questions in Kiswahili language. To ensure accuracy of the translation, the tools were back-translated from Kiswahili to English by the research team. The data collected from the pre-test was also used to train the research assistants on how to transcribe the tapes and produce a verbatim transcript. The pretesting of tools involved conducting one FGD of young people, one
FGD of women, one health provider IDI and two adolescent IDIs. Some questions were deleted from the initial adolescent FGD tool and included in the probes.

4.7 Development of a comprehensive model for provision of SRH services to young people in Kenya: the process.

The process of developing an ideal model for provision of SRH services to young people in Kenya took three interrelated processes as shown in Figure 15.

I: Identification of components of health service delivery models

a) Using literature review findings on approaches to improving SRH for young people (section 2.2 and section 2.3) and development of health care delivery models (section 2.5), 12 essential elements for the development of a health service delivery model were identified (listed in Table 12). These elements provided the framework or building blocks upon which the development of the SRH service delivery model was conceptualised.

b) By examining primary data responses from young people, community members, health service providers, facility and programme managers; key findings were identified with regards to respondents’ views on the SRH problems of young people and their perceptions of existing SRH services. The process involved a detailed examination of the findings for each group of respondents and teasing out salient issues, relevant to SRH service delivery. This process led to the identification of commonalities in the findings with regards to the following thematic areas: SRH problems of young people, experiences and perceptions about available SRH services, barriers and enabling factors for SRH service provision and utilisation. Also included were thematic areas addressing pragmatic issues, as well as strengths and weaknesses of the different SRH service delivery models.

II: Using the findings from steps 1 and 2 above, a comprehensive SRH service delivery model was provisionally developed

III: The suggested model was then presented to stakeholders, involved in the provision of SRH services to young people, so as to get their views on the model developed. Stakeholders’ views on the suggested SRH service provision model were obtained through two main processes: participatory stakeholders’ workshops and key informant interviews.
Figure 15: Key steps in the development of the model for provision of SRH services

I: Identification of components of health service delivery models

a) Using literature review findings of both SRH interventions for young people in Africa and components of health care delivery models

b) Examination and synthesis of primary data on views and perceptions of respondents on the SRH problems of young people and the available SRH services
   - Young people
   - Community members
   - Health service providers
   - Facility and program managers

II

- Application of research findings in the model framework

Provisionally developed SRH service model

III: Review by stakeholders through a series of workshops and key informant interviews

Revised SRH service provision model
4.8 Ethical considerations

4.8.1 Research Ethics Committee Approval

Ethical approval was obtained from both the Liverpool School of Tropical Medicine Research Ethics Committee and the Kenyatta National Hospital Ethics and Research Committee.

4.8.2 Consent for the in-depth interviews and focus group discussions

Before the individual interviews were done, informed consent was obtained from each research participant, who signed a consent form as an indication of agreement to participate in the study. For respondents who were not conversant with English, the research team gave an explanation and made the request in the local language (Kiswahili). With regards to FGDs, verbal consent was obtained from all group members and only one consent form was signed by the FGD moderator to signify the group’s acceptance to participate in the study. This was done after an explanation had been given to the participants about the purpose of the study and the importance of their views as service users and stakeholders. Respondents were also given information sheets which had details about the purpose of the study. Permission was sought from the respondents to have the interviews and discussions tape recorded. Respondents were assured of privacy and confidentiality and that the data collected would only be accessible to the research team. Participants were informed of their right to refuse to participate in the study and that they were free to withdraw from the discussion at any time. Participants were informed that they may not benefit from the study directly but the results of the study would be helpful in improving youth friendly service provision to young people in future.

4.8.3 Consent from young people below 15 years

According to the Ministry of Health, National Guidelines for HIV Testing in Clinical Settings (2006), sexually active adolescents who are below 15 years are regarded as mature minors and are allowed to give consent when in need of SRH services (NASCOP 2006). In this study, adolescents below 15 years who took part in the in-depth interviews were not mature minors and hence consent to participate in the study was provided by the parents or guardians but adolescents’ thereafter confirmed their agreement to take part in the study by signing an assent form.

4.9 Data analysis

Qualitative data analysis is a continuous process that begins at the initial phase of data collection and aims at bringing meaning to the object under study (Rabiee, 2004). Data
collected using qualitative research methods is often large in quantity and hence the process of data analysis involves reducing this data into a format that is manageable, with the end product being the generation of new knowledge or hypothesis. Qualitative data analysis is mainly concerned with uncovering people’s opinions, views and feelings about the object of study, irrespective of the validity of this views (Thorne 2000). Due to the large quantities of data collected in qualitative research, it is essential to have the data collection and analysis taking place in tandem so that subsequent interviews and discussions build onto the previous ones (Dey 1993; Krueger and Casey 2000). Analysing of qualitative data is therefore an inductive process that is highly iterative, time consuming and largely driven by the researcher (Lofland et al. 2006). The purpose and objectives of the study are important elements of qualitative data analysis, as the analytical process is geared towards answering research questions raised at the onset of the research process. In this study, a thematic framework approach (Ritchie et al. 2003a) was used to analyze qualitative data collected. The analytical process was systematic and followed the following five key steps (see Figure 16) (Pope et al. 2000):

- Transcription of the tapes and field notes
- Checking and validating the transcripts
- Development of the thematic framework
- Coding of the transcripts using the thematic framework
- Charting and interpreting the data

While the five steps have been listed in a linear manner, the data analysis process was not always linear but rather it involved moving back and forth between the different steps in order to seek clarifications of the responses and understand the context within which particular responses were made (Ritchie, Spencer and O’Connor 2003a).

**Figure 16: Analytical process for qualitative data**
4.9.1 Transcription of the tapes

Transcription is the process of transferring audio- or video-taped materials into verbatim text documents for convenient reference, storage and analysis (Cope 2009). Transcription of the data collected in this study was done by the research assistants under the guidance of the principal researcher. For health care providers and young people whose interviews were conducted in English, the verbatim transcriptions were done directly in English. For young people and community members whose interviews were done in Kiswahili, the verbatim transcription was done directly into English from Kiswahili. Initially the plan was to have the tapes, where the interviews were conducted in Kiswahili, first transcribed in Kiswahili and then translated into English but it became apparent that the process would take longer and the cost would be beyond our means. A decision was then made to have the tapes carefully transcribed directly into English. This was also supported by the fact that members of the research team were conversant with both English and Kiswahili languages. Moreover in most instances, respondents mixed the two languages during the discussions. The transcripts were typed out and each transcript saved as an individual word document with clear labelling showing the study site, type of interview and respondents gender.

4.9.2 Checking and validation of the transcripts

In order to ensure accuracy and consistency of the transcripts, checking and validation of all the transcripts was done by the Principal researcher, who is conversant with both English and Kiswahili languages. Transcript checking was done so as to ensure their accuracy and conformity with what was said by the respondents. This was a rigorous activity that involved listening to the tapes while, at the same time, reading the transcripts to ensure accuracy in language translation, making amendments where necessary. The process was done in batches of transcripts according to the respondents in the study. Checking and validation of the transcripts was also used as a way of familiarization with the data and initial identification common thematic areas (Robinson 1999). To ensure accuracy of the transcripts, six of the transcripts were randomly selected and reviewed by an independent researcher conversant in both Kiswahili and English, who cross-checked them for accuracy and language translation consistency (Mays and Pope 1995). Apart from the typing errors the transcripts were found to be accurate and of good quality.

4.9.3 Development of the thematic framework

Following familiarization with the data, a thematic framework for each set of transcripts, by category of respondents, was developed. This was guided by the research questions, objectives of the study and the major themes and concepts that emerged from each set of transcripts.
or rather the repeating ideas that came from the raw data (Auerbach and Silverstein 2003; Spencer et al. 2003). All the data was explored inductively to generate thematic categories (Pope, Ziebland and Mays 2000). This stage led to the development of a thematic framework which was subsequently used for coding or indexing. A thematic framework was developed for each category of respondents: young people, community members, health service providers, and facility managers (see Appendix I). The identification of broad categories of the thematic framework was informed by the research objectives. Initially, five transcripts of each category of respondents were read one by one while noting on the right hand margin of the transcript the themes generated from each paragraph section of the data. Once all the five transcripts had been read, the themes recorded on the margin of the transcripts were then sorted and merged together to construct the initial thematic framework. The sorting of the identified themes involved listing all the themes identified and re-grouping them into main themes and sub-themes or sub-categories (Ritchie, Spencer and O'Connor 2003a). In developing the thematic framework, the following questions were asked while reviewing the raw data and using a social constructionism orientation:

*What is the meaning of what the respondent is expressing in this section of the data?*

*Is this expression similar to what has been said earlier?*

Answering these questions helped to identify emerging themes and group similar sections of the data into similar categories. For example “SRH problems” was a thematic area that was derived from sections of the data where respondents identified the SRH problems young people experienced. The specific health problems like unsafe sex, early/unwanted pregnancy and abortion formed the sub-themes or categories (see Table 19).

Particular attention was paid to the frequency with which emerging issues were mentioned among the different respondents, differences in views across the respondents and specific examples of personal experiences given by the respondents (Krueger and Casey 2000). Identification of similar thematic areas across the study groups helped increase the trustworthiness of the data (Patton 1999). The data analysis process also involved identifying majority views, minority views and also conflicting arguments.

### 4.9.4 Coding of the transcripts using the thematic framework

An open coding approach, also commonly referred to as indexing, was used to code the transcripts and conceptualize the data, using inductive analysis (Richie and Spencer 2002; Strauss and Corbin 1990). Computer-aided qualitative data analysis software (CAQDAS) NVIVO8 was used for data organisation and management. The NVIVO8 programme is essentially a data management tool that systematically aids the data analysis process (Pope,
Ziebland and Mays 2000). It has enormous flexibility with respect to data handling and manipulation, as it significantly improves the way the data is accessed, retrieved and viewed (Blismas and Dainty 2003).

NVIVO8 was used to accelerate the coding process. This programme has a “drag and drop” feature which allows for easy coding of the text on to the different themes, sub-themes or categories which are referred to as “tree nodes.” The programme allows for multiple coding of text onto different “tree nodes” and this helps in the identification of links and associations within the data. This process is also called “cutting and pasting” where sections of the data with similar or related themes are put together (Pope, Ziebland and Mays 2000). It also allows for easier retrieval of data related to either a specific node, or a combination of nodes and searching of data associated with key words.

Table 19 shows the thematic framework that was used to code data from IDIs and FGDs with young people plus a brief description of the broad thematic areas. Broad thematic areas were further subdivided into sub-themes or categories. The build up of the sub-themes occurred as the coding progressed (Ritchie, Spencer and O'Connor 2003a). If a new theme emerged it was simply added onto the existing list. For example the broad thematic area “young people’s experiences with available SRH services” was further subdivided into two sub-themes: “positive experiences” and “negative experiences”. During the coding process, if a data section was describing positive experiences with SRH service provision, that section of the data was coded at both the main thematic area and the sub-theme; and likewise if the description of the data was a negative experience.

To give another example sections of the data that were answering the question, [what are some of the reasons that would make young people or an adolescent not seek health care from the health facility/ youth centre?], were all dragged and dropped under the broad thematic area, “reasons young people do not seek health care”. Retrieving and reading through the coded data at this thematic area led to further categorization of the data into the categories of health provider related concerns, service delivery related and youth related concerns.

Table 19: Thematic framework for coding FGDs and IDIs with young people

<table>
<thead>
<tr>
<th>SRH problems: sections of the data where respondents described the SRH problems young people faced.</th>
<th>Where young people seek healthcare sections of the data where young people identified the sources of health care</th>
<th>Young people’s experiences with available SRH services sections of the data where young people discussed their experiences of the available SRH services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe sex</td>
<td>Parents / Friends / Relatives</td>
<td>Positive experiences</td>
</tr>
<tr>
<td>Early/ unwanted pregnancy</td>
<td>Health Facility</td>
<td>Negative experiences</td>
</tr>
<tr>
<td>Abortion</td>
<td>Unqualified / Herbal / Traditional</td>
<td>Other</td>
</tr>
<tr>
<td>Sexual Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ignorance – inadequate information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship / growing up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of proper parental guidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty and employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Media influence
- Prostitution
- School dropout
- Early Marriage
- Drug and Substance abuse

**Addressing the SRH problems of young people**  
sections of the data that described how the mentioned SRH problems could be addressed

- Young people and contraception
- Young people and condom use
  - Encourage condom use
  - Condoms not used / discouraged
- Female condom concerns
- Parental Guidance and education
- Youth and RE education

**Health services young people seek**  
sections of the data where young people identified the SRH problems that made young people seek health care

- Contraception
- Pregnancy related services
- STI
- HIV related services
- Sexual Violence
- Counselling and SRH information
- Drug addiction rehabilitation
- General health
- Abortion

**Reasons young people do not seek healthcare**  
sections of the data where young people discussed some of the reasons why they do not seek health care

- Health Provider related concerns
- Service delivery related concerns
  - Cost
  - Clinic setup
  - others
- Youth related concerns
  - Fear

**Youth and improving access to SRH services**  
sections of the data where young people gave suggestions on how services could be improved

- Increase availability
- Improve HSP attitude
- Increase awareness of availability
  - IEC / Outreach / Advertisement

---

### 4.9.5 Charting and interpreting the data

In interpreting data one strives to derive meaning from verbatim texts, while being imaginative and analytical enough to identify the relationships between individual quotes and make linkages within and between the data as a whole (Rabiee 2004). After all the data had been coded, the rest of the data analysis was done manually. This involved reviewing the data in each thematic area or “tree node” and using intuition, summarising the findings in each category (Blismas and Dainty 2003) as well as examining associations within and between the transcripts (Ritchie and Spencer 2002). Analytical categories were then indentified and used in writing results summaries (Ritchie, Spencer and O'Connor 2003a).

Charting of the data involved copying the data from each sub-theme or “tree node” in NVIVO8, pasting the coded data in Ms Word and constructing a three column table consisting of the following column headings: coded data, dimensions identified and analytical categories as shown in Table 19 (Ritchie, Spencer and O'Connor 2003a). Table 20 shows the analysis of data under the sub-theme “positive experiences”.

---

**Table 19**  

<table>
<thead>
<tr>
<th>Coded Data</th>
<th>Dimensions Identified</th>
<th>Analytical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraception</td>
<td>Benefits of contraception</td>
<td>Increase availability</td>
</tr>
<tr>
<td>Pregnancy related services</td>
<td>Consequences of pregnancy</td>
<td>Improve HSP attitude</td>
</tr>
<tr>
<td>STI</td>
<td>Knowledge about STI</td>
<td>Increase awareness of availability</td>
</tr>
<tr>
<td>HIV related services</td>
<td>Awareness of HIV</td>
<td></td>
</tr>
<tr>
<td>Sexual Violence</td>
<td>Prevention of sexual violence</td>
<td></td>
</tr>
<tr>
<td>Counselling and SRH information</td>
<td>Support during counselling</td>
<td></td>
</tr>
<tr>
<td>Drug addiction rehabilitation</td>
<td>Recovery from addiction</td>
<td></td>
</tr>
<tr>
<td>General health</td>
<td>Maintenance of health</td>
<td></td>
</tr>
<tr>
<td>Abortion</td>
<td>Legal rights to abortion</td>
<td></td>
</tr>
</tbody>
</table>

**Table 20**  

<table>
<thead>
<tr>
<th>Reasons for not seeking healthcare</th>
<th>Solutions for improving access to SRH services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>Increase availability</td>
</tr>
<tr>
<td>Clinic setup</td>
<td>Improve HSP attitude</td>
</tr>
<tr>
<td>Others</td>
<td>Increase awareness of availability</td>
</tr>
<tr>
<td>Fear</td>
<td></td>
</tr>
</tbody>
</table>

---

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Table 20: Description of the data analysis process

<table>
<thead>
<tr>
<th>Coded data</th>
<th>Dimensions identified</th>
<th>Analytical categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Views about available services” – positive experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent FGD/01-Langata-girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R4: They are good they help</td>
<td>Services are good and helpful</td>
<td>Good and helpful services</td>
</tr>
<tr>
<td>R1: It helps even in your house. Like that one of family planning can really help you in your house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R5: You can go to another hospital and then they tell you the family planning methods are bad, they do spoil you if you are young, so there, you will be scared to use it and say it will spoil me. If you find someone else to tell you that that is a lie, if you use them you will be fine you will be happy to use</td>
<td>Scary advice –FP methods are bad, they “spoil” one</td>
<td>Would be happy to use FP after proper advice</td>
</tr>
</tbody>
</table>

Presentation of summary findings aimed at identifying individual opinions, groups opinions, areas of disagreement and contradiction (Kitzinger 1995). Concurrent examination of findings from FGDs, IDIs and different respondents was used to identify points of convergence and departure (Lincoln and Guba 1985). This methodology of data analysis was applied to all the transcripts. With regards to data from the young people, data were analyzed to show perceptions and experiences of the available SRH service as expressed by girls, boys, younger adolescents (12-14), and the study sites (Nairobi or the districts). The identification of the original data source was maintained in the analytical process for easier reference and data retrieval.

4.10 Trustworthiness of the data

Trustworthiness is a term used in qualitative research to establish whether data collected during the research process is credible, transferable, dependable and confirmable (Lincoln and Guba 1985). Trustworthiness of the data collected in this study was met through triangulation of three aspects of data collection: i) having different respondents, ii) using different methods of data collection such as IDIs and FGDs, iii) using different researchers with different experiences to conduct interviews and moderate group discussions (Patton 1999). For example, the discussions on the use of contraception with both boys and girls showed that they were not supportive of young girls, who had not given birth, using contraceptives because of the perceived negative side effects. Similar sentiments were expressed by community members who indicated that contraceptives should be a reserve for married women or girls who have given birth to at least one child. The same views were expressed by some health service providers who also stated that they would not encourage young girls to use contraception, especially the hormonal methods like depo provera. From these views we can conclude that there is some convergence of views.
with regards to the use of contraception among young girls and this could be reflective a general societal view which, in turn, affects SRH service use.

Member checking was also another method that was used for assessing the trustworthiness of the research findings (Lincoln and Guba 1985). Member checking was done through a series of stakeholder workshops with health service providers and facility managers, who took part in the study as well as those that did not participate in the study (Lincoln and Guba 1985). In these workshops the principal investigator presented the key research findings while allowing for feedback from the participants. The aim of the workshops was to establish whether the interpretation of the research findings was reflective of the views expressed by HSP and the health managers. It was also to countercheck whether the concerns young people had, about HSP and the available SRH services, were in agreement with the views of HSP.

4.11 Positionalities in the research process

It is well acknowledged that since the researcher is an instrument in qualitative research it is important to know the values, beliefs, knowledge and experiences the researcher brings into the research process and how this may negatively or positively affect the research process (Patton 1999). This is also known as reflexivity and has been shown to enhance the understanding of the area under study (Jootum et al. 2009).

In this case, the principal researcher had over five years experience working at the national level with the Ministry of Public Health and Sanitation (MOPHS), as a programme manager overseeing the implementation of the National Adolescent Sexual and Reproductive Health (ASRH) programme. Her duties broadly included stakeholder co-ordination, policy formulation and review, resource mobilisation, development of five-year health sector plans, development of annual operational plans and participation in reproductive health research. In 2005, the researcher coordinated the process that led to the development and dissemination of National Guidelines for the Provision of Youth Friendly Services in Kenya (MOH and DRH 2005) and the Adolescent Reproductive Health and Development Policy Plan of Action (MOH and NCAPD 2005). The researcher also personally coordinated the development of the Adolescent Sexual Reproductive Health Trainer’s Manual for Service Providers (MOH and DRH 2006) and National Life Planning Skills: a trainer’s manual for youth peer educators (in draft) (DRH 2006a), and actively participated in the development of the National Reproductive Health Policy (MOH and DRH 2007).

As part of her duties, the researcher actively participated in the training of health service providers and youth peer educators at the district level, including Laikipia district which was one of the study sites. She also took part in a situation analysis of ARH and stakeholder analysis
that was undertaken in Nyanza province (DRH 2006b). The stated activities took place as part of her daily work before the idea of undertaking a PhD degree on SRH services matured.

Because of the researcher’s active involvement in the ASRH programme, she came to be recognised as the “contact person” or “key person” for the ASRH programme and became the “information source” on ASRH for the MOPHS. She also was often called upon, by the senior management, to represent the Ministry of Health at both national and international conferences, making oral presentations where possible. The researchers’ role developed further to include writing of policy briefs for the Director of Medical Services (DMS), the Minister for Health and Her Excellency, The First Lady. The policy briefs basically included information regarding the situation of ASRH in Kenya, what measures the MOPHS had put in place to address this situation and the challenges facing the Division of Reproductive Health (DRH) in ASRH programme implementation.

The researcher awareness of her previous knowledge was essential during the research process, as it increased her sensitivity towards the research participants and prevented her from making premature judgements, imposing her personal views and opinions on the responses made. She portrayed herself as someone who was not fully aware of the experiences respondents had and was interested in hearing and learning more from what the respondents had to say. This self-awareness and open minded approach to the research process enabled the researcher to further probe participant’s responses by asking for more clarifications and meanings of issues raised.

The researcher’s position at the Ministry of Health could have influenced the research process positively with regards to gaining access to the relevant offices, obtaining the necessary permission to conduct the research and obtaining appointments with health managers. Although the researcher had relinquished her responsibilities at the DRH, it was not possible to completely delink from this position. Health care providers and programme managers still regarded her as “DRH staff” and some addressed her as such. To counter this perception, the researcher constantly reminded the respondents of her new role and encouraged them to be open in expressing their views about questions asked. For example respondents could use statements like, “you know what I mean”, but they were constantly reminded them to explain further.

As a previous policy maker, the researcher’s interviewing other policy makers and programme managers posed some challenges. Some respondents felt the researcher was asking them questions to which she already knew the answers. To overcome this, the researcher made her position known to them from the onset. She informed them that although she had previously worked at the policy level on the ASRH programme, she was no longer holding that position and was now in a new role as a researcher enquiring about the views they had about the services.
The potential negative influence of hierarchy and having worked at the policy level within the health sector may have influenced the focus of the research towards SRH problems. It may have also influenced the responses from HSP who may have not been “telling it as it is” but may have led to telling the researcher what they felt the researcher wanted to hear.

Being a policy maker and conducting this research as part of the researcher’s PhD may have created tensions among colleagues, where they regarded the research as her personal gain instead of informing service delivery.

Being referred to as a “daktari” (a Kiswahili word for doctor) had some power in itself and could have influenced the participation of service providers and other research participants. This was seen during FGDs with boys and community members, especially men. Although the researcher was a young female doctor, the power games played out to the advantage of the data collection process as the boys and men were open in their discussion about sexual issues. They did not show any indication of withholding information during the discussions and interviews.

In the FGD with women from Nairobi, as the discussion progressed, the women started placing the researcher in the position of a “role model” to their girls who were not well educated. Being a doctor and especially being a female doctor, regardless of speciality, is regarded as a noble achievement in African society. This framework of mind facilitated free discussion on SRH issues, to a point where the women started seeing the researcher as a “resourceful person” who could easily create rapport with their sons and daughters and subsequently give them advice on sexuality, life choices and the importance of education.

In appreciating this awareness of self, the researcher was able to almost achieve anonymity by casual dress, to the extent that she would gain extra information by listening to casual conversations and being taken for a transgressing member of the public or patient. This greatly helped the triangulation process. In one of the health centres in Nairobi, during one lunch break, the researcher sat among clients waiting to receive medication at the pharmacy. This gave her an opportunity to hear about their informal complaints. Some of the clients complained of lack of drugs at the facility and long waiting times. As the researcher stood up to walk to the ladies, one support staff who was cleaning the waiting bay began shouting at her, informing her not step on the cleaned floor. This happened after the researcher had just completed conducting an FGD with boys at the same facility, where the boys reported support staff being unfriendly to clients.

The researcher position’s herself as an insider to this research process (Bonner and Tolhurst 2002; Kanuha 2000) and as such she did not require a third party to interpret the meanings of responses from the research participants. For example while discussing about sexual behaviour, the word “sex” was rarely used but different phrases were used to mean sex such as “walking
with someone”, and “going with someone”. Respondents also had a way of referring to contraceptives such as “using family”, and “family drugs”. Being able to understand some of the idioms used in the discussions also assisted in the data analysis and interpretation process. For instance in emphasising the fact that parents had neglected their responsibility of educating their children on sexuality, men used the phrase “.....parents have put their luggage down (wame weka Mzigo wao chini)...” As an insider, the researcher was also able to appreciate the local world and put meaning to what respondents believed to be true knowledge from their own perspective. The main disadvantage of using an insider perspective is that one may make assumptions of respondents’ meanings of commonly used statements and hence fail to probe further on the actual meanings of the information, which is taken for granted (Kanuha 2000).

The Kenyan society labels young girls who are unmarried and sexually active as “spoilt” as they are expected not to engage in sexual activity. Discussion of the sexuality of young people and what constitutes a healthy sexual relationship is generally restricted in the Kenyan society. The researcher grew up in the rural area where these social and cultural norms have great influence on one’s thinking and this may have negatively influenced her approach to the research process. In exploring young people’s SRH, the researcher may have gone directly to addressing SRH problems young people experience instead of exploring more around the SRH problems what constitutes healthy sexual relationships and how boys and girls interact. Being a mother of teenage girls may have led the researcher to address young people in a motherly way. The researcher’s own cultural values and religious beliefs may have discouraged her from addressing aspects of same sex relationships, an aspect of adolescent sexuality that is not addressed in this thesis.

Due to the researcher’s older age, language may have been a barrier during some interviews with young boys from the slums of Nairobi where they speak “sheng” or “ghetto language” a newer form of slang language consisting of a combination of English, Swahili words and words from other local languages.

Having participated in this research has been an eye-opener for the researcher; especially with regards to information sharing that is taken for granted by both policy makers and researchers. There is a big information gap between policy makers and researchers in general. Having actively participated in the policy making process, it is sad to note that policy makers refer very little to research during the policy making process and the development of health sector plans. Often interventions are adopted at country level because it is an initiative that is being promoted by the World Health Organisation (WHO) or any other UN agency but evidence from within the country is often missing. Most current research findings are available in peer reviewed journals which are not easily accessible to the policy makers, especially from developing countries. Even if the journals are free online, some policy makers may not be fully aware of the appropriate
internet sites to conduct the search. Some of the policy makers are also too busy and may not have time to search for information from peer reviewed journals. In addition, peer reviewed journals are often regarded as “academic reading material” as the presentation of the findings is “scientific” and in a language that may not be easily understood by policy makers. Computer use competency may also act as a barrier to policy makers accessing online information.

On the other hand researchers may be reluctant to fully engage with policy makers during the research process and may only wish to engage them during the results dissemination stage; an approach that is likely not to make significant impact.

4.12 Summary of the methodology chapter

This chapter describes in detail the methodological approach used during the research process, a summary of which is depicted in Figure 13. This study takes a social constructionism approach (section 4.2.1 and section 4.2.2) to gaining an in-depth understanding of young people’s lived experiences, the local labelling and meanings placed on SRH services by the society and how this tensions, values and belief system influence service provision and utilisation. This study makes the assumption that the sexual behaviour of young people is created and enhanced through social processes and institutions and that through social interaction, young people learn social norms and cultural values and ultimately exhibit behaviour that conforms to these beliefs and practices. Young people, community members, health service providers, health facility managers and programme managers are described as respondents for primary data collection. Focus Group Discussions, In-depth Interviews, Key Informant Interviews and participatory stakeholders’ workshops are discussed as prime methods of data collection.
Chapter 5: Results

5.0 Introduction

This study aimed at firstly exploring experiences and perceptions of young people aged 10-24, community members, health service providers (HSP), facility managers and policy makers on the SRH problems of young people and available SRH services. Secondly, the study sought to explore the different models of SRH service provision and, through a consultative process develop the a SRH service delivery model for young people in Kenya. The study had four main objectives,

1. To explore the SRH problems of young people and gain an understanding of their perceptions of the available SRH services
2. To explore community members’ views on the SRH problems of young people and their perceptions of SRH service provision to young people
3. To explore health service providers’ perceptions and experiences of SRH service provision to young people
4. To explore the different models of SRH service provision and, through a stakeholder consultative process, develop an SRH service delivery model for young people in Kenya

The results in this chapter are presented to reflect views of respondents by gender, study site, facility type and service users /non-users or mixed users (an FGD consisting of both users and non-users). The findings presented in each section give an account of respondents’ views on the SRH problems young people experience and their perceptions of available SRH services. The results chapter is presented in three sections as per the study objectives and respondents interviewed: young people, community members and health service providers. Results for objective 4 are presented in Chapter 6.

Section 5.1 describes views obtained from young people and aims at exploring young people’s experiences with regards to their SRH problems, health seeking behaviour and perceptions of available SRH services.

Section 5.2 presents findings from community members’ perspectives on the SRH of young people. The section aims at exploring community members’ views and perceptions of the SRH problems young people experience and the existing SRH services.

Section 5.3 provides a detailed description of experiences and perceptions of health service providers with regards to the SRH problems, and provision of SRH services to young people.
5.1 **Objective 1: To explore the SRH problems of young people and gain an understanding of their perceptions of the available SRH services**

A total of 18 Focus Group Discussions (FGDs) were held with young people aged between 15-24 years (Table 21). Thirteen of the FGDs were held with young people from Nairobi while five FGDs were held with young people from the districts. Ten FGDs were held for girls and eight for boys.

Table 21: Details of respondents who participated in young people’s FGDs

<table>
<thead>
<tr>
<th>FGD-ID No</th>
<th>Gender of FGD</th>
<th>No of Respondents</th>
<th>Age range</th>
<th>Services respondents were recruited from</th>
<th>Location of FGD (Nairobi/districts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Girls</td>
<td>7</td>
<td>16-22</td>
<td>Users of integrated services in MCH and FP clinics</td>
<td>Langata health centre (HC)</td>
</tr>
<tr>
<td>02</td>
<td>Boys</td>
<td>8</td>
<td>22-24</td>
<td>Users of youth centre (YC)</td>
<td>Nairobi youth centre</td>
</tr>
<tr>
<td>03</td>
<td>Girls</td>
<td>6</td>
<td>21-24</td>
<td>Users of youth centre</td>
<td>Nairobi YC</td>
</tr>
<tr>
<td>04</td>
<td>Girls</td>
<td>6</td>
<td>16-24</td>
<td>Users of integrated services in MCH and FP clinics</td>
<td>Woodley clinic</td>
</tr>
<tr>
<td>05</td>
<td>Girls</td>
<td>6</td>
<td>18-23</td>
<td>Users of integrated services in MCH and FP clinics</td>
<td>Woodley clinic</td>
</tr>
<tr>
<td>06</td>
<td>Boys</td>
<td>8</td>
<td>16-23</td>
<td><strong>Mixed service</strong> users from the community</td>
<td>Kibera HC</td>
</tr>
<tr>
<td>07</td>
<td>Girls</td>
<td>6</td>
<td>20-24</td>
<td>Users of integrated services in MCH and FP clinics</td>
<td>Kibera HC</td>
</tr>
<tr>
<td>08</td>
<td>Boys</td>
<td>8</td>
<td>17-24</td>
<td><strong>Non-service</strong> users from the community</td>
<td>Kawangware church</td>
</tr>
<tr>
<td>09</td>
<td>Girls</td>
<td>10</td>
<td>16-24</td>
<td><strong>Non-service</strong> users from the community</td>
<td>Kawangware church</td>
</tr>
<tr>
<td>10</td>
<td>Boys</td>
<td>6</td>
<td>18-24</td>
<td><strong>Mixed service</strong> users from the community</td>
<td>Mathare HC</td>
</tr>
<tr>
<td>11</td>
<td>Boys</td>
<td>8</td>
<td>21-24</td>
<td><strong>Mixed service</strong> users from the community</td>
<td>Mathare HC</td>
</tr>
<tr>
<td>12</td>
<td>Girls</td>
<td>10</td>
<td>17-19</td>
<td>Users of integrated services in MCH, FP and VCT clinics</td>
<td>Mathare HC</td>
</tr>
<tr>
<td>13</td>
<td>Girls</td>
<td>8</td>
<td>16-23</td>
<td>Users of integrated services in MCH, FP and VCT clinics</td>
<td>Mathare HC</td>
</tr>
<tr>
<td>14</td>
<td>Boys</td>
<td>7</td>
<td>19-24</td>
<td><strong>Mixed</strong> users (non-service users from the community; users of VCT services)</td>
<td>Kirinyaga District</td>
</tr>
<tr>
<td>15</td>
<td>Girls</td>
<td>8</td>
<td>15-24</td>
<td><strong>Mixed</strong> users (non-service users from the community; users of VCT services)</td>
<td>Kirinyaga District</td>
</tr>
<tr>
<td>16</td>
<td>Boys</td>
<td>8</td>
<td>17-24</td>
<td><strong>Mixed</strong> users (non-service users from the community; users of youth centre)</td>
<td>Laikipia District</td>
</tr>
<tr>
<td>17</td>
<td>Boys</td>
<td>7</td>
<td>16-24</td>
<td><strong>Mixed</strong> users (non-service users from the community; users of youth centre)</td>
<td>Meru district</td>
</tr>
<tr>
<td>18</td>
<td>Girls</td>
<td>7</td>
<td>15-22</td>
<td><strong>Mixed</strong> users (non-service users from the community; users of youth centre)</td>
<td>Meru district</td>
</tr>
</tbody>
</table>
Respondents who participated in In-depth Interviews (IDIs) are shown in Table 22. A total of 39 IDIs were conducted with young people from all the study sites out of which 15 were males and 24 females. Most respondents were aged between 20-24 yrs (21), followed by 15-19 yrs (10) and lastly 10-14 yrs (8). Majority of the respondents (32) were service users while seven respondents were non-service users.

Table 22: Details of respondents who participated in in-depth interviews of young people

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Gender</th>
<th>Age range</th>
<th>Educational level</th>
<th>M/Status</th>
<th>Service users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td>10-14</td>
<td>15-19</td>
<td>20-24</td>
</tr>
<tr>
<td>Kirinyaga</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Laikipia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Meru</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Nairobi YC</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Woodley</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Langata HC</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Kibera HC</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15</td>
<td>24</td>
<td>8</td>
<td>10</td>
<td>21</td>
</tr>
</tbody>
</table>

The findings in this section outline views and perceptions of young people on the following aspects:

- Their SRH problems
- Suggestions on how these SRH problems can be addressed
- Perceptions of existing SRH services.
- Barriers to seeking SRH services
- Suggestions on how to improve access to SRH services

5.1.1 Sexual and reproductive health problems of young people

Although young people were asked to identify common SRH problems they experienced, their responses were broad and gave a reflection of the cultural, social and economic environment in which they lived (Figure 17). Problems associated with SRH that were commonly mentioned included: early and unprotected sexual activity, early/unwanted pregnancy, unsafe abortion, infection with STIs and HIV/AIDS, sexual violence and female genital mutilation. Other RH concerns mentioned by young people included inadequate information on RH, problems related to physical body changes during the period of adolescence and challenges related to adolescent relationships. Young people also mentioned other social problems which they considered important, though not directly linked to RH, but were considered to contribute to the SRH
problems experienced. These included: lack of parental guidance on sexuality and growing up, poverty and unemployment, drug and substance abuse, media influence and peer pressure. Other problems mentioned included prostitution, early marriage, and school drop-out.

Poverty and unemployment were said to heavily influence young people into engaging in risky reproductive health practices. It was implied that “health issues” that affected young people came about “due to poverty” coupled with unemployment which was seen to lead youth into idleness and feeling of hopelessness.

Figure 17 gives an illustration of the SRH problems young people experience and their possible interrelationships. Early sexual encounter is central to the SRH problems young people experience.

**Figure 17: Young people's perspectives of their SRH needs**
5.1.1.1 Sexual activity among young people

From the FGDs of boys and girls from all the study sites, there was agreement that young people start engaging in sexual activity at a very early age. The first sexual activity was quoted as being between 11-15 years, even 9 years. Girls were said to be more likely to start having sex at an earlier age, before they gain a proper understanding of the consequences involved. Both boys and girls indicated that young people who were sexually active were labelled by the community as being “bad” and “spoilt”.

“...girls start getting involved in sex when they are still young, before they understand anything; you find that at an early age they get pregnant” (FGD-girls, Nairobi, service users)

Boys from both Nairobi and the districts described the sexual behaviour of young people as being, “very experimental”, “very encourage-mental” and driven by “curiosity” and a sense of “feeling mature”. Youth were said to be driven by curiosity to find out more about sex. For instance, boys from Meru stated that if young people were constantly informed of the bad side of sex, including during teachings in church, they would want to experiment and find out how bad it really was. They also stated that when they experimented having sex, they found the experience being not as bad as they had been informed.

“...youths are told they should not do [have] sex, even in church we are told sex is bad; we are just there to see how is it bad and, is it bad really? So when we go there [have sex] ...people just enjoy”, (FGD-boys, Meru, mixed users).

Similar views were also mentioned by girls FGDs from the districts

“What I can say, because youths are young and they are very curious to engage themselves in sex, someone decides let me do this and see what will happen, so since they are curious he/she will involve herself/himself in sex and can get infected with HIV or get pregnant and since the pregnancy is unwanted they will have abortion” (FGD-girls, Kirinyaga, mixed users)

The negative aspect of sexual intercourse that was being propagated by the society was, in this case, said to be acting as a motivator for young people to engage in sex. Boys suggested that asking young people not to do something repeatedly left them wanting to try it out, so as to understand why they should not do it.

Financial and material gains were identified by both girls and boys as major reasons why young people, particularly girls, got involved in early and unsafe sex practices, including having many sexual partners. It was noted that financial and material gain drove girls into early sex, often
with older partners. This was particularly said to happen among girls who were orphaned, or those from poor backgrounds, who had to find a source of income. This was commonly referred to as “sex-for-maize-flour”. Some girls eventually ended up engaging in prostitution, as the exchange of money for sex became a habit.

“...You find that in most areas especially the slum areas, there are those girls who support their families they are orphans and you find that maybe a girl is the first born in the family so she has to fend for the siblings. She ends up going in prostitution....” (FGD-girls, Nairobi, service users).

“...and some do it because of poverty, someone sees that if I stay like this, I will not get something to eat, so she decides it is better I have sex so that I can get money to buy food. Sometimes one is forced into it, since she has no money, you go and talk to him nicely, and he gives you money” (FGD-girls, Nairobi, service users).

“Poverty, let’s say the girl comes from a very poor family, so she will want to look for money so that she can help her family, and if she gets a boy [boyfriend] who is a bit wealthy, she will be forced to go there do what is supposed to be done [have sex], without preventing anything [using any protection]; so that at least she can get the money and take it home, so that her siblings can get a little food” (FGD-boys, Nairobi, non-service users).

Media influence on young people’s sexual practices, especially pornographic material, was mentioned by majority of boys from all the study sites. Pornography was rarely discussed among girls, since they indicated that they did not often browse the internet. Most television programmes were said to have some pornographic content which perpetuated sexual activity among young people; pornographic material was said to be easily available on the internet particularly through the mobile phone.

“...that habit [sex] is also enhanced by these movies, because 80 percent of TVs [programmes] have pornographic movies in them......but also even the mobile phone; this is the thing where the young people are actually accessing everything.....” (FGD Boys, Meru, mixed users)

Drug and substance abuse was also said to drive young people into risky sexual behaviour. Drug use was generally said to be very addictive and tended to increase young people sexual drive or libido and this made some of them get involved in sexual activity and crimes such as rape. In one of the group discussions with boys in Kirinyaga, one of the boys who had used bhang had the following to say,
“......young people nowadays are not smoking cigarettes for your information, they are taking bhang. Before I did not know how it smelt, but nowadays I have seen it and even puffed and if you have not taken it, you will have a headache and it’s a must you must buy it, you see those challenges, these drugs end up engaging us into---- for instance if it is sex, you are not prepared, you are under drugs, there is a lot of rape, you see that kind of thing”. (FGD-Boys Kirinyaga, mixed users)

“Most of the time they are addicted to drugs and also they engage in sex a lot. That's the other problem they have”, (IDI-14yr old boy, Meru, service user)

“They [young people] get in drugs, they become drug addicts. Some engage in crime and others maybe they are girls, and they get to perform sex without arranging and then they pregnant”, (IDI-19yr old girl, Meru, services user)

5.1.1.2 Unwanted pregnancy and abortion

The majority of boys and girls, from all study sites, mentioned unplanned pregnancy as one of the SRH problem that affected adolescent girls. Once pregnant, the majority of girls dropped out of school, got married or ended up undergoing unsafe abortion. Girls ended up getting married early since they did not have alternative options. In the IDIs, one girl from Nairobi who became pregnant at age 17 confirmed that she became pregnant while she was idle at home, after being away from school for one year due to lack of school fees. By the time she went back to school, she was already pregnant and so she had to drop out.

“..... I have seen it mostly in Kibera slums you find a 16 year old girl, okay, I am not accusing [anyone] because I also got pregnant when I was 17, I was in form one, it [unwanted pregnancy] is now a major issue here..... I feel bad because I have never accepted that I am a mother, but I take care of my son very well in fact, but I have never accepted that I am a mother”, (IDI 23yr old girl, Nairobi, service user).

In the FGDs, majority of the girls also indicated that early pregnancy was a problem in the community and that some of the girls got into early pregnancy because of the unfriendly relationship they had with their parents; this made them run away from home and go to stay with their boyfriends

I think unwanted pregnancy and for that case early pregnancy is a problem in a way that you know young girls who are not that educated may engage themselves in sexual issues and in the process they are not qualified to be mothers and then pregnancy”, (FGD-Girls, Nairobi, non-service users)
“...sometimes it depends with the parents....if you get annoyed and feel that you are not relating well, it brings early pregnancy because when you differ, you just see its better I go to my boyfriend and stay there”, (FGD-Girls, Nairobi, non-service users)

Girls also got unwanted pregnancy in the process of looking for money to buy personal effects such as sanitary towels.

“Some parents can lead you to get pregnant; they are not even bothered when you start your periods. If you ask them to buy for you lotion, they cannot, some parents are drunkards both your father and mother. So in that situation they will not even know if you have started your periods, if you ask them to buy you pads they are not able, in that process of looking for someone to buy for you pads you get pregnant”, (FGD-Girls, Nairobi, service user)

In the FGDs with girls from Nairobi, there were concerns about boys refusing to take up responsibility once they made girls pregnant by “denying” or “disowning” them. This was said to be a major burden to girls as they were left to fend for the child on their own. The majority of boys in Nairobi reaffirmed the denial of responsibility if a pregnancy occurred “accidentally”, “unplanned”, “unexpectedly” or by “bad luck” and one had no means of financial support for both the child and the girl. It was also stated that some of the boys were pressurized or forced by their families to deny such responsibilities.

“Maybe you are sure it [the pregnancy] is yours. Maybe you are not sure, but if you are sure it is yours, maybe you do not have even a house and someone comes to you with a lot of stories, you are forced to deny but you know it belongs to you. But you just refuse (FGD boys, Nairobi, non-service user)

“Like if he makes you pregnant and then runs away from you or he denies that the child is his, is a big problem”, (FGD-girls, Nairobi, service users)

“...once a girl gets pregnant and the boy maybe they had not planned, the boy will deny, then the girl will get a problem of taking care of the child alone”, (IDI: 14 years, girl, Laikipia, non-service user)

This was summarized by one respondent who said that:

“What is there is that boys are so willing to have sex, but they are not responsible to take the outcome afterwards, about sex they are ready, even yesterday, but if they are told; yes you have had sex and this are the results can you take the responsibility? Most boys are not in that situation. The boys will not take it, they will not be ready” (FGD boys, Nairobi, service user).
In the IDIs, one boy from Nairobi gave a personal experience where his sister had gotten pregnant while still in school and so she had to drop out of school. The boy who had made her pregnant refused to take responsibility as he said he was not ready to be a parent; the sister had therefore been left to shoulder the burden of taking care of the baby by herself.

“Like here in Kibera girls drop out of school because of teenage pregnancy. Here in Kibera we can count those girls who are in school, they are very few, Like for me I am a victim, my sister dropped out from school because of teenage pregnancy and right now she is still at home she is rearing the child and after all that, the guy who they brought the child, the guy did not want the issue so he refused that pregnancy and he went away, so my sister is all alone with baby”, (IDI 24yrs old boy, Nairobi, service user)

The girls also indicated that some of the boys who made girls pregnant were young and sometimes still in school and would not take on fatherhood responsibilities. Most girls expressed concern that although some of their male partners would accept to marry them in case of unwanted pregnancy, they would not show any caring feelings towards them. The girls then end up just staying under hard conditions due to lack of alternative choices.

“There are others who can stay with [marry] you but he does not bother with you, he tells you that is your own problem, that is what you wanted, if you want we can stay together but I will not bother with you in anyway”, (FGD-Girls, Nairobi, service users).

“He will accept yes for some time but he will still move out with other girls because he will get bored, he does not want anything to do with that girl so most of the time you will find he is still moving with other girls secretly”, (FGD-Boys, Nairobi, non-service users)

Most boys in Nairobi suggested that it was the responsibility of the girl to ensure that she prevented herself from getting pregnant and that they found it difficult enquiring or initiating discussions with girls about contraceptive use.

“You know a boy does not care, when I have finished with her [had sex] I just go my way, if she wants to get pregnant or she does not want, it is her problem” (FGD Boys, Nairobi, non-service users).

The majority of boys from all study sites also suggested that some girls actually wanted to get pregnant and at times pregnancy would be used as a tool for securing commitment from their boyfriends, more so, if the boy had a good job and was financially stable. A few boys in Nairobi indicated that some girls chose to become pregnant due to peer pressure. Such girls regarded pregnancy to be a “fashion” or “class thing” and therefore became pregnant intentionally as a
way of identifying with their peers; a statement that was refuted by most the girls during their FGDs.

“Yes it is like fashion because if they sit around, you hear them saying; “you do not have a baby, what are you waiting for?” So to them, they see as if it is a normal thing, they do not see it as something surprising”, (FGD-Boys, Nairobi, non-service users)

“It is not that girls want to get pregnant, No, you cannot leave your house and say today I am going to get pregnant, can you do that really? And you are still in school?” (FGD-Girls, Nairobi, service users).

Abortion was mentioned by both girls and boys as a problem affecting the young girls. In most cases, an abortion occurring in the community was reported to be unsafe. Abortion was said to occur among girls who got pregnant and were in school, girls who were not ready for marriage and in cases of pregnancy as a result of rape. In some cases girls who went into prostitution and got pregnant opted to having abortion. Parents were said to contribute to their girls procuring unsafe abortions because of their threats “….if you ever get pregnant in my house I really do not know what will happen…..” So when a girl got pregnant she would be scared to face the parents and would opt to go for an unsafe abortion without the parents’ knowledge. Some girls ended up dying if the abortion was not done by qualified personnel or it was self-induced, in which case the girl would be taken to the health facility for treatment.

“That one [unwanted pregnancy] brings about abortion….it brings about abortion and abortion kills….or it can lead to complications” (FGD-Girls, Nairobi, service users)

“…..parents don’t have money and if a girl is staying with them, it makes her look for other ways of getting money like doing prostitution and then she ends up pregnant, and since she doesn’t have money, she will end up doing an abortion and with abortion, you find she dies or becomes ill, because she went to TBAs and did not go to hospital”, (FGD-Boys, Nairobi, Non-service users).

“Even with the pregnancy let’s say I am pregnant I am fearing my parents……because many people think when I am pregnant my father or my mother will kill me so they end up aborting”, (IDI-21 year old girl, Nairobi, service user)

“You will find that if one gets pregnant, you start wondering now what will I do, and my parents back at home are so strict, so you find someone takes advantage and say she has to go and remove it, and by doing an abortion you will be risking your life isn’t it. You can either die or live, so you cannot just suggest, today I want to be pregnant, you cannot”, (FGD-Girls Nairobi, service users)
There were concerns among girls about the role doctors and the abortion debate in general since doctors still end up treating young people who present to the health facilities with abortion complications.

“To hit the nail on the head, abortion is there. It is a fact, so education on care after abortion care should be there to prevent complication and death because people will never stop doing abortion because even if you do abortion and it is not complete, the doctor will still go ahead and complete it. So we need some information on after abortion, the way she has said, some things are left, what can you do then? (FGD-Girls, Nairobi, service users)

5.1.1.3 Sexually Transmitted Infections (STIs) and HIV/AIDS

Boys and girls from Nairobi and the districts mentioned STI/HIV/AIDS as problems young people experienced. The most commonly mentioned STIs were HIV/AIDS, syphilis and gonorrhoea. In one FGD with boys from Nairobi, they also mentioned herpes. The majority of girls and boys indicated that young people got infected with STIs because they often had unprotected sex, many sexual partners, and sexual partners who were much older.

“Youths have sex anyhow, you find that boys have sex with many different girls, today it is this one, tomorrow he changes to a different girl. So you find he can get syphilis. This syphilis he gives [spreads] to another one....” (FGD girls, Nairobi, service user).

“You can get gonorrhoea, syphilis and HIV from being sexually involved. Then they start spreading it to other people,” (FGD-Girls Nairobi, service users)

“The bigger one is HIV because when you get to HIV, although nowadays there are drugs which can make you live longer, but on the other hand it may lead to death.” (IDI-20yr old girl, Nairobi, service user)

“There is the usual one about HIV/AIDs, pregnancy - mostly unwanted because the youths are in schools or in colleges, so I think pregnancy and HIV [are common problems]” (IDI-19yrs old boy, Meru, non-service user)

The majority of girls and boys were aware of the signs and symptoms of some STIs. Known symptoms of STIs mentioned by boys from Nairobi included itchiness in the private parts, discharge of pus and feeling pain while passing urine. They were also aware of the fact that gonorrhoea was easier to notice in men than in women.
“If you go for a short call you will feel a lot of pain, you can also see pus....in men gonorrhoea can be noticed easily but in women you cannot notice it faster, faster like that” (FGD-Boys, Nairobi, Non-service users)

Girls also indicated that younger girls may not know that they have an infection like gonorrhoea or syphilis. Girls in Kirinyaga mentioned that if a pregnant woman is infected with syphilis, she can pass it on to the baby during birth.

“Younger girls also if they get an infection like gonorrhoea or syphilis they may not know they have it....” (FGD-Girls, Nairobi, service users)

“You can find that sometimes during birth if a mother is pregnant and they get syphilis, during birth a mother can infect the child,” (FGD-Girls, Kirinyaga, non-service users)

Both girls and boys from all study sites reported lack of keenness, among young people, in knowing their partner’s HIV status before engaging in unprotected sex as they operated on the assumption that their partners were medically fine. In the in-depth interviews, a boy who worked as a peer educator in Nairobi, expressed concern that some of the new cases of HIV were occurring among young people who had received information about HIV/AIDS. The reasons given for engaging in risky sexual activities were flimsy such as “niliteleza” meaning “I tripped” (by mistake, bad luck or it was unavoidable).

In the FGDs Nairobi boys expressed concerns of a trend among youths whereby, when involved in a new relationship, they would use the condom during the initial three or four sexual encounters. After three to four months they would start convincing themselves that they know their partners well. The issue of trust then sets in and they start having sex without protection, before undertaking any preliminary medical tests like HIV testing and counselling. They begin to say, “they are used to each other”, and “they now know each other”

“There is this tradition that if you use a condom for 3 to 4 time, trust comes in. You end up saying okay we trust each other now so we can have sex without a condom. So you will find that most boys, once they use the condom maybe three or four times, the fifth time he will have sex he will not use a condom,” (FGD Boys, Nairobi, non-service users)

Similar views were expressed by girls from the districts,

“...because like the youths do not consider going to the VCT for test so when somebody comes to approach you, you just assume they are alright so you end up messing yourself because he will have sex with you and transmit the diseases to you,” (IDI-18yr old girl, Kirinyaga, non-service user).
Sexual violence, specifically rape, was mentioned as a problem affecting both young girls and boys in all study sites. Rape was said not to have an age limit as it occurred among children, teenagers and even older women. Cases of sodomy were said to occur among boys. The perpetrators of rape were said to be boyfriends and relatives such as fathers, uncles and brothers. During the FGDs among girls and boys, it was stated that girls contributed to being raped because of their mode of dressing. Also idleness, influence of drugs and substance abuse also influenced men into raping girls. However girls reported that boys used rape as a tool to counter rejection from girls. See Table 23 for the quotations from young people’s IDIs and FGDs on sexual violence.

In the IDIs, one girl indicted that girls moving about at night alone contributed their being raped. One boy also talked of girls changing their mind to say that they had been raped after initially having consensual sex. However a few girls and boys also reported that rape was not common in their communities and that they had not encountered rape.

Sexual violence was discussed more in the FGDs compared to the IDIs. In the girls FGD in Nairobi, beliefs around rape especially for persons infected with HIV led men into raping young children. There seems to be a belief that if one is HIV positive and rapes a young child who is a virgin, they would be healed. In the boys FGD in Kirinyaga district, an extreme case was reported of a man who raped a five year-old and killed her.

**Table 23: Quotes on sexual violence from IDI and FGDs with young people by gender**

<table>
<thead>
<tr>
<th>IDIs</th>
<th>Girls</th>
<th>Boys</th>
</tr>
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<tbody>
<tr>
<td>“Rape, there I don’t see before a person has raped you where will you be?...like at night, if you are raped at night as a girl at that time, where will you be”</td>
<td>“For girls early pregnancy, defilement and even in some cases they are forced to have sex with their relatives,” (IDI-20yr old girl, Nairobi, service user)</td>
<td>“Well I have not encountered any rape so I cannot say anything,” (IDI-19yr old girl, Nairobi, service user)</td>
</tr>
<tr>
<td>“If they use drugs a lot it leads them to do things which they are not supposed to do .....it can lead you to rape someone, and it makes you have sex without using a condom”</td>
<td>“let’s say me now a girl meets with a boy then you agree [to have sex] and then after you are satisfied you find that some change and say they where raped but in the beginning she is the one who asked for it”, (IDI-18yr-old boy, Nairobi, service user)</td>
<td>“Rape, currently, I have never heard about any rape cases,” (IDI-19yr old boy, Nairobi, service user)</td>
</tr>
<tr>
<td>“You know sometimes you can be forced if you don’t want, maybe from rape and then you become pregnant...”</td>
<td>“some of them they walk at night and they are raped”, (IDI-14yr old boy, Meru, service user)</td>
<td></td>
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<tr>
<td>“It [rape] is not very common here but in some places it is”, (IDI-18yr old girl, Kirinyaga, Non-service user)</td>
<td>“In my opinion there are rape cases and some of them are reported late, also there is misunderstanding between the youths and their parents”, (IDI-24yr old boy, Meru, non-service user)</td>
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<tr>
<td></td>
<td></td>
<td>“[rape is ] not very common in this area”, (IDI-19yr old boy, Meru, Non-service user)</td>
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</table>
## Sexual violence

<table>
<thead>
<tr>
<th>FGDs</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“But some girls contribute to their being raped, you find you are a girl and you are still walking at night, you find her on the street at 10pm, 11pm and also the way we dress, there are some who put on very short skirts and they walk in the street, so if boys see her like that, what do they think?”</strong> (FGD-Girls, Nairobi, service users)</td>
<td><strong>“Like there was this case of a guy who raped a five year old girl, then killed her”,</strong> (FGD-boys, Kirinyaga, mixed service users)</td>
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<tr>
<td><strong>“You find that most of the rapists are relatives, is it true? The way you live with your uncle, in the same house, the way you are dressed and your body is really good, you dress not well, you see that can also lead to rape”,</strong> (FGD-Girls, Nairobi, service users)</td>
<td><strong>“That one [rape] occurs and is brought by the way these girls dress, taking drugs. The parents have to teach the children on how to dress........the ladies put on mini dresses and you do not have a girlfriend”,</strong> (FGD-boys, Nairobi, non-service users)</td>
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<tr>
<td><strong>“Age you can find a girl of 12 years. 15 years and sometimes you will find even old women are being raped, and even young boys are being raped”,</strong> (FGD-Girls, Nairobi, service users)</td>
<td><strong>“Sometimes you do not have a girl friend and also it depends on some food, there are others when you eat that make you to be aroused like oily food, eggs and groundnuts, so if you do not have a girl friend when you see a child or a goat you will rape it”,</strong> (FGD-boys, Nairobi, non-service users)</td>
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<tr>
<td><strong>“Also small children are being raped like a child of 5 years, even sometimes we see others in the news, we hear and also we see, a small child you hear has been raped somewhere”,</strong> (FGD-Girls, Nairobi, service users)</td>
<td><strong>“Idleness brings something like rape you see a beautiful girl with mini-skirt and she’s beautiful you will be tempted, and maybe you have taken drugs like cocaine”,</strong> (FGD-boys-Nairobi, non-service users)</td>
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<tr>
<td><strong>“You know some believe that if one takes bhang, takes drugs or drinks alcohol or if the girl had another relationship out there with a young boy and she refused, he will go and organize a gang of young youths out there to rape her, or he will wait till night comes and then he will rape her, it is believed that those who drink alcohol and take bhang, and those boys who abuse drugs are the one who rape people out there”,</strong> (FGD-Girls, Nairobi, service users)</td>
<td><strong>“I can say here, rape is high because it comes with the way women put on clothes these days, you find that women put on very short skirts, they are not events skirts, making men be lured and rape them because they are idle”,</strong> (FGD-boys-Nairobi, non-service users)</td>
<td></td>
</tr>
<tr>
<td><strong>“And also, there are those people who believe that if you rape a girl who is still virgin and you are HIV positive, if he rapes this child who is still a virgin, one will get healed”,</strong> (FGD-Girls, Nairobi, non-service users)</td>
<td></td>
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<tr>
<td><strong>“Rape you find that most of the young girls nowadays if you are going out with a person, or you are after money and then the guy realizes that you are after their wallet they end up raping you and you don’t have anything to do to complain. So it deprives you of your self esteem. And then there is also rape from the fathers, brothers, and generally in our community”,</strong> (FGD-Girls, Nairobi, service users)</td>
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</tbody>
</table>
5.1.1.5 Lack of proper parental guidance

The discussions from both girls and boys in all the study sites indicated that lack of proper parental guidance was believed to be the genesis of some of the SRH problems adolescents and young people experienced. Parents were said not to listen, talk to and advice their children appropriately on sexuality issues because, either they did not have time, or were afraid and uncomfortable having such discussions. Lack of proper understanding or open communication channels between parents and their children was highly emphasized by boys and girls from all study sites as evidenced by the quotes in Table 24.

"Another challenge for the youth is the time when we get to adolescent age, our parents fail to teach us how to behave, if it is a girl, she is supposed to be told that if you do this and this there will be repercussions that is why you find that young girls are becoming pregnant at an early age, that is why some are contracting diseases outside there because our parents are failing to teach us and it ends up badly for our children” (FGD girls, Nairobi, service users).

“..the problem of parents not telling their kids about these things [SRH] that is the biggest problem because if a parent tells you at an early age .....let’s say an example a kid when you tell her this is bad when she is doing that thing back in her mind she will be remembering I was told this is bad so better I not do it because my mum will beat me or something will happen.....if you tell her when she is big like me, I will say...all those things I have been doing them.”, (IDI-21 yr old girl, Nairobi, service user)

In one of the FGDs with girls in Nairobi, one of the respondents shared her experience of the first time she had her monthly period. She described the experience as “shocking”

“.......out of experience I started my periods when I was in class 8, I felt ashamed but it started when I was at home but I did not know. I was having a stomach ache but I didn’t know why my stomach was aching, that started at night. The following day I woke up and went outside our house without knowing I had stained my dress. Another woman outside [-a neighbour-] saw me and she was like, your dress! I asked her what about my dress, what does it have? I went back to the house and told my mum my dress is folded I am being told out there my dress. She told me to go and change. When I turned to walk away I heard her scream “My God”, I was so shocked about that. I was also shocked at the way she approached me. It scared me. She did not talk to me; she took me to her
friend for advice, while I kept on crying. I cried for a long time, avoiding friends and not wanting to go to school. And also that issue of buying pads---- (FGD Girls, Nairobi, service users)

Cultural practices were mentioned to be other factors that hindered communication between parents and young people. Boys from Meru reported that according to their traditional practices, after circumcision, boys were not expected to sit with their mothers and have open discussions about sexual issues. Girls also stated the fact that parents do not mention “the big word” (sex) in the presence of their children.

5.1.1.6 Other SRH problems young people experience

Other SRH problems young people identified included lack of information about adolescence and growing up, relationships, menstruation, and peer pressure. Most girls noted that young people and especially girls lacked information about their sexual and reproductive health as well as knowledge and skills on boy-girl relationships and particularly how to interact with boys during puberty.

“What I can say is lack of knowledge ...a girl does not know, if I do this [have sex], what are the consequences, you get that when a girl reaches the puberty stage, mixing with boys becomes a challenge. Yes they can mix but what do they do? ----and if they mess up their lives [get pregnant] they either go for abortion or all that. Now you see they don’t have the information that mixing with boys is not bad, but what do you do with them” (19-yr old girls, Nairobi, service user).

Similar views were also expressed by boys aged 15-19 and 20-24, as shown by the quotes in the Table 24.

Table 24: Views of young people on lack of information on SRH by age and gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>10-14 years</th>
<th>15-19 yrs</th>
<th>20 – 24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls</td>
<td>“[young] people are not informed, so they end up falling into temptations..., they end up engaging in sex and some even abuse drugs... they do not relate well with their parents as in they can’t be free to tell them anything that they do when they are out there..... adolescents don’t follow parent’s advice they are so much on the peers groups...” (IDI-14yr old girl, Meru, service user)</td>
<td>“The parent should also sit down with her daughter and make her understand [about adolescence]...let them [parents] not get out of the house at six in the morning and come back 10.00pm in the night; they leave when the girls are sleeping and they come back when the girls are sleeping .....the girls do not have time with their mothers”, (IDI 19 yrs girl, Nairobi, service user)</td>
<td>“Yes and some are ignorant and even the case of another friend of mine who is a peer educator, we were just discussing experiences and she said if they were given an option between HIV and having a baby and someone said I would rather have HIV than a baby, so they were telling her that with a kid one can continue with their life even if they want to go to school they will go... “. (IDI-23yrs girl, Meru, service user)</td>
</tr>
<tr>
<td>Boys</td>
<td>“One problem you know they lack ....many [young] people they don’t have people to tell them”</td>
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</table>


Although concerns regarding relationships of young people were not extensively explored in this study, married girls from Nairobi identified concerns related to their sexual partners or husbands having multiple sexual partners.

“It [marriage] is not safe, because you can be faithful but your husband brings for you diseases...it is not so safe. You cannot trust each other all the time. You can trust them and maybe he is having sex outside the marriage,” (FGD-girls, Nairobi, service users)

Information regarding girls’ menstruation is a concern that was raised by girls from both Nairobi and the districts. Girls were concerned about lack of basic information on body changes, how to handle themselves when their menstrual cycle begun, how to wear sanitary pads, their personal hygiene and what to do in case of pain related periods. The anxiety associated with menstruation together with lack of sanitary wear was said to negatively affect girls’ concentration in school and could also lead to school absenteeism among girls. Girls from poor families who could not afford sanitary pads were said to use pieces of blankets, which they could even share among themselves,

“girls are shy, you can find a girl who does not have pads, she will think of a way of stealing from her mother so that she can go and buy pads but still she will not know how to use them, how to wear them. So parents should be free with their children because there is no way I will get my periods and take pieces of clothes to use and when I stain my clothes?”, (FGD-Girls, Nairobi, service users)

“Girls when they start to see periods, there are others who do not even know what periods are....you need to tell them the signs of menstruation flow, what to do; and they are supposed to know also if you start to see this and if you play around, you will get pregnant; and mostly in girls when they get big breasts you do not know even what to do,”, (FGD-Girls, Nairobi, service user)
“Like when you have your periods sometimes you experience a lot of pain, you may wonder what’s up?” (FGD-Girls, Kirinyaga, Mixed service users).

Peer pressure was reported as a need young people experienced. Girls reported during FGDs that peer pressure lead young people into getting involved in early sex, drug abuse and prostitution. Peer pressure was also said to influence the mode of dressing among young people. Similar views were expressed by the boys in the FGDs; boys also mentioned being drawn into theft by peer pressure. In addition boys mentioned that some girls got pregnant as a result of wanting to belong to a certain class or group of girls (as previously stated in section 5.1.1.2). Avenues identified through which peer pressure influenced young people’s behavior included the media and friends. Friends who were perceived to have a negative influence on young people’s behavior were often referred to as “bad company”. Table 25 gives some verbatim quotes by girls and boys on peer pressure.

Table 25: Views of young people on peer pressure by gender

<table>
<thead>
<tr>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Sometimes its peer pressure, if you are walking with a bad group it can influence you badly, some friends are not that good, they may give you negative advices some will give you positive, so if someone is still in the adolescent stage, some of them are imitating, they don’t know even what are good days and bad days [safe days], for that case, they get pregnant” (FGD-girls, Nairobi, non-service users)</td>
<td>“...It [pregnancy of girls] is like fashion because if they sit around, you hear them saying; you do not have a baby, what you are waiting for? So to them, they see as if it is a normal thing, they do not see it as something surprising,” (FGD-boys, Nairobi, non-service users)</td>
</tr>
<tr>
<td>“Maybe she is my friend [points at one of the girls] she tells me if you have sex you will get this and this, then I will force myself to engage in whatever she is telling me, so I will be influenced by her”, (FGD-girls, mixed service users)</td>
<td>“Also teenagers tease each other. Once you are teased, you start saying actually I am being left behind, others are going ahead why don’t I join them. So he joins them without thinking carefully you find someone is affected [HIV infected] without knowing it”, (FGD-boys, Nairobi, non-service users)</td>
</tr>
<tr>
<td>“Maybe they [parents] have no money to give you, you join a certain group and you may get involved in bad things [sex]”, (IDI-19 yr old girl, Meru, non-service user)</td>
<td>“.... there is peer pressure, the youths of today it’s as if they are trying to tell the others that if you want to be a real man or woman you must be engaged in sexual behaviour, so they go ahead and do the same [have sex]”; (FGD-Boys, Kirinyaga, mixed service users)</td>
</tr>
<tr>
<td>“We have seen so many who tell you, they have already had sex and then they insist on you going to try it also”, (IDI-23yr old boy, service user)</td>
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</tbody>
</table>

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5.1.2 Addressing the SRH problems of young people

Young people were asked to make suggestions on how some of the SRH problems identified could be addressed. From Nairobi and the districts, boys and girls mentioned use of contraception including condoms and traditional methods (safe days) as ways of preventing pregnancies. With regards to STI and HIV/AIDS prevention, condom use, abstinence and not having many sexual partners were mentioned. Emphasis was also placed on youth’s education and counselling and providing accurate SRH information to young people especially by parents. This next section looks further into young people’s views on use of contraception.

5.1.2.1 Young people and Contraception

There were contradictory views among young people about contraceptive use, commonly referred to as family planning. It is worth noting that within the Kenyan context when respondent’s referred to family planning often it included all modern contraceptives, with the exception of the condom. When respondents talked about condoms, they referred to it by its exact name or by using acronyms such as CDs. Contraception /family planning were discussed more among girls FGDs and slightly among boy’s FGDs. It was not extensively discussed during in-depth interviews and at the districts. Table 26 provides verbatim quotes of girls and boys views on use of contraception/family planning among young people.

The majority of girls from Nairobi reported that contraceptives were effective in the prevention of pregnancy, however, they believed that girls who have not had their first child should not be given hormonal contraceptive (injections and oral contraceptives [OC]), as their belief was that this would prevent them from conceiving in future. Contraception was said to be a reserve for married women or girls who have given birth to at least one child. An important observation made was that the use of the word “family planning” among young people, especially boys, always made them have a disconnection in the discussions, as they felt it was not within their domain since they did not have families yet.

The majority of girls from Nairobi believed that family planning “medication” “accumulates” in one’s “body” or “stomach” and ends up “spoiling you”, especially when used for a long time. The girls said that family planning should only be given to girls who have already begun childbearing

“If you start family planning and you are not married, when you get married you may miss to get a baby, me I know family planning is recommended for people who are married, and you use when you have given birth and the baby is small. Now if you say youths should be given family planning and they are not married, how does it help them? Those medicines just accumulate in the body and end up damaging your organs,
and at times it spoils your health” (FGD Girls, Nairobi, FGD-Girls, Nairobi, service users)

Among pregnant girls who had come for ANC services in health centres in Nairobi, further probing to find out if any of them had ever used contraception, before having their first child confirmed, that none of the girls had used any contraception before the birth of their first child. One of the girls reported that she was afraid that if she used contraception or “drugs” she would not get pregnant afterwards.

“Me I was afraid, because of the drugs, I was afraid, because you can use those drugs [contraceptives] and then you do not get pregnant. You use the drugs, you do not give birth then you will just stay like that”, (FGD-Girls, Nairobi, service users).

Heavy menstrual flow and weight gain were reasons given by a minority of young people for adolescent girls not using contraceptives. A few of the girls indicated not using pills or not knowing what contraceptives were.

Table 26: Girls and boys views on use of contraception and family planning among young people

<table>
<thead>
<tr>
<th>Girls and Boys views on contraception /family planning</th>
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</thead>
<tbody>
<tr>
<td>Girls views on contraception or family planning</td>
</tr>
<tr>
<td>“It is good because you can get pregnant anytime. So it is better to use. As long as you have started being sexually active”, (FGD-Girls, Nairobi, service users)</td>
</tr>
<tr>
<td>“I have also heard that people are different and that if you have never used it is good if you can go get examined first before you use, but you find that young girls who are still in schools they just go and buy in chemist, and start to use”, (FGD-Girls, Nairobi, service users).</td>
</tr>
<tr>
<td>“it is better they are given to prevent [pregnancy], but others like injections they should not be given.....the injections are bad; they spoil one and makes one not be able to give birth; (FGD-girls, Nairobi, non-service users)</td>
</tr>
<tr>
<td>“Because now she has already reached motherhood, She is now a mother. Once you have given birth, you have to protect yourself. There is no other way. Yes, she can use, even though according to the age, it is not good but she can use, because she has already given birth” (FGD-Girls, Nairobi, service users)</td>
</tr>
<tr>
<td>“[Family planning] pills? I don’t know pills, is it pills or which ones are they? Pills, I have never used them so I really do not know much about them”, (FGD-Girls, Nairobi, service users)</td>
</tr>
<tr>
<td>“Even these drugs [pills] they lead people to sexual behaviour, so I will not encourage that...but even if you do not provide FP pills they will still engage in sex they will still abort”, (FGD-Girls, non-service users)</td>
</tr>
<tr>
<td>“But it [family planning] will increase sexual immorality because if you are injected then you can go anywhere”, (FGD-Girls, Non-service users)</td>
</tr>
<tr>
<td>“I have heard of another advertisements on the radio saying to avoid pregnancy a girl should use family planning, but I asked myself, if she uses family planning, what about STIs? Then I saw there is nothing that it is helping, okay family planning but what about STIs? You have advised them how not to get pregnant but you have not advised them on how to prevent STIs “, (FGD-Girls, Nairobi, service users)</td>
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5.1.2.2 Young people and condom use

Boys and girls from all study sites reported conflicting views about condom use among young people. In the discussions most young people did not talk about their personal experiences, but referred to condom use by a third party; “other youths”, “other people”. Condom use among youth was said to be good as it protected one from STIs especially HIV and early pregnancy. The majority of boys and girls from all the study sites stated that condom use should be encouraged among young people since they are likely to have many sexual partners and short-term sexual relationships. However, young people admitted that very few of them were using condoms.

Majority of boys and girls from all study sites reported that young people shied away from using condoms for of a number of reasons including: lack of societal support, not knowing how to use, refusal by girls, blind trust and myths and misconceptions on condom use. Lack of sexual satisfaction, condom not being 100 percent effective and increased sexual activity, were some of the misconceptions young people had towards condoms. Other details misconceptions of condom use are listed in Table 27.

Views of younger adolescents (12-14yrs) on condom use

Knowledge of younger adolescents (12-14), especially girls, on condom use was limited. Of four girls aged 12-14 who were interviewed using IDIs, one (12 yrs) in Meru could not respond to the question on condom use even after repeated probing. This was because she seemed to be very shy. The rest reported that they did not know much about condoms and the diseases they prevented since they had not been taught about condoms or condom use. One girl from Meru reported that young people above 14 yrs were the ones who used condoms.
“We have not been taught [on condom use]…...you know they use to prevent the
diseases but we have not been taught that…. I don’t know if it is for preventing which
diseases” (IDI, Girl 14 years, Laikipia, non-service user)

Boys the same age (12-14yrs) were more knowledgeable and reported that young people used condoms for prevention of HIV, pregnancy and other STIs. One boy from Laikipia reported that some young people did not use condoms because they thought a condom could get torn while in use; although he could not provide more details as he said that he had never used a condom. He also said that although the use of condoms was taught at their school, they were advised to abstain from sex until they got married.

Table 27: Myths and misconceptions on condoms by young people

<table>
<thead>
<tr>
<th>Condom myths</th>
<th>Verbatim Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a condom is like eating a sweet in its wrapper</td>
<td>They hate using condoms because they say it’s like eating a sweat in its wrapper. They also say a condom is not 100% assurance that one won’t contract HIV” (IDI-18yrs boy Kirinyaga, non-service user)</td>
</tr>
<tr>
<td>A condom is not 100% effective</td>
<td>“It is not perfect, not protective because it is not 100% perfect” (FGD Boys Laikipia, mixed users)</td>
</tr>
<tr>
<td>One is being unfaithful if they use a condom</td>
<td>“Immorality, they think it is immoral, they think one is being unfaithful when they use a condom” (IDI-23 yrs girl, Kirinyaga, non-service user)</td>
</tr>
<tr>
<td>Condoms are for prostitutes, people who have no relationships</td>
<td>“they say it is not good to use condoms and others they say condoms are for prostitutes, people who have no relationships”, (IDI-23 year old girl, Meru, service user)</td>
</tr>
<tr>
<td>It is better, it is fun not to use a condom</td>
<td>“…they say it is better, it is fun not to use a condom some even suggest to their girlfriends to use the pill” (IDI-19 year old boy, Meru, non-service users)</td>
</tr>
<tr>
<td>Even if you use a condom it will burst</td>
<td>“some say they do not use because it has tiny holes below it, if you sleep with a person you may get a disease (IDI-22 year old girl, Nairobi, service user)</td>
</tr>
<tr>
<td>Condoms have some holes</td>
<td>“Some say maybe when you use a condom…..some maybe it can burst, or maybe it can have some holes, it can burst in the process of using it. (IDI-19 year old girl, Nairobi, service user)</td>
</tr>
<tr>
<td>If I use a condom, my girl friend will not feel. I will not be a man enough</td>
<td>“…Most of them tell me, if I use a condom my girlfriend will not feel. I will not be man enough”, (IDI-19 year old girl, Nairobi, service user)</td>
</tr>
<tr>
<td>A condom can remain in the body after use</td>
<td>“There are some who say it is bad, it can burst or remain inside your stomach, it later brings you problems in the tummy later, you stay in hospital” (FGD-girls, Nairobi, service users )</td>
</tr>
<tr>
<td></td>
<td>“Sometimes, there are people who use it, but they do not know how to use it. For example, a boy may want us to use it, but he doesn’t know how we are supposed to use the condom, so you may go [have sex] with him and the condom may end up getting stuck inside me, it is me who will be the one to suffer”. (FGD-girls, Nairobi, service users)</td>
</tr>
<tr>
<td>Condoms have oily chemicals</td>
<td>“…some say that those CDs they have some chemicals, those oily” (IDI-20 year old girl, Nairobi, service user)</td>
</tr>
<tr>
<td>You don’t need to use a condom if you trust your partner</td>
<td>“…in contrast others feel like they don’t have to use a condom, they feel like they trust their partners” (IDI-20 year old boy, Nairobi, service user )</td>
</tr>
<tr>
<td>Condoms promote immorality</td>
<td>“our youths today take advantage of these condom, they tend to promote immorality, because I know I can go [have sex] with many ladies because I have a condom” (FGD Boys, Nairobi, service users)</td>
</tr>
</tbody>
</table>
5.1.2.3  Parental guidance and education

Majority of girls and boys emphasised the need for parents to give their children proper guidance and education on matters related to sexuality, growing up and reproductive health. It was noted that for this to be effective, parents needed to talk to young people with openness and give factual information without being evasive. Young people stated that they placed great value on advice given by parents as they were likely to remember such advice in adulthood. Specifically girls reported the need for parental advice on matters concerning menstruation such as proper use of sanitary towels, personal hygiene and how to handle painful menstruation. They also needed advice on prevention of pregnancy and STI/HIV. Girls expressed the opinion that it was their right to receive such advice from their parents especially their mothers and lack of such discussions had denied them the chance to establish cordial mother-girl relationships, resulting in difficulty in initiating personal discussions with parents, when the need arose.

“In our families, parents should open up to their children and start to educate them because this is not like the old days, you should just talk to your kids and they will grow up knowing such that, when they want to do something they will remember mum told me this; it should start in the family, parents should be open to their kids”, (FGD girls, Nairobi, service users).

“parents should be able to talk about sex with their children, because now the world is changing, there are diseases, it’s not like their times, if you do not tell them someone else will and whoever will tell them will be wanting to have sex with them, so she will not have an idea concerning sex, the person telling her will be having his intentions of telling her, so if she could have talked with the parents earlier on, she will know about sex” (FGD-Boys, Nairobi, service users)

“Parents to be free with their kids, that is the only way....if you are harsh to me and you are my parent I will not tell you anything because if I tell you this and this you will beat me up...” (IDI-19 yr old girl, Nairobi, service user)

A few of the girls and boys from Nairobi noted that some parents were “too strict and harsh” towards their children and did not give them a chance to mature, make decisions independently or socialise with other young people. They stated that some young people were often confined to the house. This was likened to having “a caged and free parrot”. While a free parrot was said to roam around and eventually settle down, a caged parrot never came back once it was released. In view of this, it was suggested that parents should not “enclose” their children but allow them to interact and socialise with their friends under “logical restrictions”. Young people also indicated that parents believed being harsh was indicative of them raising their
children well; on the contrary, young people felt this affected them negatively as such young people tended to act irresponsibly when an opportunity arose.

Girls from Nairobi said that parents made assumptions that young people were aware of certain RH information when, in the reality they were not. For example a parent would assume that the adolescent was aware of STIs such a gonorrhoea when, actually, what the adolescent knew was only the name. Young people also singled out the fact that having learnt biology in school was not a substitute of getting information and advice from parents.

"This parent thing ...... you are 20 years but you are still a child, he has not opened up to say okay you are my child but you are growing up....” (FGD Girls, Nairobi, service users).

In an FGD with boys in Kirinyaga, parents’ openness in discussing sexual issues with their children was also emphasised,

"We are trying to say, a spade should be called a spade and not a spoon. Our parents as our role models need to hit the nail on the head....say it the way it is, and not making it look nice like applying oil on it”, (FGD-Boys, Kirinyaga, Non-service users)

Although the need for receiving SRH information from parents was highly emphasised by young people, they also recognised that parents lacked the capacity to do so. There was a felt need to educate parents on how to talk to and advise their children. It was deemed necessary to teach parents on how to discuss SRH issues with their children, in order to break communication barriers.

"We should find a way of targeting the parents to educate them so that they can educate their youths” (FGD-Girls, Nairobi, service users).
5.1.3 Perceptions of existing SRH services by young people

5.1.3.1 What type of health care do young people access?

Young people from all study sites report that they seek health care when in need of the following health services: contraception, pregnancy-related services, abortion services, STI and HIV-related services, post-rape care, SRH information, counselling on sexuality, general counselling and general health care as illustrated in Figure 18.

Figure 18: Health care services young people access

Pregnancy-related services: Both boys and girls from all the study sites stated that young people seek health care when in need of pregnancy-related services, such as pregnancy testing, ANC and skilled care during childbirth. Young people sought health services if there was suspicion that they could be pregnant and wanted a pregnancy test.

“If you had sex [unprotected] and want to know if your girlfriend is pregnant, you can go to the hospital and get tested” (FGD-Boys, Nairobi, non-service users)

“.........maybe you are also just scared that you are pregnant so you can go and be tested, you can go to the hospital for testing”, (FGD-Girls, Nairobi, service user).

“Like if a girls is pregnant, they can go to the clinic”, (IDI-14-yr old, boy, Laikipia, non-service user)
Among girls who were seeking ante-natal care (ANC) services, they indicated that one could go to the hospital during pregnancy to check the baby, for the treatment of any pregnancy complication and testing of HIV

“.....because when you are pregnant you do not know how it is inside your tummy maybe you have a lot of problems. There are some drugs you are given at least you become okay. And you could be having problems which you cannot tell by yourself”, (FGD-Girls, Nairobi, service users)

**Abortion-related services:** A few girls and boys from Nairobi and the districts reported that young girls seek abortion services especially when the pregnancy is unwanted and they are still in school.

“Because sometimes the parent, her child has gone into form one [secondary education], and she doesn’t want people to talk, or she does not want to be called a grandmother. She knows she will be ashamed since people will start talking, so and so’s child is pregnant and she has just enrolled into form one, and maybe she has really struggled to get the school fees, shopping, so that the child can go to school. So she sees its better she takes the girls to those clinics, she gets an abortion and then goes back to school”, (FGD Girls Nairobi, non-service users).

Abortion services were sought from private clinics, although it was reported that some girls would initially attempt to induce an abortion on their own and then go to a health facility if they developed complications.

“For me, I can say for instance you have had an abortion and you have complications so you seek health care, because if you have a complication you will fear to stay at home, so then they seek health care” (FGD Girls, Kirinyaga, mixed service users)

**STI services:** Treatment of STIs was commonly mentioned by both boys and girls in all study sites as a reason why youth sought health care. Examples of STIs mentioned were gonorrhoea and syphilis. The majority of both boys and girls reported that STIs were examples of illness where a young person had no choice but to seek health care. STIs therefore forced young people to go for health care, but this was only done as a last resort because of the pain experienced.

Boys from the districts reported that the majority of young people sought health care for treatment of STIs only when the illness was in its advanced stages, after trying herbal treatment and/or self medication and when not getting better. They also gave an indication that some health care providers, who were of their own age, also brought for them medication secretly.
“When it is in its advanced stages, after long suffering one cannot even allow the parent to know, he will only share with his peers. Even some doctors who are our age, they can even bring for you [medication] on the side, secretly” (FGD Boys Kirinyaga, mixed service users)

“If you are infected with STI, you will have to go to the hospital for treatment” (IDI-19 year old girl, service user)

**HIV related services:** Boys and girls from all study sites mentioned HIV-related services such as Voluntary Counselling and Testing (VCT) as reasons that made young people seek health services. Going for VCT services was often referred to as “being tested” “knowing one’s status”, “knowing if one is infected” or “having it”. Most young people sought these services when they had a sense of “suspicion” or “doubt” within themselves, did not “trust” their partners, or were showing “signs and symptoms” of opportunistic infections such as prolonged cough. The suspicion came about if one was having many sexual partners, commonly referred to in the discussions as “walking badly” or “not walking right”.

FGD with boys from Nairobi also indicated that young people influenced each other positively into seeking VCT services, especially where their friends had also been “tested”. Some even opted to go for VCT in a group.

“All you find that friends in the community really influence each other in so many ways different ways, they will convince each other and say let us all go for VCT together, so you will find some will go and some will not because of fear”. (FGD Boys, Nairobi, service users)

Other reasons given for seeking VCT services, mentioned by both boys and girls in Nairobi, were the desire to have a healthy boy-girl relationship, if one had previously had many sexual partners and wanted to change the sexual behaviour, as a requirement for a job interview or college admission.

Girls also reported that they came for HIV related services while pregnant because it was a necessity.

“I have come to know my status of HIV because I have never been tested...yes I may get scared because I have never been tested but I have confidence that if I am tested, I will be negative, because I am pregnant I have to be visiting the clinic also, because I am pregnant I have to know”, (IDI-20 year old girl, Nairobi, service user).
Sexual violence: the majority of young people also mentioned the fact that young people seek health care when in need of treatment after being assaulted sexually. This occurred to both young men and young women.

Counselling and SRH information: The need for counselling and getting SRH information was mentioned as a reason why youth sought health care by the majority of girls and boys from all study sites. In most cases counselling was often linked to VCT. A few girls and boys in Nairobi and the districts mentioned that young people went for counselling services in relation to physical body changes occurring during puberty, such as painful breasts, development of facial acne, and menstrual problems (irregular and painful menses).

“Like when you have your periods, sometimes you experience a lot of pain (cramps), you may wonder what is up with you and then you end up seeking healthcare” (FGD girls, Kirinyaga, mixed service users).

In the IDIs a few boys from the districts also reported that young people may visit the youth centre for counselling, especially if they had communication problems with their parents and guardians, and in relation to drug and substance abuse.

5.1.3.2 Sources of SRH services

Young people were asked to identify sources of SRH health advice and care. The majority of girls and boys from all study sites stated that they sought health care or health advice from the following sources: friends and relatives, public and private health facilities such as dispensaries, clinics, youth centres and VCT centres. Girls and boys from Nairobi also mentioned traditional herbalists and going to church elders for counselling.

Friends and relatives: friends were reported to be the first help and advice contact young people had in case of a SRH problem. Relatives such as older siblings, aunties and uncles were also mentioned. Parents were said to be informed last and only if the situation got worse. While some friends were said to motivate and encourage young people to seek health services, others encouraged them to self-medicate.

“another one will tell you it is normal for girls to have discharge, just wait it will be over, some tell you it will clear; so by the time you go to the hospital 2 months down the line it will be worse” (FGD girls Nairobi, service users).

In the IDIs, the majority of boys in all study sites stated that on noticing that they had an SRH problem, most young people would initially keep to themselves but eventually informed their friends and if possible their parents or go to the health facility for treatment. In contrast,
younger adolescents (12-14 years) mostly mentioned informing their parents, siblings and teachers if they had an SRH problem, who would then accompany them to the health facility.

“First of all they keep quiet and then when the problem keeps persistent they go to hospital and tell the service providers”, (IDI-18 year old boy, Kirinyaga, non-service user)

“Because some are not free with their parents they just stay with it, and it becomes such a burning issue for a long time..... if they have people they are close to and they can trust them who can advice them accordingly they tell them” (IDI-14 year old girl, Meru, service user)

“...first if you have a mother you tell them........school children tell their teachers...” (IDI-14 year old girl, Laikipia, service users)

Public and private health facilities: Boys and girls from all study sites indentified both public and private health facilities as sources of health care. Public health facilities were preferred because they were cheaper and affordable. The majority of girls from Nairobi reported that they would seek health care from a government facility that was near them, since they were cheaper.

“Private [hospital] will be difficult for example if you don’t have money if your pocket cannot measure up............you will just go to the government hospitals since they are cheap” (FGD Girls, Nairobi, service users)

On the other hand, boys reported that they sought health care from private facilities if it was a personal issue like treatment of STIs, because they were served faster and were not asked may questions.

Traditional / Herbal: A few boys and girls from Nairobi reported that young people seek traditional or herbal treatment, especially if they wanted to have an abortion for unwanted pregnancy. This was because services were cheaper, they did not want their parents to know, or they were referred by friends who had received similar treatment.

A minority view of boys from Nairobi was that if young people were unwell, they took herbal medication first and only went to seek medical advice if they did not get better.

“..........so he [young person] will say let me hold on a bit while taking herbal, or if it gets worse he tries somewhere else, so when it gets too much he can now go to hospital” (FGD-Boys, Nairobi, mixed service users).

In contrast, among girls from Nairobi, a minority indicated that they would seek health care from the hospital first and if they did not get better, go for herbal medication. Other services
young people mentioned that could be obtained from herbalists include traditional FP, treatment of STIs, immunity boosters and blood purifiers. Some girls also sought childbirth services from traditional birth attendants.

5.1.3.3 Young people’s views about the available SRH services

This study explored opinions and views young people had towards existing SRH services. The findings are presented to reflect whether expressed views and experiences were positive or negative and also to reflect views of girls and boys from integrated facilities or youth centres (Table 28).

5.1.3.4 Positive views and experiences of SRH services

Positive views are presented to show views about services provided within, a) integrated facilities and b) youth centres.

A) Integrated services

Within integrated facilities, young people’s description of positive views of available SRH services is presented in three thematic areas: characterisation of good services, cost of services and the general services improvement.

Characterisation of good services

In Nairobi girls who were pregnant and were visiting health centres for ANC services or contraceptives, reported that the services they received were good and helpful. This perception came about because of the way girls said they interacted with health service providers (HSP) and the type of treatment they received at the facility.

Majority of pregnant girls from health centres in Nairobi stated that HSP were cordial, friendly, welcoming and helpful. The girls said that they tended to develop trust between themselves and HSP after initial interaction. They felt that HSP were giving them proper advice especially during pregnancy such as proper examination, giving them information on the health of the unborn child, advice on baby care, nutrition and treatment of ailments during pregnancy. These services were said to be important in helping girls prepare for childbirth, although there were concerns about being referred for laboratory tests in other health facilities; they wished to have all the services at the same facility.

“These services help you know where you are heading to, maybe you got pregnant and you did not know when you will give birth, so they will tell you such that when it
reaches that time it finds you ready financially and psychologically”  (FGD girls, Nairobi, service users)

“They treat people well. Like if you are pregnant they give you advice where you do not understand”, (FGD-Girls, Nairobi, service users)

“They [friends] told me it is a good clinic; they do take good care of people. I am visiting for the first time and I have seen it, they treated me well, they do not talk to you rudely, they are not being rude..........it is a good clinic, it is clean, they give you medication.”  (IDI-20 year old girl, Nairobi, service user)

“...I have heard so much from my mother because she used to come here......she told me this is good clinic because she used to visit it, so she told me to visit here because they are good in taking care of people”, (IDI-20 year old girl, Nairobi, service user)

Boys also said that services available at the health centres in Nairobi were serving the health problems of women and children well.

*If we talk about services here [health centres in Nairobi], mostly we will not talk about youths, we will mostly talk about mothers......we can say the services here are smart.......on the side of mothers, the services are perfect....*”  (FGD boys, Nairobi, mixed service users).

**Cost of services**

Services in health centres in Nairobi were said to be affordable. The majority of girls and boys said that services at health centres were affordable and there was a waiver system for clients who were unable to pay.

“This place is really good they help us a lot but private do not help that much...[health centres] are far much better than private where they charge you [a lot of ] money and then they do not assist you much”  (FGD Girls, Nairobi, service users)

Some of the girls reported that they had been referred to the facility by their friends and family because the services offered at the facility were cheaper and good

“They [friends] say it is good, because even me I never used to come, but I was told how this place is then I started coming.......this clinic is not expensive and when she [a friend] had problems with money came she here found it to be cheap and that helped her”  (IDI-20 year old girl, Nairobi service user)
General Service improvement:

The majority of boys from health centres in Nairobi noted that there had been noticeable service improvement in most public health facilities, within the previous three years, which included facility renovation, HSP approach and relationship with clients. Public health facilities were said to also have qualified staff in place, unlike private health facilities available in the slum areas.

“What I can say about the services of this clinic for the last 3 years, there has been an improvement; its services have been of good quality. Because earlier on even coming to a city council clinic [health centre] was very difficult. First of all the way the nurse would treat you, you would not like even to go in there, you are sick and here you are being harassed but nowadays they have really improved” (FGD Boys, Nairobi, mixed service users)

Similar sentiments were expressed by boys from the districts,

“Nowadays I can say at least the government has done a lot, at least it has facilitated some trainings maybe to teach these people on ----if you go to the [district] hospital right now, you will find that it has changed a lot, according to the way even the service providers are talking to clients and handling the clients, it’s not like those 1990’s, you find that at least nowadays they are handling them well” (FGD Boys, Meru, mixed service users).

B) Youth centres

The majority of girls and boys from around the youth centres gave a variety of views and opinions, regarding their perceptions of the available SRH services. They outlined both health and non-health benefits, although most of the perceived and reported benefits were non-health related. Young people expressed such benefits in terms of what they had personally gained from their participation in activities at the youth centres.

Health benefits

The majority of girls and boys reported that young people were appreciative of the youth centre because it offered a wide range of health services. Youth centres were described as “good”, “friendly”, “open”, “useful” “helpful” and had HSP who were young, friendly, easy to talk to and understanding.

“I think it is a good place for us to go because it is not like the other place [general VCT]...where most people go but this one [youth centre] is for the youths only and some
of the staff working there are youths like them, and they understand what they go through, so it is easier working with them”, (IDI-14 year old girl, Meru, service user)

“They [services] are important because they can give you advice and if you abide you benefit, like the ones for diseases if you abide you will prevent them”, (IDI-14yr old girl, Laikipia, non-service user)

“It [youth centre] helps because they encourage them [young people] to go for more condoms if one requires and then they encourage people mostly the youths to go to the VCT......... there was this girl she was healthy you could not tell she was HIV positive, but when she went to the VCT and got tested she was found to have the virus, she came and wrote a letter to everybody she had associated [had sex] with telling them she was infected and after that she decided to commit suicide. Luckily she was found by a counsellor who went and counselled her and she decided that she was not going to kill herself but she will use ARVS”, (IDI-18 year old girl, Kirinyaga, service user)

Boys and girls from youth centres indicated that young people received free SRH services such as treatment of STIs, VCT, health information and advice on prevention of HIV and pregnancy, and education on condom use. Youth centres also provided a good environment where privacy was respected and there was friendliness among staff.

“The advantage of the clinic [youth centre] is it’s rare to get a girl who comes here because of a headache, it is always about STIs.......something to do with reproductive health.....maybe fungal, bacterial and she will get help here, so that has really helped a lot” (FGD Girls, Nairobi, service users).

In Laikipia boys indicated that services offered at the youth centre were good, because they felt the facility provided a wide range of services. The counselling services were good, especially in situations where parents were not able to inform their children about RH matters.

“They provide everything, I can go there to play, to watch movies, I can be guided, I can be tested [VCT]”, (IDI-14 year old boy, Laikipia, service user)

It is worth noting that three young adolescents (12-14yrs) who took part in the IDIs at the districts had not visited the youth centre because they were in school and did not have free time to visit the youth centres. They were therefore unable to give any personal experiences with regards to the SRH services provided. However they indicated that they had heard from their friends that the youth centre was a good place because HSP gave advice to young people on how to plan for their future lives, prevent HIV, early pregnancies and early marriages.
Non-health benefits of youth centres

The majority of girls and boys from youth centres identified the following as non-health benefits they received from these centres:

- **Prevention of idleness** – the youth centres prevented idleness, especially for out-of-school young people. Activities at the centres which young people could engage in included drama, peer education and participating in outreach activities to schools and the community. The centres also had resource rooms, or libraries, where young people could access SRH information in the form of magazines, booklets, videos or DVDs. Specific to the Nairobi youth centre this included internet access, games like pool and a gymnasium.

- **Step-wise use of SRH services** - girls from Nairobi youth centre reported that the above resources at the youth centre provided an opportunity for young people to use services in a step-wise manner. Young people could come to the facility, play games or be involved in other activities and then eventually end up going for a service.

  “Like within the centre, there are small boys down there, before they used only to come to the pool area, the next round they reach the TV room, and nowadays they are up here [next to the clinic]” (FGD-Girls, Nairobi, service users)

- **A confidence builder and information gap-bridge** – activities at the youth centres were linked to building young people’s confidence in terms of improving their moral values, self-esteem, communication skills and general interpersonal interaction with peers and members of society. Youth centres were said to provide an opportunity where young people could learn about SRH information and other types of health information not learnt in school.

  “To me, what I can say is the youth centre has really helped me because when I left school I could barely talk in front of people but you see the things I have encountered in this youth center, I have at least learned to stand up and talk in front of people. I have known what I did not know when I come from school, as in how to speak myself how to take care of my own body, what I can do so that I can keep away from negative things I always stay positive. How I can face the challenges in life, the centre has really helped me” (IDI-19 year old girl, Nairobi, service user)

- **Vocational training and career progression** – The Nairobi youth centre provides an opportunity where young people can undergo vocational training to enable them to acquire skills such as computer training, use of the internet (at a minimum fee) and writing CVs. The youth centre also provides a chance for young people to make applications to colleges or universities and identify and develop in their careers. One girl reported that she joined
Nairobi youth centre through drama and has since progressed to become a peer educator. She was now thinking of becoming a professional counsellor.

"Most of them appreciate it [youth centre] because it builds their moral values, some of them, others they use it as a stepping stone so that they can have a brighter future. So most of them say it is a good facility in our area where the youth can access services, can use it as a stepping stone to access other information...." (IDI-19 year old boy, Nairobi, service user)

**Outreach activities:** the majority of boys and girls from Nairobi and Meru youth centres indicated that the facility organised educative outreach activities to schools and the community through drama and art. Provision of mobile VCT and contraceptives services were also included in the community outreaches. Meru youth centre was said to host students from neighbouring secondary schools, who come to learn more about the youth centre and receive counselling by youth peer educators on matters regarding career guidance, life skills and other aspects of RH upon request.

“.....some schools every term, or even twice a month, they have to make a bunch of their students to come there because it has really assisted a lot, maybe when it comes to career guidance and also in-terms of life skills and according to the peer educators who are there..... (FGD-Boys, Meru, mixed service users)

**5.1.3.5 Negative views about and experiences of SRH services**

Likewise young people’s negative views are presented to shows experiences of boys and girls with a) integrated services or b) youth centres.

**A) Integrated services**

Both boys and girls mentioned the following as some of the negative experiences they had within integrated services: negative HSP attitude, concerns over provider gender, long waiting time, lack of essential drugs and corruption in public health facilities. In addition boys mentioned the following: uncomfortable health seeking environment, lack of awareness of available services, YFS service unavailability at the facility, lack of anonymity and privacy, lack of SRH educative information, lack of proper directions to service delivery areas and lack of honesty among young people.
Negative health service provider attitude

Majority of boys and girls from all study sites indicated that HSP had great influence on their perceptions of available SRH services. The majority of girls from health centres in Nairobi described how simple things mattered to them such as: how they were being asked their names, simple greetings, HSP facial expressions, how HSP received them and allowed them to express themselves and explain their problem, and the response received from health service providers.

Some HSPs especially females, were described by both girls and boys as being abusive, harsh, disrespectful, sluggish and not keen on their work. Young people also said that they were “shouted at” also by the support staff without any compassion to the extent that they felt degraded.

“Sometimes you can find someone is really sick and she is lying on a seat you find one is shouting at you because she wants to clean, “wake up and take your illness far way”

(FGD Girls, Nairobi, service users)

Long waiting times

The majority of boys and girls from Nairobi and Kirinyaga were concerned about long queues that were present at the facilities. Boys from Nairobi indicated that most of them were impatient and needed to be treated quickly when they went to a health facility, without being lectured or tossed from one department to another. Long queues were said to lead to long waiting times and made clients spend a lot of time at the health facilities. Because of the long queues, most boys gave up waiting for services and preferred going to private health facilities.

“So you find that the majority of the people around prefer to go to a private hospital instead of coming here because of the line, also they see that a private doctor will treat you better than the one who is here, so you find most people go to private clinic instead of coming here”, (FGD Boys, Nairobi, service users).

Most boys from Nairobi and the districts also stated that it was difficult for them to give their views about available SRH because they did not frequent health facilities. However they mentioned long queues as a negative experience. One boy reported seeking services at the facility but going away without treatment because of the long queues. The boys indicated that in spite of the services being cheap, the long waiting time scared them away.

Lack of essential drugs

Lack of medication especially in government facilities was reported as one of the negative experiences young people had when they visited public health facilities. The majority of girls
from health centres in Nairobi reported that government facilities lacked drugs and clients were then asked to buy these themselves. The only drugs that seemed to be available were painkillers. Nairobi health centres only had in stock drugs which young people regarded as cheap and ineffective.

“There are drugs that are to assist someone are the ones you will be written for and asked to buy, but those like painkillers, they give you. But the most important ones for the body [one has to buy],” (FGD Girls, Nairobi, service users).

In another FGD with girls in Nairobi, they gave an example which showed that if two people went to a health centre with different kind of illness, they would be given the same type of medication

“…..but there you are given the same medicine, you find that if you have a cold and the other one has malaria, you will be given the same medication” (FGD Girls, Nairobi, non-service users)

Corruption in public health facilities

Corruption in public health facilities was mentioned by a minority of boys and girls in health centres in Nairobi and the district. Corruption stemmed from the way client flow was handled by the support staff with HSPs giving favours to clients they were acquainted with.

“……there is a day I came here and I differed with another lady, because with her, she is a worker here and the doctor is inside waiting for the names of patients and she has the books, so her work is I don’t know whether she is given 20 shillings or what, she passes with cards for people she knows and takes them to the doctors place, you see someone who came after you, you hear them being called, and that is bad” (FGD Girls, Nairobi, service users).

Uncomfortable health seeking environment

The majority of boys from integrated facilities outlined concerns they had about the general facility layout. They indicated that the facility layout, including the waiting area, seemed to have been designed for women and children. The majority of boys stated that they did not feel comfortable sitting in the waiting area, “between women”. However the boys indicated that services at the facilities were perfect with regards to women and children; but when it came to youth (especially boys), they had been neglected by the system. The boys also felt that integrated facilities did not have youth-specific services, or even a youth specific room where they could have meetings or discussions.
“Mostly these ones for the government [health centres] us we know they are for mothers, so you know many youths do not come here, mostly we know it is for mothers who are expectant, they have come to give birth, so mostly we normally do not know if youths come here. So you find many youths go to private because you know if this is only the government hospital that is in this slum and you know it serves mothers alone, so if you come here and you are a youth, you don’t seem like you have come to be treated. You look like you have come to see your wife or somebody else” (FGD-Boys, Nairobi, mixed service users)

“….it’s like this waiting area if I go and sit there, they [women clients] will look at me wondering, so I will just leave”, (FGD Boys, Nairobi, mixed service users).

B) Youth centres

Young people’s negative views on youth centres were described in two thematic areas, lack of clinical staff at the youth centres and concerns related to games at the health facilities.

Lack of clinical staff

The majority of girls from Nairobi youth centre expressed dissatisfaction with the lack of a full time clinician at the youth centre. The girls said that the youth centre had a part-time nurse, who was available only three afternoons a week. This was seen as a major problem for young people especially if one had a problem on the days the nurse was not available,

“I believe STIs if you want a nurse whom you want to talk to, but I think most of the time she is not available, she comes thrice in a week, so if you get a problem on the day she is not here, there is a problem” (FGD Girls, Nairobi, service users).

Unavailability of clinical services on a full-time basis was said to have a negative effect on community awareness and outreach activities. Girls from Nairobi youth centre expressed fears that lack of a clinician at the facility on a daily basis resulted in missed opportunities. A young person visiting the clinic on the day the clinician was unavailable missed advice or treatment all together. Advertisements and information given to young people in the community, encouraging them to come to the youth centre for SRH services were therefore seen to be “fake”.

“---no I feel there should be a nurse here throughout, if I come on Monday, and then we talk, we advertise this place, and say here at the youth centre there is a nurse and then they come here on Monday and miss them, it’s kind of fake ----- so a nurse or doctor being here throughout can help” (FGD Girls, Nairobi, service users).
Games at the facilities

There were conflicting views about the importance of games particularly snooker or “pool” within youth centres. While games were said to prevent idleness, games such as pool could turn a facility into a meeting base for particular groups of boys. There were concerns, from girls at Nairobi youth centre, that games such as pool only attracted boys and even made girls shy away from coming to the centre. Similar statements were expressed by boys from Nairobi health centres, who stated that games may hinder access to services by young people especially if they were not well located within the facility, like being placed at the entrance.

*It depends, you see like Eastleigh, [Nairobi youth centre] there is a pool table; it has been made into a base for youths to pass time. So if you come from somewhere and go there, you will just find your friends, if you decide to go and see a provider, they will be waiting to ask you what had you gone to do? So that thing [pool table] requires to be put right behind and these other service in front, so that if you go in for consultation, if you come out, you go your way”* (FGD-Boys, Nairobi, mixed service users).

The negative aspects of games did not come up from discussions and interviews with young people from the districts.

**Table 28: Young people's views and experiences of available SRH services**

<table>
<thead>
<tr>
<th>Facility type</th>
<th>Gender</th>
<th>Positive views and experiences of SRH services</th>
<th>Negative views and experiences of SRH services</th>
</tr>
</thead>
</table>
| Integrated facilities | Girls | • Characterisation of good services  
• Positive health service providers (HSP) attitude or approach  
• Cost of services | • Health service provider attitude  
• Provider gender  
• Long waiting time- long queues  
• Lack of essential drugs  
• Corruption in health facilities  
• Boys feel uncomfortable sitting between women |
| | Boys | • Organisation of services- services perfect for women and children  
• Health provider attitude is positive  
• Cost of services- affordable, waiver system available  
• General service improvement (improved HSP attitude, facility renovation, facility is clean, qualified HSP  
• Facility location- walking distance | • Negative HSP attitude  
• Uncomfortable health seeking environment  
• Lack of awareness of available services  
• YFS service unavailability  
• Youth-related resources not available such as library, games  
• Provider’s gender  
• Long waiting time  
• Corruption in public health facilities:  
• Lack of proper directions to facility and service areas  
• Lack of honesty and openness among young people  
• Games – may be made into a meeting base for certain boys |
<table>
<thead>
<tr>
<th>Facility type</th>
<th>Gender</th>
<th>Positive views and experiences of SRH services</th>
<th>Negative views and experiences of SRH services</th>
</tr>
</thead>
</table>
| Youth centres | Girls  | ▪ Good services- youth-only services:  
▪ Health service providers – are younger  
▪ Non-health benefits of participation in YC activities – personal gains, self development, career progression  
▪ Youth centre attractiveness- youth activities, games, step-wise use of services  
▪ Parental support | ▪ Lack of full-time clinical staff  
▪ Available SRH services not provided on a full-time basis  
▪ Occasional lack of supplies such as drugs  
▪ Young people not aware of services offered at YC  
▪ Negative community perceptions on condoms  
▪ Community unaware of available SRH services |
|              | Boys   | ▪ Health benefits  
▪ Wide range of services available: VCT, treatment of STIs, contraception, counselling, games, educational films watching movies  
▪ Health provider attitude- positive  
▪ Youth centre attractiveness and non-health benefits of the YC  
▪ Outreaches to schools and community  
▪ Mobile VCT and contraceptive services:  
▪ Integration of mobile services into other community activities such as sporting activities | ▪ Limited hours of operation for public facilities  
▪ Inaccessibility – with regards to public transportation  
▪ Lack of essential supplies  
▪ Lack of awareness of available services at YC by young people  
▪ Poor system of getting updated SRH information |

5.1.4 Barriers to seeking SRH services by young people

Both girls and boys were asked to state reasons that hindered them from accessing SRH services. The reasons given were reflective of negative views and experiences young people have with regards to available SRH services, some of which have been presented in section 5.1.3.5. Figure 19 shows a diagrammatic representation of young people’s responses segregated by facility type, integrated facilities and youth-only facilities.

Reasons given by young people, as to why they do not seek health care, are similar for young people from both integrated services and youth centres and among boys and girls. These views are presented in three broad thematic areas: concerns about health service providers (HSP), concerns about service delivery and concerns among young people themselves.

5.1.4.1 Health service providers’ concerns

The majority of young people, from all study sites, indicated that some of the hindrances they faced in accessing health services were related to the way they were handled by HSP. Most concerns expressed by young people were linked to integrated facilities. Girls from Nairobi health centres reported that HSP sometimes gave advice that was scary and which discouraged
them from using services like contraception. Young people said they were afraid of HSP because of being asked personal and judgemental questions such as “who send you to go have sex and when you get a disease then you come here seeking treatment” (FGD girls, Nairobi, service users), or “don’t you know CDs [condoms] are there?..” (FGD boys, Nairobi, mixed service users). Young people also dreaded receiving a hostile reception from HSPs (including support staff), meeting HSP who were elderly and similar to their parents’ age, as well as those not familiar with their language.

“...we fear old people especially those health personnel, we fear how we can go because maybe they are elderly and the same way I consider my father it’s the same way I will consider those working in those health facilities” (FGD boys, Kirinyaga, mixed service users)

HSP concerns were also linked to their availability at the facility. Girls from Nairobi youth centre were concerned about not having a full-time clinician at the facility. The youth centre had a nurse who worked part-time, three afternoons a week and so young people who came on days the clinician was not on duty got discouraged, were not willing to come back and even informed their friends not to come to the centre. Boys from Meru also stated that young people failed to come to the youth centre if they did not get along, on a personal level, with staff who worked at the facility.

Within Nairobi there was a minority view regarding HSP gender among both boys and girls. Boys stated if they found a female provider and they had “a male problem”, they may not open up and therefore lie to the HSP. On the contrary girls stated that they would prefer to be attended to by male HSP because they believed they were more keen, friendlier and kind.

“If you are a lady and you go and find a gentleman he will attend to you but if you find the women [lady nurses] they do not have respect” (FGD-Girls, Nairobi, non-service users).

5.1.4.2 Concerns about service delivery

An uncomfortable health seeking environment and long waiting time were some of the service delivery concerns that were raised, by the majority of boys and girls, around integrated facilities. Details of the above have already been presented in section 5.1.3.5. Other service delivery concerns that were raised included: service un-availability and lack of proper directions to service areas

Lack of proper directions to service delivery areas was a minority view that was expressed by boys from integrated facilities in Kirinyaga and Nairobi. They boys stated that they felt uneasy
asking staff or other clients’ directions to specific service areas and would prefer if there were signs to show the location of specific service areas.

5.1.4.3 Young people’s concerns about available SRH services

The majority of boys and girls, from all study sites, expressed the following as some of the reasons for not seek health care: fear and HIV status assumptions, lack of anonymity, lack of awareness of available services, negative peer influence and societal expectations and responsibilities. With regards to youth centres, negative peer influence, lack of time to visit the youth centre and transport costs also prevented young people from visiting the youth centres.

The majority of young people from all study sites indicated that fear was the main reason why young people failed to seek health care. Fear of knowing their HIV status (“the big disease”), the stigma associated with HIV, fear of being embarrassed by being asked personal and private questions, and fear of being seen going to a health facility, youth centre or VCT clinic.

Girls and boys from Nairobi youth centre reported that young people feared coming to the centre because they believed they would be tested for HIV. They feared being tested for HIV because they believed that if they were found to be HIV positive, they would die soon and be despised or isolated by their friends.

“Some think when they come here [Nairobi youth centre] the only thing they are going to be tested for is HIV/AIDS ........and if they are found to have it what will happen? So they even fear entering past the entrance; because out there, there is a sign post written VCT”, (Girls FGD, Nairobi, service users)

“what I see the thing that is very hard for youth to go for is VCT, you will find it is hard to go, you find that even going there is a long step, he cannot go, he sees as if he is climbing a mountain” (IDI-18 year old boy, Nairobi, service users)

Similar sentiments were expressed by boys from Meru who admitted not ever visiting the youth centre,

“-----services as VCT, and most of them they are afraid of that, that is one thing which is making them not to go there, even I myself I fear that, I have never gone there, I would like to go but there is something which is making me afraid and that is the thing which applies to the others-------- “, (FGD Boys, Meru, mixed service users)

“They are afraid of knowing if they have HIV, others if they know they can kill themselves, things like that”, (IDI-14 year old boy, Meru, service user)
Young people making assumptions that their sexual partners were HIV negative, after being in a relationship for a few months, was raised by both girls and boys from both from Nairobi and the districts. This made them not to undergo HIV counselling and testing before having unprotected sex.

Young people’s fears were also specifically related to the inability of the services to be anonymous. Boys from Nairobi youth centre stated that youth feared going to open places where they felt “everyone was watching them” and from Nairobi health centres, boys and girls reported that they feared meeting their relatives and neighbours at the facilities. This made them go to look for services from far places where no one knew them.

“Sometimes some prefer to go and be attended by strangers and not people from round who knows them” (FGD girls, Nairobi, service user)

Lack of awareness of available services was expressed by girls and boys from integrated facilities and youth centres. Both girls and boys from Nairobi reported that they were not aware of the services available to young people at health centres; boys and girls in the districts reported that most young people, within the catchment area, were not aware of the range of activities and services available at the youth centres. Some boys even suggested that they did not know the use of the youth centre.

“Most of them do not know about what is at youth centre ..........you see the youth are....do not know what kind of youth friendly [services] you are targeting to them.......” (FGD-Boys, Meru, mixed service users)

“Maybe it could be an STD, you will shy off because you don’t want them [friends] to know that --- because these diseases you get through immoral behaviours, you find that you will not go because you want to pretend to the community that you are good, so you shy off from going there” (FGD-Girls, Kirinyaga, mixed users).

Girls also indicated that they may not visit the health facility because of the household duties they have,

“Maybe girls are busy, boys are free because when your mother leaves you she tells you when I come back I want to find you have finished this work, so you will prefer to stay at home and do the work”, (FGD-Girls, Nairobi, non-service users)

“Girls are left with a lot of work in the house”, (FGD-Girls, Nairobi, service users)
Lack of time to visit the facility was mentioned by younger adolescents (12-14) who were in school, while transport costs were a hindrance to young people who lived in rural areas.

“Maybe some their homes are far from the clinic......some don't have transport,” (IDI-14 year old girl, Laikipia, non-service user)

“Lack of knowledge of the services provided; some can just come and if they are not helped, they just leave,” (IDI-23 year old girl, Meru, service user)

Negative peer influence discouraged young people from accessing SRH services. This occurred when young people, who had previous negative experience about a particular facility or service, discouraged their peers from accessing the same. Social expectations, such as house duties assigned to girls and parental restrictions, prevented girls from visiting the facilities. Wanting to “pretend to the community that you are good [not sexually active]” also made young people not come to the facility.

“Maybe it could be an STD, you will shy off because you don’t want people to know that --- because these diseases you get through immoral behaviours, you find that you will not go, so you shy off from going there” (FGD-Girls, Kirinyaga, mixed service users).
Figure 19: Young people's reasons for not seeking health services

Views of young people from integrated facilities

Health provider concerns
- Advice may be scary and discouraging
- Poor provider approach and being judgemental
- Limited Knowledge of HSP
- Language barrier
- Prefer same gender provider (boys)
- Age of provider
- Favouritism to clients they know

Service delivery related concerns
- Uncomfortable health seeking environment
- Long waiting time
- YFS service unavailability
- Lack of proper directions
- Games – may be made into a base for some boys
- Lack of appropriate or effective drugs

Young people related concerns
- Fears – knowing HIV status, being seen going to facility/VCT or YC
- Assumptions: Assumes that partner is HIV negative
- Lack of openness and honesty among youths
- Lack of awareness of available services
- Societal expectations and responsibilities
  - Parental restriction on girls
  - Girls having a lot of housework

Views of young people from youth centres

Health provider concerns
- Lack of full-time clinician - Part-time hrs are inconvenient (NYC)
- Young people may not get along with staff working at YC

Service delivery concerns
- Service unavailability- lack of full-time clinician - part-time hrs are inconvenient (Nairobi YC)
- Absence of proper direction
- Games - May only attract boys: make girls shy away: may be a hindrance if not well located

Young people's concerns
- Fears - embarrassment, knowing HIV status
- Lack of anonymity - being seen going to the health facility; facility location
- Lack of awareness of available services
- Negative peer influence: preferring advice from peers: being discouraged by peers with negative experience: ‘know it all’ attitude
- Lack of time to visit youth centre. Young people are students or working
- Lack of transport and distance of service from community
5.1.5 Suggestions from young people on how to improve services

Young people made several suggestions on how SRH services could be improved. As shown in Table 29, majority of boys and girls mentioned: increase of SRH service availability, improving HSP attitude, creating awareness available SRH services and having educational materials on site as some of the ways of improving access to SRH services by young people.

Other suggestions that were raised specific to the Nairobi youth centre included having a full-time clinician available and a request that the Ministry of Health (MOH) take on the responsibility of addressing the SRH problems of young people, on a national scale, including financing peer education initiatives and activities.

Increase of SRH service availability

The majority of girls and boys from all study sites mentioned setting up more service delivery areas, as a way of increasing access to SRH services. Setting up more youth centres was mentioned by young people from both Nairobi and the districts. Setting up more services in the rural areas was mentioned by boys from the districts, including using mobile clinics to reach young people who were in the most remote areas.

To ensure anonymity, the need for service integration was mentioned by boys and girls from integrated facilities. They indicated that the room where STIs and VCT services were offered should have many more services.

“The services should include many so that it is not for STI or HIV, they should also include things like malaria so that people do not know what one is going for” (FGD Boys, Nairobi, mixed service users).

Improving HSP attitude

The majority of boys and girls from all study sites indicated that they would like to be attended to by HSP who were respectful, patient, friendly, understanding, much younger and kept consultations confidential.

“The services you provide are the ones that will make one come here.....if you serve us in a bad way we shall not come and we will not tell others” (FGD girls, Nairobi, mixed service users).

In the IDIs, one boy from the districts emphasized the need for having HSPs who were patient, friendlier and more informed about adolescent sexuality, so as to respond to young people’s questions appropriately.
“..They [young people] should be given time to chart for instance if someone goes to the health provider, the provider should give him/her time to express themselves”, (IDI-18 year old girl, Kirinyaga, non-service user).

**Increasing awareness creation of SRH services**

Most girls and boys from all study sites suggested increasing awareness among other young people, of the availability and importance of available SRH services. This could be done through outreach activities in the community, schools and churches. Use of radio, posters, magazines, sporting activities and entertainment fun-activities were also mentioned as some of the channels through which young people could be reached. It was said to be important to reach out to the youths instead of only expecting them to come to the health facilities.

“outreaches is what will help them because most of them do not know about what is at the youth centre……..the youth do not know what kind of youth friendly [services] are available” (FGD Boys, Meru, mixed service users).

Boys from the districts also mentioned the need to inform parents about the available services, so that they could allow their children to visit the youth centres.

The majority of boys from all facilities were particularly concerned about involvement of other young people in awareness creation. They likened it to “if you want to catch a thief send a fellow thief” (FGD, Boys, Nairobi). This was because from their experience, if an older female HSP went to talk to young people in the community with regards to asking them to visit the facility for HIV-CT, their advice would often be disregarded.

“You find an old woman [HSP] finds youths sitting somewhere and then she tells them – you go and get tested- they just laugh it off. They tell her, yes we will go, but once she goes away, they say among themselves – leave that mother alone”, (FGD-Boys, Nairobi, mixed service users).

Girls from integrated facilities mentioned use of word-of-mouth, radio advertisements and giving out of brochures to clients as ways of providing information to young people.

“It needs you to advertise in the radio or……..you just give out [brochures] to those who come here. If we go with it, you give it to a friend then he/she can give it to another person”, (FGD girls, Nairobi, mixed service users)
Having educational materials

The majority of girls and boys from all study sites mentioned the need to have up to date educational materials on SRH. The materials could be placed at the facilities, in the library and other places which young people frequent. Similarly, channels of awareness creation could also be used to pass these educational materials, including giving information pamphlets to clients visiting the facility. Boys and girls from Nairobi youth centre, especially those involved in peer education were concerned about having SRH information that was outdated, and hence expressed the need to have a system where educational materials were frequently updated.

Boys from Nairobi reported that they could easily access SRH information from the internet using their mobile phones. However, the discussion on use of internet in accessing SRH information was limited among the girls.

“When you have a phone, you can get it [SRH information].....when you have a phone, you can go to the internet ......” (IDI-18 year old boy, Nairobi, service user)

“Most of the information I do get from, personally the web.....” (20year old boy, Nairobi, service user)

“...from the internet and the magazines because we have a cyber here [at the youth centre] so we always browse, we always get magazines form other NGO’s in terms of IEC materials”, (IDI-21 yr old boy, service user)

One girl from Nairobi reported accessing information in the cybercafé at the youth centre

“when you come here in the library there are a lot of brochures or materials you can read also you can get information from a youth coz we have learned about reproductive health also in our computer you can access the internet”, (IDI-21 year old girl, Nairobi, service user).

Increasing operation hours

Boys from the districts noted that the youth centres were not open during weekends and public holidays when young people had time.

“...we don’t open the centre on Saturdays and you find most of the youths in the community are free on Saturdays, so they depend on the centre but in a way they are blocked from using it......so if it is possible to open throughout from Monday to Monday more youths will access the facility and also get more information”, (IDI-24year old boy, Meru, service user)
Another suggestion made was having services at night, especially mobile VCT services within the town centre, as a way of reaching out to more young people.

Putting mechanisms in place to reduce waiting time, such as having youth-only rooms, having suggestion boxes, proper service directions within the facility and having other resources such as library, games, TV, movies at the facilities were also mentioned as ways of increasing access; although girls from Nairobi noted that games may only attract boys.

One girl from Nairobi youth centre mentioned having girl-talks as a way of attracting girls while a few girls from health centres mentioned having “things to do with beauty” to attract girls.
Table 29: Suggestions from young people on how to increase access to SRH services

<table>
<thead>
<tr>
<th>Gender</th>
<th>Youth Centres</th>
<th>Health centres / or integrated facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls</td>
<td>Increase of SRH service availability&lt;br&gt;• Full-time clinician&lt;br&gt;• Available medication (STI)&lt;br&gt;• Establish more youth centres, especially in rural areas</td>
<td>Increase of SRH service availability&lt;br&gt;• More services to be made available at facility (lab), maternity&lt;br&gt;• Facility to be neat, attractive and well organised</td>
</tr>
<tr>
<td>Girls</td>
<td>Improve HSP attitude&lt;br&gt;• HSP to be more friendly</td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>Create awareness&lt;br&gt;• Sensitize YP on importance of youth centre through fun-activities, radio, posters, music entertainment, churches,&lt;br&gt;• Encourage openness among adolescents&lt;br&gt;• Advertise services through outreaches in community, have girls-talks&lt;br&gt;• Give out educational materials, booklets, magazines&lt;br&gt;• Other resources - have library, games</td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td><strong>Note: Girls not able to give suggestions (12yrs and 14yrs)</strong></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>Increase SRH service availability&lt;br&gt;• Set-up more youth centres&lt;br&gt;• MOH to be involved in addressing SRH of young people, support youth activities, peer education&lt;br&gt;• Set-up more services in rural areas (mobile clinics)&lt;br&gt;• Increase operating hours/ night services (VCT)</td>
<td>Increase SRH service availability&lt;br&gt;• Wide range of services in same room&lt;br&gt;• Have proper service directions&lt;br&gt;• Have youth-only rooms</td>
</tr>
<tr>
<td>Boys</td>
<td>Improve HSP attitude&lt;br&gt;• HSP to be friendly, kind, patient, polite, confidential, not have very elderly staff</td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>Increase awareness creation of SRH services&lt;br&gt;• Create awareness of youth centre – through outreaches, advertising in sporting activities, websites&lt;br&gt;• Have youth talk to other youths about the services available&lt;br&gt;• Take the education to the schools</td>
<td>Increase awareness creation of SRH services&lt;br&gt;• Create awareness of services available, having seminars, free medical campaigns, use of artists&lt;br&gt;• Involve the youth in mobilising other youths / Peer education</td>
</tr>
<tr>
<td>Boys</td>
<td>Youth centre accessibility&lt;br&gt;• Location of youth centre should be accessible, close to public transport</td>
<td>Reduce waiting time&lt;br&gt;Have educational materials&lt;br&gt;• Have educational materials on SRH problems and treatment options&lt;br&gt;Other resources – have library</td>
</tr>
<tr>
<td>Boys</td>
<td>Have educational materials&lt;br&gt;• Update educational materials</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Objective 2: To explore community members perceptions of SRH problems and service provision for young people.

This section presents findings of community members’ perceptions of SRH service provision to young people. It explores their views with regards to the SRH problems of young people and their perceptions of the existing SRH services. The results are presented in four sub-sections. Section 5.2.1 presents views from community members on the SRH problems of young people; section 5.2.2 describes their knowledge regarding availability of SRH services and their perceptions of the services; section 5.2.3 outlines community members’ understanding of barriers young people encounter when seeking SRH services, and lastly, section 5.2.4 lists suggestions, made by community members, on how to improve access to SRH services by young people.

A total of 83 community members (44 males and 39 females) took part in the FGDs (Table 30). Participating community members included church leaders, CHWs, CBDs, retired teachers, members of the provincial administration and small scale business men and women. Some members were unemployed. The duration of each FGD was between 1hr-1hr 45 minutes.

Table 30: Details of community members who took part in community FGDs per study site

<table>
<thead>
<tr>
<th>Identification No of FGD and Gender</th>
<th>No of respondents</th>
<th>Location of FGD</th>
<th>Composition of community members and No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>01 - Females</td>
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<td>9</td>
<td>9</td>
</tr>
<tr>
<td>02 - Males</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>03 - Males</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>04 - Women</td>
<td>-</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>05 - Males</td>
<td>8</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>06 - Mixed</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>07 - Males</td>
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<td>08 - Mixed</td>
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<td>10 - Women</td>
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5.2.1 Community members perceptions on the SRH problems of young people

Community members from all study sites mentioned the following as the major SRH problems young people experienced: early sexual activity, infection with HIV and STIs, early/unwanted pregnancy, abortion, sexual violence, Female Genital Mutilation (FGM) and lack of information on SRH. The underlying factors which were said to affect the SRH of young people were media and peer influence, lack of parental guidance, poverty, unemployment, drug abuse, poor living conditions, especially housing and dropping out of school.

5.2.1.1 Early sexual activity

The majority of the community members, from all study sites, expressed concern that young people start having sexual intercourse at an age as early as 8, 9 and 10 years. Community members used certain terms to describe sexual intercourse which included “going with someone”, “walking with someone”, “being with someone”, “bad manners” and “they will just go”. The living environment, media and peer influence were reported to have an influence on young people’s sexual behaviour.

The living environment, and particularly the housing set-up, largely affected children living in slums, both in Nairobi and the districts. Parents were said to “have sex when the child is seeing……so the child pick this up and starts doing the same” (men’s FGD, Nairobi). This was because families in the slums live in single-roomed houses, which are shared between parents and children, with only a curtain separating the area where children and parents sleep. Some families use “double-decker” beds where parents sleep on the lower bed and children sleep on the upper bed. Children were therefore exposed to sex in their homes through “seeing” and “hearing” what their parents were doing.

“…..the way we are living, we are living in houses made of iron sheets, these small houses, and that is where you are continuing with that job [having sex] and there you are sleeping with the child, now the child will not sleep, she will be hearing what they are doing……”, (women’s FGD, Nairobi).

The media was also identified as playing a major role in influencing young people to engage in early sexual activity, because of the movies and programmes shown on the main television channels. Community members felt that once young people watched movies and advertisements that were sexual in nature, they often went ahead to experiment on the same.
“...that age of youth, after watching these videos and whatever, pornographic, even pornographic books that they read, they want to practise. That is another problem that makes them lose direction” (men’s FGD, Laikipia)

Most community members acknowledged that some parents exposed their children to pornographic materials by making pornographic books and videos available within the reach of children at home. An example was given by a female respondent from the districts where an eight year old child carried a book with pornographic pictures to school and showed it to other pupils.

5.2.1.2 Early pregnancy

Most community members mentioned early and unwanted pregnancy as a common problem young people faced. They also reported boys’ denial of responsibilities related to pregnancy and because young girls do not have the capacity of supporting themselves and the baby, this task of taking care of the baby ended up being the girl’s parent’s responsibility.

“...because the girls only give birth to the children and because they do not have anything to support the children, so you find parents are not at peace nowadays you know because of having to take on a lot of the burden which is not theirs, the burden which belong to the children” (women’s FGD, Nairobi).

5.2.1.3 Sexually transmitted infections (STIs) and HIV/AIDS

The majority of community members reported that STIs, including HIV/AIDS, were common problems young people experienced. This was brought about by engaging in unprotected sex, especially during the process of sexual experimentation, and having multiple and short-term relationships. They expressed the opinion that young people, who were having sex for the first time, were not fully aware of the consequences of unprotected sex and some did not know how to utilize the available protective methods.

“......so you can find there are harmful effects such as HIV/AIDS and other diseases that are sexually transmitted; so it leads them to things like these because they are new things to them, it’s not something they have been doing and they do not have knowledge about it. So even that way of protection he cannot know how to protect himself because he just goes into things that he does not understand”, (men’s FGD, Kirinyaga).

Both men and women from Nairobi reported that they were aware of young people finding difficulty in informing their parents, if they had an STI, and only informed parents if the condition got worse.
“...so it becomes also difficult for them to tell their parents I have been infected with a disease, so this will just force them to persevere and suffer silently”, (women’s FGD, Nairobi).

The same sentiments were expressed by women from Kirinyaga,

“You know they fear you will ask them where did they get this disease because they knows they are still young and they have entered this life of sex so they feel embarrassed, that is when the decide to keep quiet...”, (women’s FGD, Kirinyaga).

5.2.1.4 Sexual violence and female genital mutilation

Community members from all study sites reported sexual violence in the form of rape as a problem that affected young people, both girls and boys. However, rape was said to be more common among girls. Female genital mutilation (FGM), commonly referred to as female circumcision, was identified as a problem at the districts. Girls are circumcised to signify attaining adulthood status. Although FGM is illegal in Kenya, most respondents from the districts reported that the practice still went on secretly.

Men from Nairobi implied that rape happened to girls because of the way they dressed. Girls were said to dress in a way that was provocative to men.

“You know raping, to say the truth, raping comes with the way the girl puts on her clothes. If you have already shown your nakedness and you are walking in front of the lion, will the lion leave you?” (men’s FGD, Nairobi).

The same group of men also said that persons who were under the influence of drugs were more likely to be involved in rape. People who were infected with HIV were also said to be involved in the rape of babies and younger girls because of the belief that they would be cured.

“...maybe if someone got HIV they think the best way is to use the small child so that the child can add him blood.....” (men’s FGD, Nairobi).

5.2.1.5 Lack of proper parental guidance

The majority of community members from all study sites acknowledged that there was a communication gap between parents and their children, especially in matters concerning SRH. Women from Nairobi and Kirinyaga reported that girls were not feeling free to discuss with their mothers the body changes that occurred during adolescence. While it was noted that girls were shy in discussing such issues, some mothers were said to be very harsh towards their daughters and used abusive language when asked such questions.
“.....you can also find that a girl has reached a stage when she starts to receive her menstrual periods but there is no single day the girl has ever told her mother that I am seeing blood, she will go and ask another person - when one starts to see blood what do you do? - So you [the mother] are a problem in that house to this child, you are not free”, (women’s FGD, Nairobi).

“You know the adolescents they do not want to open up to even their parents they want to be open to their friends of their age and that does not help, because if they could be open to their parents, they could tell them what they are feeling...”, (mixed FGD, Laikipia).

Men from Nairobi, Kirinyaga and Laikipia expressed fears that, as parents, they had failed and neglected their responsibility of educating their children about issues regarding health and development and were equally to blame for the problems their children were going through.

“.....so we are saying these things have reached where parents have put their luggage down, that is why children are getting spoilt, drugs, children giving birth before they have reached that stage, then we start blaming those children but we should be blamed... “, (men’s FGD, Kirinyaga)

Lack of communication between children and parents was seen as the cause of the breakdown in traditional community social networks, where older men and women were used as educators to teach young people about growing up and appropriate behaviour.

“long time when an old man or the father speaks, there is a time he would sit down the boys and does counselling for them, the girls the same, but these days, after a child goes to school, counselling is the TV.....” (men’s FGD, Kirinyaga)

The majority of community members from all study sites discussed the behaviour of young people today, in reference to their own experiences when they were younger. They indicated that the new generation of young people was difficult to handle. This was because they were being brought up in an environment that was very free and friendly to them. The introduction of a government policy abolishing corporal punishment (caning), especially in schools, was raised as a factor that had led to decreased discipline among young people. Young people were said to disobey their parents and teachers with the knowledge that they would not receive tough punishment. It was suggested by a few of the respondents that corporal punishment should be re-introduced in schools. Community disciplinary channels, such as a community elder punishing a child, who had made a mistake, even though he was not the parent, were also said to have been eroded. Respondents perceived raising children in such an environment as being “very difficult”.

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“Long time ago they were being disciplined but nowadays we have given the children a lot of space. Following the way the government said we should not have the cane in schools that has made it hard for teachers....”, (men’s FGD, Nairobi)

“The youths of today have no discipline like the youths of yesterday. When we were youth we were disciplined, we gave our parents respect, and these ones don’t have respect...” (men’s FGD, Kirinyaga).

On the other hand, both men and women from Nairobi, reported that parents were not changing with the times and were still living in their old days and expected their children to exhibit the same behaviour. It was stated that parents need to appreciate the fact that “the world is changing”, and “young people are growing up into adults”. It was felt that parents need to learn how they could approach and talk to their children if there had to be openness between them. Things that were noted to be changing, that parents need to be aware of were: the mode of dressing, the way young people openly showed affection, ways of disciplining children, and young people being able to answer back or ask questions when being addressed by parents or elders.

“.....the problems we have is the approach of a parent to the child, parents nowadays have lacked that wisdom of approaching children, because you want your child to still live in the years like 1990’s, yet this is year 2009 where people are supposed to make themselves look nice, dress in a certain way. So us parents we have failed on how to approach our children we do not know they are growing, you still see as if your child is like 5 years old”, (women’s FGD, Nairobi).
5.2.2 Community members knowledge and perceptions of available SRH services

5.2.2.1 Knowledge of available services

The majority of community members, from all study sites, reported that they were not aware of the full range of SRH services available at the health facilities within their catchment area.

Women from Nairobi reported that they were not aware of the existence of youth centres in their communities, although they mentioned a VCT centre that was in their neighbourhood. They reported that the VCT centre lacked clients privacy as it was easy for anyone to be seen going to and from the facility.

“…..for now I have never seen such services here maybe down there they may be there but here we don’t have such services”, (Women FGD, Nairobi).

Both men and women from Kirinyaga, which did not have a youth friendly centre, reported that they were aware of SRH services that were generally available at the health centres and the district hospital which youth had access to such as VCT, general counselling and the provision of condoms. They also mentioned youth activities and teachings which took place in churches.

“…in the whole district of Kirinyaga I have never heard of a place that provides services to youths [only] “, (men’s FGD, Kirinyaga).

“You know the services they can get in a hospital it is like VCT you know this one is a must, they must get things like counselling, they are talked to a lot, you know it is not parents who are talked to about this issues mostly it is to the youth and that is something I know at every health centre or in the hospital, that is something common, it is a must they get, so we are sure counselling or these things of VCT those ones they are getting there is no problem”, (men’s FGD, Kirinyaga).

On being probed further whether health centres also provided contraception (commonly referred to as family planning) to young people, most men and women reported that youths were only taught about family planning methods but were not given the methods.

“Most of the time I see they are not given [family planning], what they are taught is to be told about it, you know us parents we can explain things in passing because there are many things for example when they are taught about preventing HIV/AIDS they are told to use the condom, isn't it?” (Men’s FGD, Kirinyaga).
In Laikipia and Meru districts, few men and women were aware of the availability of youth centres at the respective district hospitals and the SRH services they provided to young people. In both instances, the services mentioned to be available at the youth centres were VCT, treatment of STI, general counselling on life skills, counselling on HIV, education by the use of videos and games. Men and women who came from the interior (rural areas) of the districts were not aware of the availability of the youth centres.

“They go there [youth centre] and they are taught things to do with counselling, things to do with HIV and there are films that they are shown”, (Mixed FGD, Meru).

On being probed as to whether young people were given contraceptives, the majority of community members reported in the negative,

“You know those who go there are children and not mothers, so they are not taught things about family planning”, (mixed FGD, Meru).

“No, I do not know if they give because there is a time we went there [Meru youth centre] with the youth, we took children there, we saw they only taught about counselling, then they showed the film then we had a break”, (mixed FGD, Meru).

5.2.2.2 Community members views about available SRH services

Community members had varying opinions about the provision of SRH services to young people. Types of SRH services discussed included VCT services, contraception, condoms and treatment for STIs. For the purpose of this study, when community members mentioned contraception they meant modern FP methods excluding the condom. Views on the condom are presented separately in section 5.2.2.4

Community members described services which they approved for young people to receive as “good”, “helpful”, and “important”, while also outlining services they felt young people should not receive. Services were described as good if they were preventive in nature and provided an opportunity for young people to be educated and counselled on different aspects of their health, while being given information on how to lead “good lives”. Services which community members thought could result in encouraging young people to engage in sexual activity were regarded as inappropriate.

Community members who knew of the availability of the youth centres were of the opinion that youth centres were “good” and “helpful” since they provided counselling, VCT, health education, education on prevention of HIV/STI and pregnancy, condom use and treatment
services. All community members indicated that they would recommend their children to visit a youth centre.

Men and women from Kirinyaga also emphasized the need to have SRH services for young people at the community level especially in the rural areas of the district. They also said that parents should be made aware of the availability of these services because most of them did not know of their existence.

“It is important for these services to trickle down to the villages so that they can reach the grassroots because like where I come from, it is travelling all the way with a child up to Nyeri, not so many of us can afford that, and other things maybe to teach, if a child is yours after the age of 15 sometimes it becomes hard, it will be good if they[services] were brought down”, (men FGD, Kirinyaga).

In Laikipia, a few of the community members who knew about the availability of the youth centre and the services it offered said that the services offered were good. One of the respondents, who had previously taken a girl to the youth centre for counselling said that the services were good and provided in friendly manner. The health providers were also friendly and understood the language of the youths.

“I think it is good, like here at Nanyuki distict [Laikipia], I have once brought a girl who had a problem, a student, and the health provider whom we found there, first at the reception we found there was a big TV and this music tapes for these young people….First they are put there and this girl who was sick now starts smiling. Then going inside the doctor we found there was a youthful doctor and he asked her, sasa! Mambo! You know that language; they understood each other very well. And then the girl was very free to talk and she explained her problem, she was treated and went back home even without been given medicine, it was just a psychological problem”, (Mixed FGD, Laikipia)

One man from Laikipia said that he had taken his child for a medical examination at the youth centre and they were served well.

“I once took my child to look for a medical certificate, this one for secondary school and the services they are getting as my colleague said they are good and they are also youth-friendly”, (women’s FGD, Laikipia)

In Meru women reported that the youth centre was good, as it reduced idleness among the youth. They also said that when youth go to the youth centre, they are counselled well and some even start showing signs of behaviour change. However, the change in behaviour of young people mentioned by the women, was only limited to the young people beginning to help their
parents with household chores like cooking, farming and accepting to go to school if one had initially refused to go to school. Changes in sexual practices were not mentioned during the discussion.

“There are those who refuse to go to school completely and when he goes there [at the youth centre] they go back to school”, (women’s FGD, Meru)

5.2.2.3 Community members views on provision of contraceptives (hormonal) to young people

The majority of men and women from all study sites were not supportive of the provision of contraceptives to young people especially girls who had not given birth to a child. This was because they believed that it would affect the girl’s ability to conceive in future. The majority of men and women believed that contraception should be reserved for married women and girls who had at least given birth to one child. The majority of men and women from all the study sites also believed that encouraging use of contraceptives among young people can lead to an increase in sexual activity.

Women from Nairobi believed that contraceptives were only to be provided to women and girls for child spacing and not to delay child bearing.

“So family planning [contraception] for people who have not given birth, it is not allowed. It is only allowed to someone who has gotten a child and sees that they don't want to get the other one quickly....but for you who doesn’t have a child, what are you going to do saying that you are planning a family”, (women’s FGD, Nairobi)

Similar sentiments were expressed by women from Kirinyaga

“I don't think it is good for them to use because contraceptives are for prevention.......what is she preventing? I am using [contraceptives] as a mother, to prevent me from getting pregnant because I am married and it's for planning [the family] and her she is using when she is still young, so I see it is bad, it is a problem to her, because others like the injection, its 50-50...you can get pregnant while using them or you don’t, so if a girl is still young and starts using the injection, she will fail to get a child in future”, (women FGD, Kirinyaga).
5.2.2.4 Community members views on condom use among young people

The majority of both men and women in all study sites were supportive of condom use among young people. However, a minority view was that condoms encouraged sexual activity among young people and were not 100 percent effective.

All community members were in agreement for the need for young people to have access to information about prevention and treatment of STIs, HIV/AIDS and prevention of pregnancy. They therefore did approve of educating young people on condom use for prevention of HIV/STI infection and unwanted pregnancy.

The majority of men from Nairobi reported that though not 100 percent effective, condoms were useful in the prevention of STIs, HIV and pregnancy and young people should be encouraged to use them. They felt that young people should be taught about condom use before they became sexually active. It was emphasised that discouraging young people from using condoms would be disastrous, as they needed to be aware of the preventive measures available to them before they started having sexual intercourse. Some men acknowledged that they had used condoms when they were young.

“Condom has really helped to prevent diseases even though it is not 100 percent but it has helped in preventing getting pregnancy, it has helped in preventing diseases like AIDS….. yes, we used them, so it is a must we teach them but we should tell them that it is not a 100 percent”, (men’s FGD, Nairobi).

A minority view from men in Nairobi was that condoms encouraged sexual activity and were not 100 percent effective

“It is bad [condom use], me I oppose it, because he already knows that I have been given a prevention which is condom, he will do what he wants and that condom sometimes, it reaches a time they say that it is not 100%, don't they say that? So he will start walking [having sex] everywhere because he will say he has a condom”, (men’s FGD, Nairobi).

A few men from Kirinyaga also had similar views

“In addition to that, you are giving a thief a bullet proof [jacket] and again you preach to him stealing is bad, isn't it? This is a child you tell them abstain from sex, isn't it, because you have not reached maturity, you are not married, and instead of teaching
them that you give them condoms, what is the condom for? Aren't you opening the way for him?” (Men’s FGD, Kirinyaga).

This view was disputed by other respondents in the FGD. One respondent who owned a small shop (kiosk) said that he always had condoms in stock as they were in demand. He noted that it was important for young people to have access to condoms because despite being provided with education on abstinence, they still engaged in sex.

“I have a shop and I must keep them, condoms, Trust [condom brand name], I must put them there. They ask for them, we sell them, they come for them, this young people are drinking alcohol, using drugs, so if you tell them, don’t go [have sex] with girls and women who are prostitutes because you will get HIV and gonorrhoea and syphilis, he knows all that because he has been to school, but he will leave here go out drink and meet them.............”, (men’s FGD Kirinyaga)

A few men and women from Laikipia also shared a similar belief that contraceptives and condoms encouraged sexual activity

“You know if they are given condoms and other contraceptives, it’s like they have been given a license of moving freely because there is nothing that they fear. And that is where they get infected with the disease”, (Mixed FGD, Laikipia)

It was also said that movies shown on television did not encourage condom use.

“The programmes they watch......most of these programmes they are watching there is no place the condom comes in as an issue, if it is the pictures that they bring it is purely live and very pleasant, they want to take that, they want to be like that person they see on TV”, (Men FGD, Laikipia).

In addition to this, the majority of men and women from all study sites reported that they believed most young people disliked using condoms because of beliefs such as lack of sexual satisfaction; condoms having been laced with the HIV virus; and that the lubricant on the condom may lead to sterility. Some young people were said not to know how to use condoms, especially when having sex for the first time. Young people who were illiterate, like among the Maasai community in Laikipia, were said not to understand the importance of the condom.

A minority view from men in Kirinyaga was that young people should not be denied any service as they were the parents of tomorrow. The men were positive about the fact that if young people were not sexually active, teaching them about condom use would not make them initiate sex. Constant condemning of the condom as a bad thing was said to be damaging to young people, because they eventually grew up knowing that the “condom is a bad thing”, and would never
use it in future if the need arose. Discouraging young people against condom use and not giving them an alternative was also said to be ineffective.

“it is very important to avail the information to the young people you tell them not to do [have sex] but if it a must they do it they should use a condom, because if you tell them not to use, they will start to view it badly and when they see a condom they will be thinking it is a bad thing and even when having sex in future they will not use, they will see it as a bad thing”, (men’s FGD, Kirinyaga).

5.2.3 Community members’ views on barriers to seeking SRH services by young people

Community members were asked to identify reasons which would make young people not access SRH services from health facilities. The majority of men and women mentioned fear, cost, lack of privacy and preference of alternative service providers.

Fear

In the FGDs with men from Nairobi, most respondents said that “fear” was the main reason why young people, as well as adults, were not accessing SRH services, especially with regards to Voluntary Counselling and Testing (VCT). The men said that this fear was associated with the results of the test and concerns about confidentiality. There is suspicion that health providers can “advertise” the test results, especially if positive, and those who went for VCT services would be subjected to the stigma associated with HIV. The men indicated that for VCT one would even prefer to spend money and go to a facility that was far away where no one knew him.

Cost of services

Transportation costs as well as cost of services were mentioned as a hindrance to seeking health care by young people. Women from Nairobi said that since young people do not have jobs and are unable to pay for the services, they end up not seeking treatment and only request assistance from parents when the condition gets worse.

Lack of privacy

Privacy of the youth centre in Laikipia, in terms of its location, was reported to be of concern among some young people. This was because as one walks towards the youth centre, one passes in front of other clinic areas where the waiting bay is within an open space. Anyone walking towards the youth centre is therefore easily seen by members of the public. This was said to interfere with young people’s privacy and anonymity.
“Because definitely there [Laikipia youth centre] it is even an open place so if someone has his own personal issues, if you go, you pass PMTCT, you go to CCC, you pass and you are seen by people, (men’s FGD, Laikipia)

The Majority of men from Kirinyaga also mentioned that most dispensaries were frequented by women and children and this made young people, including themselves, shy away from using the facilities.

“If you go to the hospital that is the local dispensaries, women are the ones who are many, when I go I get women only........women and children........even me if I go there I become shy and run off and go to the private.....among 20 women there is one man”, (men’s FGD, Kirinyaga)

**Alternative service provider preference**

Men from Laikipia reported that young people fail to go for health care at the district hospital youth centre because there were other service providers (Vuma NGO), within the district, who offered similar services and conducted outreach activities to the community and the schools. The staff at Laikipia youth centre were said not to be reaching out to young people in the community and informing them about available services. Vuma was also said to be strategically located in terms of offering clients anonymity when they went to the facility.

“On that issue patients you see district [youth centre] lack clients because of Vuma [an NGO] that is here, Vuma have a program, they cover the whole of great Laikipia and they visit schools and you find after a session they say they leave their contacts and they say in case of anything, of if you have your own issue you can call us on this number or visit us at our facility which is at a certain place. So you find that many instead of them going to the district hospital, or the youth centre, they divert to Vuma”, (men’s FGD, Laikipia).
5.2.4 Community members’ views on SRH service improvement

Community members were asked to outline some of the measures which they thought needed to be put in place, to improve access to SRH services by young people.

Increase availability of SRH services

The majority of men and women from all the study sites reported that efforts should be made to have SRH services available in rural areas and, at the community level for them to be within reach of most community members. The services available were said to be limited to the district hospital and major towns.

“And they [government] should also put up more youth centres so that they can be near them in the villages and interior places, like us we come from far, so that we can get these services to the far since coming here is a problem [with transport]”,” (women’s FGD, Meru)

Women from Meru suggested the setting up of mobile youth clinics in order to reach out to youths in the rural areas,

“Mobile services that will help, you know if someone is using transport and they don’t have, if there is a place you are using 200 shillings and you do not have, you cannot go”, (mixed FGD, Meru).

The same suggestion of setting up mobile clinics in the rural areas was made by a local administrator (Chief) from Kirinyaga who said that services targeting the youth were not available in his area. Men from Kirinyaga also said that youth services should be available at the dispensary level.

“....take them [services] to the interior if possible they should put mobile clinics, I would be happy if you come to teach people in my area. If I announce for a meeting if they are youths, you will find that they have all come, because there is something new that they are being taught and getting them is easy”, (men’s FGD, Kirinyaga)

Community outreach activities

The majority of community member from both Nairobi and the districts suggested putting in place mechanisms for reaching out to youth by community leaders, parents and health care providers. It was suggested that reaching out to youths can be done through the media (television, radio, brochures, booklets, production of information on CDs), organisation of seminars during the school holidays, in churches, schools and community meetings (barazas).
The men from Laikipia pointed out that health service providers who were working at the youth centre need to make an effort to reach out to the young people in the community, the schools and through the churches, similar to what was being done for services such as immunization.

“Mostly they do not have many clients [at Laikipia youth centre], it is good if they come out maybe they go to the village.....they be given a vehicle by the hospital they go to a certain school get the youths and talk [to them]”, (men’s FGD, Laikipia)

....they have a programme or even in the church. I have said there is a mother who is a nurse and she is doing that campaign for immunization very much, they can do the same”, (men’s FGD, Laikipia)

Men from Kirinyaga said that it was easy for church leaders and the local provincial administration (chiefs and assistant-chiefs) to organize youth meetings in the community, by calling them to a central place for health education or health talks.

“.....we can use even the media because it can be a little hard to reach the youths easily, so those people who can reach the youths easily are like us preachers it is easy for us...if we look at the assistant chief he can reach them easily because he is in government service, so if he calls for a meeting of parents with youths and then he tells them on a specific date I want you to bring for me all the youths, it is a must they will come”, (men’s FGD, Kirinyaga)

Men from Kirinyaga also mentioned the production of educative youth programmes which could be aired on television and radio. The men also suggested recruiting more youth peer educators at the youth centre to help in educating the youth in the community. They also mentioned the need for parents to take up their old responsibility of educating young people on reproductive health.

**Improve client-provider relationships**

The majority of men from Nairobi suggested that, in order to alleviate the fear young people had towards seeking SRH services, health providers had to find innovative ways of improving their relationship with young people. It was indicated that health care providers need to identify ways of bringing youths closer to the health facility to increase familiarity with the youth centre and the services the facility provided.

“They should try to bring programmes of bringing people close to them, okay they can hold a few meetings there, youth to come for participation of 1,2,3, other things, to be there they are educated from there someone will be free to come there, they become free with the doctors, talking to them, so you will find that this person will be free to go and
be tested. But to say that someone will just come from the villages (slums), and go somewhere like Liverpool (VCT) here, or he leaves and goes to any other place to get tested, alone, he will not enter there”, (men’s FGD, Nairobi)
5.3 Objective 3: To explore health service providers’ perceptions and experiences of SRH service provision to young people.

This section presents findings from IDIs and FGDs with health service providers (HSP). The findings describe views and experiences of HSP with regards to provision of SRH services to young people. The results are presented in five sub-sections. Section 5.3.1 gives insights into HSP knowledge of available national polices and guidelines for provision of youth friendly services (YFS). Section 5.3.2 outlines HSP experiences in SRH service provision, by listing common SRH problems young people present with at health facilities and SRH services available at the facilities. Section 5.3.3 provides a description of HSP experiences with regards to SRH service provision, while paying close attention to the provision of contraceptives, HIV/AIDS related services and HSP competency. Section 5.3.4 lists barriers to SRH service provision, while section 5.3.5 outlines suggestions mentioned by HSP for improving the provision of SRH services.

Table 31 shows details of HSPs who took part in the IDIs and the facilities from which they were selected. Of the 19 health providers who took part in the IDIs, 15 were nurses, 2 were clinical officers and 2 were counsellors; 16 were females and three were males. The average age of the service providers interviewed was 41 years, the youngest being 27 years while the eldest was 51 years. The average number of years the providers had provided SRH services to young people was 8.7 years with the least number of years being 2 and the highest number of years of service provision being 20. Table 32 provides the details of HSPs who took part in the FGDs. A total of 18 HSPs took part in the FGDs. HSPs who took part in both IDIs and FGDs were working in the following clinical areas; the maternity unit, female ward, obstetrics/gynaecology ward, the youth friendly centre, outpatient department, comprehensive care clinic (CCC), MCH/FP and the VCT unit.
Table 31: Details of HSPs who participated in in-depth interviews per health facility

<table>
<thead>
<tr>
<th>No</th>
<th>Facility name/ Type</th>
<th>Location of facility</th>
<th>Gender, cadre and number of HSPs</th>
<th>Working unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>Mathare North HC</td>
<td>Within Nairobi</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Nairobi youth centre</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Langata health centre</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Woodley clinic</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Kibera health centre</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Meru district hospital</td>
<td>-</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Laikipia district hospital</td>
<td>District hospitals</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Kirinyaga district hospital</td>
<td>District hospitals</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>3</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 32: Details of HSPs’ FGD respondents

<table>
<thead>
<tr>
<th>FGD No</th>
<th>ID</th>
<th>Cadre and (No of respondents)</th>
<th>Gender</th>
<th>Total respondents</th>
<th>Working areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td>MCH, youth centre, VCT, CCC, maternity Gynae ward, Female ward</td>
</tr>
<tr>
<td>01</td>
<td>Nurses (8)</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Nurses (8)</td>
<td>1</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counsellor (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical officer (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>5</td>
<td>13</td>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3.1 HSP knowledge of policies and guidelines

This study sought to examine HSP understanding of YFS and their knowledge of supporting policies and guidelines. HSP were asked to describe their understanding of YFS concept, awareness of existing policies and guidelines on YFS and their knowledge of RH rights of young people.

5.3.1.1 HSP understanding of the concept of youth-friendly services

The majority of HSP from all study sites were aware of, and had a relatively fair understanding of the YFS concept. HSP described YFS in terms of the way young people were approached, welcomed, listened to, handled, understood, given privacy and confidentially so as to facilitate free interaction.

HSP from Nairobi described YFS as services that were non-discriminatory, confidential, where young people were welcomed and not denied any SRH service. In addition they noted that HSP providing YFS needed to be friendly, understanding and ready to listen so that young people could open up and freely explain their problems.

“"Youth friendly services that is these youth……if at all they come for the services, we are not supposed to deny them, you can just give them the services….any services”, (03-IDI-HSP, Nairobi).

The HSP from Nairobi youth centre described YFS in terms of accessibility, availability, and confidentiality, attitude of the staff and range of services provided:

“"Youth friendly, I want to believe youth friendly is services, it’s either an institution that offers the services to the young people……there is availability of the services….the confidentiality has been resolved to the young people to accept the services, and the attitude also of the staff depends on the services of these youth, accessibility, also the variety……of the services has also contributed to these services being called youth friendly” (07-IDI-HSP, Nairobi youth centre).

Service providers from the district hospitals also suggested that YFS were services which made youth feel welcome and they in turn referred their friends for the same service.

“"These are services whereby a youth feels wanted, that is what I think it is or what I do to make the youth feel useful and there is a future for them and you make him feel good and he will be in a position to influences the other youths to seek services..."(16-IDI-HSP, Kirinyaga).
HSP from the districts identified some of the key features they thought were important if one had to provide SRH services to young people in a friendly way. This included understanding their language, the way of approach, having HSP who were younger, empathetic, knowledgeable and kind; but not motherly or fatherly.

“…..you should be knowledgeable to attend to them like you see these [young] people, most of the time they are on the internet so they may be very informed than you,” (FGD-HSP, Laikipia)

5.3.1.2 Health service providers’ knowledge of national guidelines

The majority of HSP from all the study sites were not aware of the availability of national guidelines for provision of youth friendly services. A few HSP had seen or heard about them but were not sure of the content.

“I have never [seen the guideline], how long have they been there...I have not seen any” (01-IDI-HSP, Nairobi).

“I think I have seen such a poster somewhere but I have not read it, it is good to be sincere”, (02-IDI-HSP, Nairobi).

“I am aware they are there but I cannot remember but I know there is a national guideline”, (18-IDI-HSP, Laikipia).

The same views were elicited from HSP from Nairobi youth centre.

“Guidelines? I am not quite sure.......now how do I put it.......I think they just introduced it in a very general and broad perspective, just the way they discuss like in science about sex education the early changes on the body system and the like. So far I doubt I am not certain about any guideline that is in place”. (07-IDI-HP-Nairobi youth centre)

On the other hand HSPs singled out other national service provision guidelines they had come across; this included the flow chart on the management of STIs, the post abortion care guidelines, the VCT guidelines, and the guidelines on sexual abuse.

“The only ones that I know about and I am practising is the issue of sexual abuse where we [the facility] are a centre of referral.... ” (05-IDI-HSP, Nairobi).

“I know only about the flow charts that are provided on how to manage the sexually transmitted diseases, the control and prevention”, (08-IDI-HSP, Nairobi)
Similar sentiments were expressed by HSP in Meru district hospital where they acknowledged that the facility had national guidelines for YFS plus several others but due to lack of safe keeping, they were not accessible to most staff.

“Yes we have some guidelines…like……we have guidelines on rape…..we have guidelines on boy’s circumcision. Those guidelines due to lack of a safe place to keep them because when they are in the offices they may not be accessible at all times but if we keep them in the rooms the MTC students go with them. We need some cabinet or lockable place in every counselling room where we can be keeping those guidelines”  
(FGD-HSP, Meru)

5.3.1.3 Health service providers’ knowledge of sexual reproductive health rights

The majority of HSP interviewed were aware of the RH rights young people have but there were some variations on how these rights were articulated. Most HSP reported that they were aware young people had a right to receive contraceptive services irrespective of the age, they have a right to information on RH; for example if they wanted to start a family planning method they had a right of being counselled on both the importance and the disadvantages of each of the methods and thereafter make their own choice; they have a right to access other services such as VCT and other HIV related services. They have a right for the treatment of ailments such as STIs and a right to education. The following are some of the verbatim extracts from in-depth interviews with HSP;

“……….I think, they have the right to the information on reproductive health I also feel that they have a right to make a choice on whether to go for a method or not to. They have a right to access either of those services whether it’s HIV or whether its family planning and the like” (07-IDHSP, Nairobi youth centre)

“Well…they have a right to know their growth and development, they have a right to practise family planning if they feel they need it, they have the right to information, right [-to-] privacy and confidentiality. they also have a right for respect as young as they are, they need to be respected a lot...”(15-IDHSP, Meru)

A health care provider from Nairobi noted that previous government policy prohibited young people from receiving family planning services but with the current policy it was permitted.

“Previously, with the previous policy youth were not suppose to be issued with family planning methods but as for now, if a youth comes, irrespective of age, we issue them with any family planning method they are asking for” (02-IDHSP, Nairobi).
A few HSP from Nairobi reported that they were not aware of the reproductive health rights of adolescents or young people.

“I have not heard about it really, I have not heard much about that, at least coz I know they have a right but I don’t know really about it in details” (05-IDI-HSP, Nairobi).

5.3.2 SRH service provision to young people

5.3.2.1 Presenting SRH Problems

Health service providers were asked to outline the types of SRH problems young people might present with at health facilities. Table 33 gives a summary of HSP responses about services available at integrated facilities and youth centres. Responses of HSP from youth centres are disaggregated to show what youth present with at either facility-based or community-based youth centres.

The majority of HSP reported that young people present to the facilities when in need of the following services: contraception, unwanted pregnancy and the need for abortion services, treatment of complications due to incomplete/or unsafe abortion, treatment of STIs, HIV services (VCT, ARVs) and treatment after sexual violence. Other presenting complaints included general counselling on social issues such as boy-girl relationships and misunderstandings between young people and their parents or guardians. Though illegal in Kenya, young people were said to be coming to the health facilities when in need of abortion services. Though not an SRH problem, treatment for drug and substance abuse was also mentioned by the majority of HSP as a reason why youth sought help.

Table 33: SRH problems young people present with at health facilities

<table>
<thead>
<tr>
<th>Integrated facilities</th>
<th>Facility-based youth centres</th>
<th>Community-based youth centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraception: oral contraceptives, condoms, implants - even those unmarried and in college, TL, rarely IUCD are demanded</td>
<td>Contraception (oral contraceptives, Depo-Provera, implants, condoms)</td>
<td>Contraception (Oral contraceptives, Depo-Provera, condoms)</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>Unwanted pregnancy</td>
<td>Treatment of STIs</td>
</tr>
<tr>
<td>Abortion services, treatment of incomplete abortion</td>
<td>Abortion services</td>
<td>HIV services: VCT, ARVs</td>
</tr>
<tr>
<td>STI treatment (syphilis, gonorrhea, trichomoniasis, genital ulcers, chancroid, candidiasis)</td>
<td>Treatment of abortion complications</td>
<td>Treatment after sexual violence: rape and sodomy</td>
</tr>
<tr>
<td>HIV services – VCT, ARVs</td>
<td>STI treatment</td>
<td>Delayed menarche, dysmenorrhoea</td>
</tr>
<tr>
<td>Treatment after sexual violence</td>
<td>HIV services: VCT, ARVs</td>
<td>General counselling (on social issues like problems in school, relationships, personal hygiene,</td>
</tr>
<tr>
<td>Puerperal psychosis</td>
<td>Treatment after sexual violence</td>
<td>Drug and substance abuse counselling and treatment</td>
</tr>
</tbody>
</table>
### Facility-based youth centres
- SRH Information on – abortion, contraception
- General counselling on relationships, misunderstandings with relatives
- Drug and substance abuse counselling and treatment
- Conflict with parents, relatives, suicidal tendencies, disclosure of pregnancy to parents
- Drug and substance abuse counselling and treatment

### Community-based youth centres
- Antenatal care (ANC) and post-abortion care (PAC) services and management of survivors of sexual violence were available at integrated facilities but not at the youth centres. Counselling services were available at youth centres but integrated facilities conducted health talks which were not youth specific. Table 34 gives a summary of HSP responses on SRH services available at different health facilities.

## 5.3.2.2 SRH services available at the facilities

HSP were asked to state SRH services that were available at their respective health facilities. Responses from the majority of HSPs indicated that contraception, HIV/AIDS related services and outreach activities were provided at all the facilities. Treatment of STIs was available at integrated facilities on a full-time basis but occasionally available at community-based youth centres, depending on the availability of clinical staff. Antenatal care (ANC) and post-abortion care (PAC) services and management of survivors of sexual violence were available at integrated facilities but not at the youth centres. Counselling services were available at youth centres but integrated facilities conducted health talks which were not youth specific. Table 34 gives a summary of HSP responses on SRH services available at different health facilities.

### Provision of contraception, treatment of STI and HIV related services

The majority of HSP from all the facilities reported that provision of contraceptives, treatment of STIs and provision of HIV related services were available at all the health facilities, with variation in the service package. Youth centres only provided the oral contraceptives, Depo-Provera, emergency contraceptives, and male condoms as contraceptive choices, while integrated facilities in addition provided implants and (in rare cases) IUCDs. Female condoms were not available at any facility and had been out of stock for over 2 years; only female condom demonstration samples were available.

Community-based youth centres (Nairobi youth centre) provided STI treatment but this was only offered three afternoons a week, due to unavailability of clinical staff. Treatment of STIs was available at the outpatient /CCC departments of integrated facilities. In Meru youth centre, young people who needed treatment for STIs were referred to the main district hospital outpatient department with a referral note, while at Laikipia youth centre, young people were escorted by a support staff to the main hospital. The support staff ensured that young people received treatment and did not have to queue once more.
Sexual health education at the health facilities

*Health talks and counselling*

At integrated facilities HSP reported that “health talks” were conducted in different departments, every morning, for all clients but the talks were not youth-specific. The talks covered a wide range of topics including contraception, condom use, drug abuse, pregnancy prevention, rape, ANC, HIV/AIDS, VCT, PMTCT, etc.

“SRH talks…….we don’t provide only to the youth, we provide them to all people who come to the facility, we usually have morning facility talks, health talks, like I said we dwell on STI/HIV, we also dwell on post rape care, ----- and referral sites, we also dwell on behaviour change, and encourage positive living for the ones who are already HIV positive” (05-IDI-HSP, Nairobi)

The health talks were mainly done in groups but occasionally individual counselling was done on clients’ special request.

“We do group counselling, we call them, in the waiting bay, we just call all the mothers at the waiting bay; we just give health talk to them…..we also do them in the room, sometimes we normally sit them in the rooms so that they can ask questions because they are normally shy...” (03-IDI-HSP, Nairobi)

HSP from youth centres reported that they were able to provide counselling services targeting young people and the subject areas covered broadly included VCT, pregnancy prevention, abortion, PMTCT, life skills, relationships, body changes and career choices.

“….we do general counselling for young people; we also do alcohol and substance abuse counselling and also refer them accordingly. We do HIV counselling and testing, we also conduct like counselling on PMTCT; on PMTCT counselling some of these clients who come for VCT are pregnant, so we just talk about counselling on PMTCT and we refer them to where they can go for the services”, (07-IDI-HSP, Nairobi youth centre)

Only Meru youth centre had an active peer education system in place. In health centres in Nairobi, HSP reported that Nairobi City Council has an urban slums project with nurses specifically allocated to work in the slums on a daily basis. Their work involved carrying out health education activities in the slum community and neighbouring schools. They provide education using posters, video shows, and also distribute condoms and oral contraceptives. It was appreciated that these nurses were much older.
“....through outreaches we go to the slums and we offer services like for family planning, VCT, but it is not specifically for adolescents but for the whole population and the turnout is normally very good, the records are kept separately”. (11-IDI-HSP, Nairobi)

**Call-in services**

Clients’ access to information through call-in services was reported not to be available in any of the facilities, unless a client made contact with the HSP on their personal mobile phones. Calling-in and e-mail services were said not to be available due to lack of facilities and equipment such as computers.

**Educational materials**

The majority of providers from all the facilities reported that they did not have a regular supply of educational materials. The available educational materials mainly covered topics on HIV and drug abuse. Educational materials on other aspects of reproductive health were said not to be available. Materials that addressed other aspects of reproductive health were said not to be readily available.

**Table 34: HSP responses on SRH services available at different facilities**

<table>
<thead>
<tr>
<th>No</th>
<th>Integrated facilities</th>
<th>Youth Centres</th>
<th>Community-based youth centres</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Facility-based youth centres</td>
<td>Community-based youth centre</td>
</tr>
<tr>
<td>1</td>
<td>Contraception</td>
<td>Contraception</td>
<td>Contraception</td>
</tr>
<tr>
<td></td>
<td>▪ Pills</td>
<td>▪ Pills</td>
<td>▪ Pills</td>
</tr>
<tr>
<td></td>
<td>▪ Depo-provera</td>
<td>▪ Depo Provera</td>
<td>▪ Depo Provera</td>
</tr>
<tr>
<td></td>
<td>▪ Emergency contraceptives</td>
<td>▪ Emergency contraceptives</td>
<td>▪ Emergency contraceptives</td>
</tr>
<tr>
<td></td>
<td>▪ Implants (Jadelle, Implanon)</td>
<td>▪ Provision of male condoms</td>
<td>▪ Provision of male contraceptives</td>
</tr>
<tr>
<td></td>
<td>▪ IUCD (rare cases)</td>
<td>▪ Refer to main hospital for other methods (MCH clinic)</td>
<td>▪ Provision of male</td>
</tr>
<tr>
<td></td>
<td>▪ Male condoms / female condoms not available</td>
<td></td>
<td>condoms, female</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>condoms not available</td>
</tr>
<tr>
<td>2</td>
<td>HIV related services</td>
<td>HIV related services</td>
<td>HIV related services</td>
</tr>
<tr>
<td></td>
<td>▪ HCT</td>
<td>▪ HCT / DTC</td>
<td>▪ HCT</td>
</tr>
<tr>
<td></td>
<td>▪ DTC</td>
<td>▪ Refer to CCC for further management</td>
<td>▪ DTC</td>
</tr>
<tr>
<td></td>
<td>▪ Clients attended to at the CCC clinic</td>
<td></td>
<td>▪ Refer to other facilities for ARVs</td>
</tr>
<tr>
<td>3</td>
<td>Treatment of STIs</td>
<td>Treatment of STIs</td>
<td>Treatment of STIs</td>
</tr>
<tr>
<td></td>
<td>▪ Clients attended to at the OPD (outpatient department)</td>
<td>▪ Refer to the OPD or CCC for STI treatment</td>
<td>▪ Session nurse comes three afternoons per week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Youth escorted by casual staff to CCC or OPD or given a referral note</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ANC services available</td>
<td>ANC Service is provided in MCH</td>
<td>ANC services not available</td>
</tr>
<tr>
<td>5</td>
<td>Post-abortion care (PAC) services available at some health centres</td>
<td>PAC provided in the main hospital</td>
<td>PAC services not available</td>
</tr>
<tr>
<td>6</td>
<td>Sexual violence management-</td>
<td>Sexual violence management-</td>
<td>Sexual violence</td>
</tr>
<tr>
<td>No</td>
<td>Integrated facilities</td>
<td>Youth Centres</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facility-based youth centres</td>
<td>Community-based youth centre</td>
</tr>
<tr>
<td></td>
<td>services available</td>
<td>referred to main hospital</td>
<td>management- clients referred to other facilities</td>
</tr>
<tr>
<td>7</td>
<td>Health talks (morning facility health talks) - family planning, ANC, STI/HIV, CCC, VCT, PMTCT</td>
<td>Counselling</td>
<td>Counselling</td>
</tr>
<tr>
<td></td>
<td>Use of condoms to prevent STI and pregnancy; post rape care, abstinence, positive living.</td>
<td>- General counselling – parenting, rape and dressing code, sexuality, drug abuse</td>
<td>- General counselling</td>
</tr>
<tr>
<td></td>
<td>▪ Peer education not active</td>
<td>- Condom use/demonstration</td>
<td>- Career guidance, relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pregnancy prevention</td>
<td>- Drug abuse counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- HCT</td>
<td>- Counselling pregnant girls on PMTC and refer them</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Peer education active in Meru and inactive at Laikipia youth centre</td>
<td>- Couple counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Peer education</td>
</tr>
<tr>
<td>8</td>
<td>Outreach activities</td>
<td>Outreach activities</td>
<td>Outreach activities</td>
</tr>
<tr>
<td></td>
<td>▪ School health</td>
<td>▪ Very active in Meru and supported by an NGO: Save the Children Canada and DSW</td>
<td>▪ Community outreach activities conducted by youth peer educators</td>
</tr>
<tr>
<td></td>
<td>▪ Community outreaches conducted by facility staff and community health workers and financed through NCC urban slums project</td>
<td>▪ Not active at Laikipia at the moment due to limited finances</td>
<td>▪ School programmes</td>
</tr>
<tr>
<td></td>
<td>▪ IGA for clients who are HIV positive (both youth and general public) coordinated through CCC to the self-help groups formed by clients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3.3 Health service providers views on SRH service provision to young people

HSPs described their perceptions and experiences in providing SRH services to young people in reference to three main aspects SRH service provision

- Provision of contraceptive services
- Provision of STI and HIV related services
- Health service provider’s competency

5.3.3.1 Provision of contraceptive services

The majority of HSP reported that they were not comfortable providing contraceptives (excluding condoms) to young girls, especially Depo-provera, implants and IUCDs. Two reasons were given for this; i) contraceptives do not offer protection against STIs and HIV/AIDS; ii) the negative side effects of contraceptives can affect a young girls’ ability to conceive in future.

One provider from Nairobi said that

“Family planning should not be given to adolescents, they should be educated only, because this is good for married people only”, (10-IDI-HSP, Nairobi).

Similar statements were made by health service providers from Laikipia,

“I would say according to my views I feel as a family planner they should not be given Depo [Provera] it should be given to a person with a known fertility; but you know updates are there that you give a person her choice but as a family planner depo delays fertility. I have seen ladies who were using Depo and after they leave it they stay for even up to 2 years without a baby so I think it should be given with caution because it delays fertility... Things like IUCD, Norplant; youths should be restricted to pills only because if you insert a Norplant in a young girl who may be having sex after a long time, so for youths it should not be advocated; also IUCD should not be advocated because youth are sexually active and IUCD transmits STIs very fast, so it should be given with a lot of caution so on my opinion they should be given [only] pills” (18-IDI-HSP, Laikipia).

Some HSP reported being in a “dilemma” and indecisive on how to handle younger girls requesting contraception and hence tended to give girls advice (on contraception) that discouraged them from taking up a contraceptive method. One health provider, from health
centres in Nairobi, reported that some of his colleagues sent away young girls in need of contraception.

“....sometimes you wonder what to do for a 14 year old girl who requires a family planning...” (12-IDI-HSP, Nairobi).

HSP from Nairobi and the districts said that they (HSP) often discouraged young people from taking up permanent contraceptive methods, irrespective of the number of children they had,

“At the end of the day the choice is theirs, we give them the advantages and disadvantages to show them that tubal ligation is a permanent method, it is irreversible and at 22 for them to decide, yes they might have four kids, but there are long-term methods that they can maybe try, before they start talking about ...tubal ligation”, (05-IDI-HSP, Nairobi).

“This issue of FP like TL I would not recommend for a youth to be done”, (16-IDI-HSP, Kirinyaga).

Another majority view from HSP, from all the study sites, was that young people were taking emergency contraceptives as regular contraceptives, some for even a period of six months. Most of them were buying from private chemists.

5.3.3.2 Provision of HIV and related services

The majority of service providers, from both integrated facilities and youth centres, were supportive of the provision of HIV-related services to young people such as VCT and ARVs. However, in Nairobi, a minority view was that young people were not adhering to the advice given to them during HIV counselling and testing. Young people were said to be coming for repeated HIV tests within an interval of a few days, giving reasons which HSP considered as flimsy such as “niliteleza” (I slipped, bad luck or unavoidable). HSP reported being surprised when they receive young boys aged between 12-13 coming for VCT or to get condoms and speculated whether such young boys were being sent by their older girlfriends to have the HIV test done.

“Youth are very ignorant, first of all because even though they are given the information about anything, they are not serious about it, and especially the HIV area because.... you will find a youth coming for a test, especially HIV test, you counsel and then you see the same youth coming for the second and third time to be tested and then you wonder whether the person is adhering to the information that you gave...... The
Another HSP from Nairobi also reported that some young people, after having consensual sex, came to the facility requesting for Post-Exposure Prophylaxis (PEP) on the pretext of having been raped

“…..they [young people] come, they cheat they have been raped, you try and ask questions to verify, not really that you are doubting, you are trying to verify time, period how long, which ARV to use if they tell you how they were raped, some of them at the end of the day you find that they had sex that they wanted to have only to realize later, they had made a mistake so they want post-exposure-prophylaxis not because they were raped”, (05-IDI-HSP, Nairobi).

HSP from health centres in Nairobi also reported that they were receiving cases of teenage girls who turn out to be HIV positive and are not sexually active. Further in-depth investigation reveal evidence of peri-natal HIV transmission as their mothers turn out to be HIV positive when investigated.

5.3.3.3 HSPs' competency in SRH service provision

The majority of the HSP, from both integrated and youth centres, reported that they did not consider themselves competent in providing SRH services to young people. Most of them reported that they did not have adequate counselling skills and had not received any special training on how to handle adolescents. The majority of them recognized that young people were a special group with special interests, who tended to withhold information and there were communication barriers between them.

“I am not very competent because sometimes they come with so many issues and sometimes I am even defeated to answer some of the questions they ask me” (03-IDI-HSP, Nairobi).

“…..I would not say I am really very competent, because sometimes you try to talk to them and sometimes the way they answer you, you feel like they are arrogant and they are like looking you down and really the communication, there is always a communication barrier, it’s a bit very hard…..” (01-IDI-HSP, Nairobi).

HSP from integrated facilities in Nairobi who had not received youth friendly service specific training said that in serving adolescents, they used their skills as mothers, their experience from
working in other departments and on-job-training from health providers who had attended the training,

“I in particular I have not been trained for youth-friendly but from the other experiences I try to put pieces, so I give what I have though I don’t feel so competent, but I am trying as much as I can” (02-IDI-HSP, Nairobi)

“...but for me I have no training, being a mother I talk to them like being a mother” (01-IDI-HSP, Nairobi).

“.........when you have people who have gone for training they come and give you feedback” (04-IDI-HSP, Nairobi).

One HSP, a clinical officer, from Nairobi reckoned that although he had not received youth-specific training, he had adequate knowledge with regards to providing treatment services to young people but his challenge was in counselling skills.

“....I have not done counselling so it could be that is a challenge to me, counselling is one of the main skills that I should have.....actually the techniques in making the youth to open up, at times they are quite protective, they can’t actually open up, so there is that barrier that the youth create which limits your access to them” (01-IDI-HSP, Nairobi)

Another HSP from Nairobi also said that although she provided family planning and STI treatment services, she had not received any specific training in either aspect,

“..as a person I am not trained in family planning but I can issue [provide services] , I am also not trained in STI management but I can use the flow chart” (12-IDI-HSP, Nairobi).

The HSP from Nairobi youth centre believed she was competent in youth friendly service provision, as she had undertaken the necessary training.

“I want to believe I do [being competent] with the skills I have acquired and the knowledge I got in college and there is always a back up in terms of the organization gives us opportunities to attend workshops, whether it is re-fresher course or there is a new test in the market and with that we sharpen” (07-IDI-HSP, Nairobi youth centre).

Health care providers from the district hospitals indicated that they had some knowledge, with regards to providing SRH services to young people, but they needed more training especially in post abortion care and post rape care:
“I personally I feel I need more training because I feel we have new things that are coming up we need updates and also counsellors need more training”, (16-IDI-HSP, Kirinyaga)

One provider from Laikipia district hospital said that she had some skills but needed more, because young people were becoming very knowledgeable by accessing information from the internet and hence could easily challenge HSPs.

“I would say I have the skills but I would need more because every time they [young people] come with something new, the youth have become very knowledgeable they would go to the internet and then they would come and challenge you with something you do not know or heard of”(18-IDI-HSP, Laikipia).

5.3.4 Barriers to SRH service provision; perceptions of health service providers

Health service providers were asked to describe their experiences of providing SRH services to young people. HSP described their experiences as being either negative or positive. The negative experiences described reflected barriers and challenges HSP experienced while providing SRH services to young people. As outlined in Figure 20 the barriers were segregated to show views of HSP from integrated facilities and youth centres. For both type of health facilities, the barriers were further classified into three broad thematic areas: views of HSP that were related to the HSP themselves, the young people and the service delivery processes.

Health service provider related barriers: limited knowledge and competency, HSP dilemmas, communication and language barriers, staff shortage, age of staff, poor staff motivation and selection criteria for HSP training were common barriers, which were mentioned by the majority of HSP from all the facilities. Limited HSP knowledge and competency and HSP dilemmas have been presented in section 5.3.3.

The majority of HSP interviewed expressed concerns about language and communication with young people, who often used “ghetto” and “sheng” languages which HSP do not comprehend.

“....the language they use at times is difficult to understand” (12-IDI-HSP, Nairobi)

“...Language also is another challenge like I had one who came and told me “manze kwa kej CD ikaburst”- I did not get it I had CD [condom] burst only but the other one “keja” I did not understand it, I came to learn it is a house so they are mostly used to talking sheng language in which the old fox [elderly HSP] do not understand” (FGD-HSP, Laikipia)
The majority of HSP from all facilities were concerned with the selection criteria used to select HSP to attend training in youth-friendly services. HSP from health centres in Nairobi indicated that some HSP who do not actually come into contact with young people (such as administrators) were attending the trainings at the expense of HSP who actually serve clients. In Meru HSP reported that some of their colleagues were only interested in receiving the training certificates “to keep in a box” and not to actually in providing services.

“...If it is something [training] on your line, you hear someone else has been picked from somewhere else and they have taken a course which is supposed to be on your line, you feel de-motivated…”, (FGD-HSP, Meru)

“…train the people who are on the ground so that they help the patients than training the bosses…..every training, the [invitation] letter is taken to the in-charge [facility manager], the in-charge themselves attend the training and they are never there, so its misuse of the funds because it is not going to the client” (01-IDI-HSP, Nairobi).

The majority of HSP, from integrated facilities, also mentioned poor HSP approach including offering advice that tended to discourage service use as other barriers to service provision. Examples of poor HSP attitude included being judgemental, having the tendency to easily condemn young people, being harsh and giving young people lectures when they presented with an SRH problem such as an STI or when in need of contraceptives or condoms.

“It is true because I look at young boy and girl who has come for condoms and it is the age of my son or daughter and I will ask, why are you taking them? And a young girl who has come for contraceptive then you start preaching to her or lecturing her and that is what they do not want” (11-IDI-HSP, Nairobi).

“Or maybe you quarrel them; where are you getting these diseases from? You are still young; do you know also you can still get HIV if you continue like this?” (FGD-HSP, Laikipia).

Service providers from integrated facilities said that youth need to be attended to by persons who were younger as they tended to see elderly HSP as their mothers and this made them not open up and freely express themselves;

“Of course the age of the staff, may be when they meet somebody who is not of their age group they say now I can’t tell this one she is just like my mother, so of course, that way you don’t expect her to open up of which maybe if she meets somebody of their age bracket she will be able to open up” (04-IDI-HSP, Nairobi).
Young people related: barriers to SRH service provision mentioned by HSP that related to the youth themselves, showed variation between HSP from integrated facilities and those from youth centres. HSP from integrated facilities felt that young people wanted preferential treatment meaning they wanted to be seen immediately they arrived; they often delayed seeking health care, lacked honesty and exhibited poor follow-up of appointments. Also mentioned was the fact that young people at times addressed HSP in an arrogant manner. Table 35 highlights some of the descriptive terms HSP used to describe their experiences in working with young people.

HSP from youth centres mentioned young people lacking accurate information especially on emergency contraception, young people being selective on the HSP to attend to them and pregnant or married adolescent girls not wanting to access serves at the youth centres.

Table 35: Descriptive terms HSP use towards young people in relation to SRH service provision

<table>
<thead>
<tr>
<th>General descriptive terms HSP use towards young people</th>
<th>Do not come for services immediately (early enough)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are a special group with special interests</td>
<td>Don’t want to be seen to be with loose morals,</td>
</tr>
<tr>
<td>Are not patient</td>
<td>Some would even talk badly at you /</td>
</tr>
<tr>
<td>Don’t want to be seen going to a health facility</td>
<td>they have no good approach</td>
</tr>
<tr>
<td>Are tricky</td>
<td>They like withholding information</td>
</tr>
<tr>
<td>Are not straight-forward</td>
<td>Do not want to queue</td>
</tr>
<tr>
<td>Provide incorrect information during consultation</td>
<td>Are ignorant</td>
</tr>
<tr>
<td>Pretend to be asking questions about other people when it’s about themselves</td>
<td>Are good at hearing but they do not adhere</td>
</tr>
<tr>
<td>Cheat you</td>
<td>Selective of the HSP to attend to them</td>
</tr>
<tr>
<td>Are quite shy</td>
<td>Dealing with youth is the most difficult thing</td>
</tr>
</tbody>
</table>

Service delivery related barriers: lack of essential equipment and supplies such as medication, contraceptives; lack of anonymity and privacy and high workload were some of the barriers that were mentioned by the majority of HSP in all the facilities. Long waiting time was mentioned by majority of HSP from integrated facilities. Cost was a minority view that was elicited from integrated facilities in Nairobi, where one HSP said that although the cost of services had been subsidised, some young girls could not afford the minimum fee.

The majority of HSP from health centres in Nairobi reported the presence of long queues at the health facilities. This made the environment unfavourable for young people to seek health
services. In addition clients who needed in-depth discussion on particular issues were not well attended to as the contact time between HSP and young people was short.

“…..time period, we have very long queues that is also another weakness, the youths are impatient, they don’t wait for long, some of them maybe have run away from home, they don’t want to be seen, all that contributes” (05-IDI-HSP, Nairobi)

Inconvenient working hours, non-comprehensive services and lack of district management support were barriers mentioned by HSP from youth centres. At Nairobi youth centre, lack of clinical staff meant that clinical services could only be available at specific times and days of the week. The majority of HSP from all facilities were also concerned that since a wide range of services was not available, young people had to be referred elsewhere for other services. In youth centres attached to a district hospital, clients were referred to the main hospital while at community based youth centres, like Nairobi youth centre, clients were referred to neighbouring clinics or hospitals.
**Figure 20: HSPs' perspectives on barriers to SRH service provision**

<table>
<thead>
<tr>
<th>Views from HSPs from integrated facilities</th>
<th>Views from HSPs from youth centres</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health provider concerns</strong></td>
<td><strong>Health provider concerns</strong></td>
</tr>
<tr>
<td>- Limited knowledge and competency</td>
<td>- Limited competency</td>
</tr>
<tr>
<td>- HSP dilemmas</td>
<td>- HSP dilemma</td>
</tr>
<tr>
<td>- Poor communication or language barriers</td>
<td>- Language barriers</td>
</tr>
<tr>
<td>- Staff shortage</td>
<td>- Staff shortage</td>
</tr>
<tr>
<td>- Age of staff</td>
<td>- Age of staff</td>
</tr>
<tr>
<td>- Poor staff motivation</td>
<td>- Poor staff motivation</td>
</tr>
<tr>
<td>- Selection criteria for HSP training in YFS</td>
<td>- Selection criteria for HSP training</td>
</tr>
<tr>
<td>- Poor HSP’s approach and attitude</td>
<td>not well structured</td>
</tr>
<tr>
<td>- HSP tended to give advice that was</td>
<td></td>
</tr>
<tr>
<td>discouraging service use e.g. contraceptive use</td>
<td></td>
</tr>
<tr>
<td><strong>Service delivery related concerns</strong></td>
<td></td>
</tr>
<tr>
<td>- Lack of equipment</td>
<td>- Lack of equipment and supplies</td>
</tr>
<tr>
<td>- Lack of anonymity</td>
<td>- Fear of being seen visiting the facility</td>
</tr>
<tr>
<td>- Lack of privacy in some clinics</td>
<td>- High workload</td>
</tr>
<tr>
<td>- High workload</td>
<td>- Facility location- youth centre</td>
</tr>
<tr>
<td>- Long waiting time</td>
<td>located next to mortuary in Laikipia</td>
</tr>
<tr>
<td>- Non-integration of services</td>
<td>- Inconvenient operating hours- not open at weekends</td>
</tr>
<tr>
<td>- Lack of enough room, working space</td>
<td>- Services not comprehensive – non-integration of services</td>
</tr>
<tr>
<td>- Cost of services</td>
<td>- Lack of management support- no logistical support for outreach activities, no maintenance of equipments for recreational activities</td>
</tr>
<tr>
<td>- Lack of system for maintenance of outdoor and in-door games such as pool table, darts</td>
<td></td>
</tr>
<tr>
<td><strong>Young people related concerns</strong></td>
<td><strong>Young people's concerns</strong></td>
</tr>
<tr>
<td>- Young people want preferential treatment</td>
<td>- Lack of accurate SRH information e.g on emergency contraception</td>
</tr>
<tr>
<td>- Young people delay in seeking health care</td>
<td>- Young people are selective on the HSP to attend to them</td>
</tr>
<tr>
<td>- Lack of honesty among young people</td>
<td>- Married and pregnant adolescents not willing to be referred to youth centre from Main hospital (MCH or General VCT)</td>
</tr>
<tr>
<td>- Poor follow-up</td>
<td></td>
</tr>
<tr>
<td>- Young people have poor approach, may talk to one badly</td>
<td></td>
</tr>
<tr>
<td>- Peer pressure – may advise each other against coming for a certain service such as contraception</td>
<td></td>
</tr>
</tbody>
</table>
5.3.5 How to improve available SRH services

HSP were asked to make suggestions on how SRH services for young people could be improved. The areas mentioned are listed in Table 36, and are categorised to reflect views of HSP from integrated facilities and those from youth centres. HSP views have also been categorised in three broad thematic areas to reflect whether the suggested improvements are targeting the health service providers, the service delivery process or the young person.

Improving staffing levels, staff training in YFS, instituting selection criteria for staff who attend training in YFS, and staff motivation were improvement areas that were mentioned by the majority of HSP from all the facilities. The need for forums or activities that bring young people into the health facilities were also mentioned. Ensuring availability of services, provision of integrated services, especially at the health service provider level, facility improvement initiatives and enhancing privacy and anonymity were also mentioned by the majority of health service providers.
Table 36: Suggestions from HSP on how to improve young people's access to SRH services

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>HSP from integrated facilities</th>
<th>HSP from youth centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health provider related</td>
<td>▪ Improve staffing levels; proper staff deployment</td>
<td>▪ Improve staffing levels</td>
</tr>
<tr>
<td>improvements</td>
<td>▪ Training more staff in YFS – will also prevent personalization of services</td>
<td>▪ Training more staff in YFS</td>
</tr>
<tr>
<td></td>
<td>▪ HSP training to include support staff</td>
<td>▪ Institute selection criteria for staff training in YFS</td>
</tr>
<tr>
<td></td>
<td>▪ Institute selection criteria for staff training in YFS</td>
<td>▪ Institute staff motivation</td>
</tr>
<tr>
<td></td>
<td>▪ Institute staff motivation and incentives such as certification,</td>
<td>▪ Motivation and incentives for youth volunteers</td>
</tr>
<tr>
<td></td>
<td>workshop attendance, recognition of good service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Motivation of youth volunteers</td>
<td>▪ HSP to conduct outreach education activities in the community through provincial</td>
</tr>
<tr>
<td></td>
<td>▪ Improve staffing levels</td>
<td>administration and disseminate RH information</td>
</tr>
<tr>
<td></td>
<td>▪ Training more staff in YFS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Institute selection criteria for staff training in YFS</td>
<td>▪ Institute staff motivation</td>
</tr>
<tr>
<td>Service delivery related</td>
<td>▪ Ensure availability of essential supplies, drugs, basic equipment for ANC/FP, HIV and pregnancy</td>
<td>▪ Ensure availability of essential equipment eg in ANC/FP: improve privacy for the same</td>
</tr>
<tr>
<td>improvements</td>
<td>tests kits, FP commodities</td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>▪ Create adequate space to attend to young people</td>
<td>▪ Have full-time services</td>
</tr>
<tr>
<td></td>
<td>▪ Need for facility improvement initiatives such as having youth-specific rooms similar to VCT/</td>
<td>▪ Provide a wide range of services including ARVs, CCC, have a laboratory</td>
</tr>
<tr>
<td></td>
<td>PMTCT rooms where youth can be served without lining up</td>
<td>▪ Set aside youth only days at the CCC once a month</td>
</tr>
<tr>
<td></td>
<td>▪ Improve privacy in the ANC/FP room</td>
<td>▪ Introduction of pay-in service system for sustainability</td>
</tr>
<tr>
<td></td>
<td>▪ Have youth-only facility if possible improvise a container</td>
<td>(Nairobi youth centre)</td>
</tr>
<tr>
<td></td>
<td>▪ Improve privacy at the service delivery areas</td>
<td>▪ Avail educational materials. Have educational messages in Cassettes, audio-CDs, DVDs</td>
</tr>
<tr>
<td>Young people related</td>
<td>▪ Need forums that can bring young people to the facility – youth-related initiatives and activities</td>
<td>▪ Have youth-related initiatives at the facility</td>
</tr>
<tr>
<td>improvements</td>
<td>▪ Have TV room with videos, library with books</td>
<td>▪ Have outreach activities to schools and churches</td>
</tr>
<tr>
<td></td>
<td>▪ Have youth activities at the facility such as games, such as pool; computers</td>
<td>▪ Have more activities at the facility to occupy young people</td>
</tr>
</tbody>
</table>
5.4 Summary of responses from three respondents: young people, community members and HSP

Figure 21 gives an illustrative summary of the results presented in this chapter. The figure shows the common thematic areas that have emerged from the three groups of respondents: young people, community members and HSPs. In summary the results show that there are some commonalities in the results with regards to the SRH problems young people experience, perceptions of available SRH services, barriers to accessing SRH services, and suggestions on how available SRH services could be improved. The figure also shows specific key findings that have emerged from the three groups of respondents as well as areas of divergent views or perceptions.
Figure 21: Summary of responses from three respondents: young people, community members and health service providers
Young people (YP)

Girls seeking ANC and
FP services at integrated
facilities described
available SRH services as
meeting their needs

CMs and YP
share similar
myths and
beliefs about
condoms use

CMs approve of SRH
services that are
educative and
preventive in nature

Community
members
(CMs)

CMs are not aware
of availability of
SRH at facilities

YP emphasized the nonhealth benefits of youth
centres: e.g. confidence
building communication,
career progression

SRH service problems of young people (YP)

Contraception, pregnancy, abortion,
STI/HIV/AIDS, sexual violence treatment
and counselling, SRH information, SRH
and general counselling
Perceptions of available services

Young girls who have never given birth
should not be allowed to use contraception

Contraception and sexuality education can
encourage YP to get involved in increased
sexual activity
Barriers to accessing SRH services by young
people

Fear, embarrassment, lack of anonymity

Uncomfortable health seeking environment

Lack of awareness of available SRH
services

HSPs lack
competency in
adolescent
counselling and
communication

HSPs have
negative
prejudices on YP
towards YP

Within youth centres, there
are concerns about lack of
clinicians and services on a
full-time basis




Parental restriction
HSPs- poor attitude, limited in
number, skills, language and
age barriers

Long waiting time

Lack of essential supplies

Limited working hours

Corruption
How to improve access

Increase SRH service
availability

Improve HSPs attitude

Awareness creation of
available services

Increase opening hours

Have youth-related activities

Boys indicated that
available SRH services at
integrated facilities are
designed for women and
children
Games at
facilities only
favour boys

The majority of HSPs
are aware of the YFS
concept but not of the
supporting policies
and guidelines

Irrespective of training, HSPs
are still conservative with
regards to providing SRH
services to young people

HSPs are torn between
societal norms and
values and respecting
YP‟s SRH service
needs and rights

Health Service
providers (HSPs)

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Chapter 6: Objective 4: To explore the different models of SRH service provision and develop an SRH service delivery model for young people in Kenya

6.0 Introduction

This chapter is presented in two sections. The first section (6.1) presents results from 11 KIIs comprising of facility and programme managers on their perceptions of available SRH services for young people. The sections describes managers’ views with regards to the supportive elements for SRH service provisions, and outlines the strengths and weaknesses of the two models of service provision, integrated facilities and youth centres (summarised in Table 38). The second section (6.2-6.7) describes the process of developing the SRH service delivery model for young people, presents the proposed model, highlights stakeholders’ views on the model and presents the final version of the model, after incorporation of stakeholders’ views.

A total of 11 key informants participated in the first round of interviews (Table 37). They included nine health facility managers drawn from health facilities visited and two programme managers from UNICEF and Save the Children Canada. Five of the facility managers were drawn from integrated facilities while 4 were drawn from youth centres. Most (5) facility managers were females while only 2 were males.

Table 37: Details of KII who participated in the primary data collection

<table>
<thead>
<tr>
<th>KII type</th>
<th>Facility type/ Organisation</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Integrated</td>
<td>Youth centres</td>
<td>NGO/ Partners</td>
</tr>
<tr>
<td>No of facility managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of programme managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
6.1 Facility and programme managers views on SRH service provision to young people

In this section, facility and programme managers’ views, on four supportive elements of SRH service provision to young people are presented. This includes: supportive policies for SRH service provision, youth involvement and participation in SRH services, planning and monitoring of SRH services, and the constraints of SRH service implementation.

6.1.1 Supportive policies for SRH service provision

Programme managers reported that SRH problems of young people are well articulated in the policy documents of three ministries, MOPHS, MOMS and Ministry of Youth Affairs (MOYA). However, the priorities and age definition outlined by the three ministries are inconsistent. While MOYA is largely concerned with addressing issues of employment and youth empowerment for young people aged 15-35, both MOPHS and MOMS aim at improving the well-being and SRH of young people aged 10-24yrs.

With the exception of health centres in Nairobi and Kirinyaga district hospital, all three youth centres visited had policies and guidelines on SRH services for young people, either in the form of posters, fliers or booklets. However, deficiencies in the link between policy implementation and service delivery were reported.

“In this area of ARH [adolescent reproductive health] we have a very good policy environment at say theoretical level, there we have a policy, we have a department, we have a division [DRH] which takes care of all that but when we go to the grass root level there is a big gap, at the district level”, (KII, Programme manager SCC)

The programme managers were also concerned about the working structure at the district level. The district has two cadres of staff who monitor provision of STI/HIV/AIDS and RH services; the district reproductive health co-ordinator (D-RHC), and the District HIV/AIDS and STIs coordinator (DASCO). The D-RHC monitors and supervises RH activities within the district, while the DASCO supervises STI/HIV/AIDS services. These two staff report to different department at both the provincial and national levels. Programme managers expressed concerns with regards to working more with the DASCO than the RH-coordinator. They felt that the current working arrangement resulted in the RH problems of young people not being addressed comprehensively as the activities tended to focus mainly on provision HIV/AIDS services.
6.1.2 Youth involvement and participation in SRH service provision

In-depth interviews with facility managers indicated that youth participation in SRH service provision varied from one facility to another, but was encouraged as it created a sense of ownership and “belonging” among young people. With regards to youth centres, the managers noted that young people were actively involved in the decision making process by being active members of the management committees. For example, at Nairobi youth centre, young people were part of the administration committee which coordinates the development of the facility annual work plan. Young people were also involved in the planning and organisation of outreach activities for schools and the community.

“.....let me talk about annual planning of each year, this document is revised by the peer educators through their committee, if there are any changes they want to make, they do the changes, then they forward it to the centre coordinator, who then gives it to the programme manager to see whether it can be changed” (KII Facility manager, Nairobi youth centre)

Youth participation was said to be dependent on availability of financial resources as it was only active in health facilities that received financial support from NGOs (Nairobi and Meru youth centre). In Meru youth centre, young people have previously been involved in the identification of the youth centre construction site, colours to paint the youth centre, games, tents and reading materials to be purchased. At facilities with no NGO support, youth participation was minimal or non-existent (Laikipia youth centre, health centres in Nairobi and Kirinyaga district hospital). Facility managers of health centres in Nairobi, reported that young people were not actively involved in the decision making process but were called upon when need arose to take part in some activities, such as the periodic clean up of the facility compound, taking part in other health initiatives such as national immunisation campaigns, “operation smile” among others.

While recognizing the importance of having a vibrant peer education system, programme managers and facility managers were fully aware of the challenges involved, ranging from peer educators high expectations, high attrition and turnover and high financial requirements. With high rates of unemployment in Kenya, young people volunteering services through peer education expect to get employed by the facility and if not, at least be given some subsistence allowance at the end of the month; an expense that public health facilities cannot provide.

“...the other challenge is that some of them come and after working for some time they want to be employed like when we have the employment in the hospital, so they expect because
they are coming to assist in the youth centre, when the hospital is employing they are supposed to be considered first.....” (KII Facility manager, Meru youth centre)

The managers pointed out that high level of peer educators’ attrition implied that projects involving peer educators had to constantly recruit and train new peer educators, which was a costly endeavour. At the community level, competing projects using the peer education strategy, coupled with lack of standardized implementation guidelines among stakeholders working in the same community, leads to the alignment of peer educators to projects that pay higher allowances. Lack of co-ordination among key partners addressing issues of ASRH at the community level (the school, the church and NGOs) also affects implementation activities, as the stakeholders have different guidelines on the SRH information to be provided to young people.

Although the majority of facility managers supported the presence of games for young people at the health facilities, a minority view was that games could also be a barrier and prevent young people from accessing services.

“..games is a nice thing to have but I am trying to think that maybe it’s not a must have......the darts, the snookers they serve more to distract and move away the youth from the core services located within” (KII Facility manager, Nairobi)

6.1.3 Planning, supervision and monitoring SRH service provision

It seems that the district health management planning process is deficient as it is not totally inclusive of all departments. None of the health centres in Nairobi had annual work plans to guide general service delivery, including ASRH services. The health centres only had activity schedules which had neither clear objectives nor set targets.

Facility-based youth centres (Meru and Laikipia) also did not have annual work plans. The manager of Meru youth centre reported not participating in the development of the annual district health plans and was, therefore, not aware of details of ASRH activities in these plans. However, the manager noted that some activities carried out by youth centre staff were individual based and formed part of their annual staff appraisal. The youth centre was also said to be implementing a plan that had been developed by their partner NGO, SCC although a copy was not available at the facility.

Nairobi youth centre was the only facility that had an action plan with detailed activities targeting young people, complete with detailed activities and budget.
Programme managers also said that supervision by the national level team was weak and did not have adequate resources.

“....the issue of supportive supervision is a big problem. I don’t think we have a strong team at the national level to support these services. If there are teams, there are no resources...” (KII Programme manager, SCC)

The programme manager, SCC and manager Meru youth centre, reported that there was a gap with regard to the collection and utilisation of data from facilities offering YFS. They reported that no one within the MOPHS at the national level, specifically requested for data on YFS. The data management system for YFS was said to be weak compared to data obtained for other services such as HIV/AIDS services. The manager stated that they were stuck with this data and did not know where to forward it to between DRH and NASCOP. Standardized data collection registers and summary forms for service statistics were also not available and information about numbers of young people coming for information, recreational activities and games was also not available. It was not clear to the managers how health information collected on YFS provision was being utilised in the planning processes, both at the national level and at the district level. Due to the existing gap in the standardization of registers and data summary forms for YFS, facilities and especially youth centres had developed their own reporting tools, either through their own initiative or as a result of guidance from the funding agencies and NGOs.

6.1.4 SRH services implementation constraints

The managers identified seven constraints they experience in the implementation of YFS: these included, lack of prioritization of YFS activities, inadequate national and district level management support, deficiencies in funding, inadequate staff, conflicts between management and young people, inconvenient opening hours for youths; and inadequate supplies and maintenance of equipment.

Lack of prioritization of YFS activities

Programme managers from Unicef and SCC identified lack of prioritization of YFS, at both national and district level, as one of the challenges facing the implementation of SRH programmes; most YFS activities were said to be missed out in the mainstream health plans. The concept of YFS was said not to have been internalised by most health service providers, including national and district level managers. It was noted that,
“...there are several planning processes but those planning at different stages may not clearly identify adolescent sexual reproductive health as a priority so these [ASRH] activities are commonly missed in many of the plans”, (KII Programme manager, Unicef)

The managers noted that adolescent health was not a key priority area, at the district level and issues of adolescent health were not given the seriousness that they deserved. An example was given of one of the districts hospitals, where a building which had been renovated to serve young people was turned into an administration office.

**Inadequate national and district level management support**

In some public health facilities where youth centres have been constructed through support from NGOs, ownership by the local management has been slow and, in some cases, the youth centres are not regarded as an integral part of the hospital; they are seen to be belonging to the supporting NGOs. In some districts some of these youth centres have closed down due to unavailability of resources and health service providers. For some, the consultation and procedure rooms have been converted into offices and cooking areas. Even when donors purchase equipment for use in the youth centres, maintenance and replacement of such equipment is not undertaken by facility management. So far management support at the district level has largely been verbal, with no financial commitment.

The programme manager of SCC said that there was no proper structure and process from the national level down to the district level, to support YFS provision. Adolescent RH was said to be a new area within the health sector and there were “no strong voices” at the district level to push for the ASRH agenda, with regards to human resource expertise.

“It is really a new area within the ministry, so there are no strong voices in the districts including expertise, human resource, at the district level. The structures do not allow the way we have [like] MCH; other departments are well guarded by the structures of the Ministry” (KII Programme manager, SCC)

The Laikipia youth centre facility manager also reported that ownership of the youth centre, by the facility management had taken a sluggish pace and that the youth centre has not been recognized as a department within the hospital since inception.

“The other one is the owning up of the whole processes, it’s like the youth centre has not been very much accepted as a department in the hospital. Especially....not part of the
hospital such that maybe when it comes to funds allocation to other department you find maybe they get quite [left out]...(KII Facility manager, Laikipia youth centre)

**Deficiencies in funding**

The majority of managers reported that most activities targeting young people were donor funded and driven. The managers noted that there was no particular budget line specific for YFS activities, facility improvement and training of health service providers. On-going activities at both national and district levels were largely dependent on donor funding, and at facilities where there was no donor support, YFS activities, with the exception of HIV/AIDS related activities, were not present.

“...even funding from the government am not sure whether there is a particular budget line from government to fund adolescent sexual reproductive health activities, they are just funded as part of reproductive health activities in terms of commodities like condoms, but the specific issues that are required, training and the rest are not factored in the funding...” (KII Programme manager, Unicef)

**Inadequate staff to work in the youth centres**

The programme manager of SCC reported that in the three districts where they supported construction of youth centres, Laikipia, Nyandarua and Isiolo districts, the facility management had been unable to allocate staff to work in these youth centres. In addition, some staff had been wrongly deployed in relation to their skills. In one district (Isiolo), the youth centre was closed down by the management due to lack of staff. Lack of staffing has a negative impact on the provision of comprehensive SRH services.

“...when you look at where we built our youth centre in Njambini [health centre] when you look at the constraints in terms of health workers they can’t, but they are very willing, they are willing, they have already employed a young person. They actually pay the young person to manage the youth centre but the only service now the young person can offer is the VCT and a bit of referral” (KII Programme manager SCC)

At Laikipia youth centre there was no permanent clinician allocated to work in the centre. Despite having adequate space for a laboratory, the centre did not offer laboratory services due to lack of staff, essential supplies and reagents. Moreover, HSP that had initially been deployed to work in the youth centre were re-deployed to the main hospital and essential equipment, such as microscopes, transferred to the main hospital laboratory (Figure 22).
“….the lab started [operating] but again the lab had other issues; the reagents, and you see now the youths are not being charged anything and most of these reagents are bought by the hospital. So it’s kind of a lab which could have demanded some extra funding from somewhere. And now, if it is the main lab, they charge and the funds they collect again goes back to buying the reagents. So, again, it was a major blow to the lab services…” (KII Facility manager, Laikipia youth centre)

Figure 22: Laikipia youth centre; laboratory turned into kitchen

Conflicts of interest in utilisation of the youth centres

The programme manager from SCC reported that there existed a conflict of interest between the facility management and young people, with regard to the utilisation of the youth centres. In instances where youth centres are located within a major hospital such as, at the district hospital, it was reported that the facility management, sometimes preferred using the youth centre as a venue for holding meetings and conducting training workshops for health workers; at the expense of delivering services to young people. In another district where SCC had supported the construction of a youth centre, the Medical Officer of Health turned the recreation room into an administration office. In addition, the district education officer turned one of the counselling rooms into an office and therefore the facility ceased being a youth centre.
“….in Meru south, there are issues, there are conflicts between health management and the youth groups in terms of facility utilization, we have board meetings, we have these trainings, where is it done? It is in the youth centre, for a whole week, which means services are not offered”, (KII Programme manager, SCC)

**Inconvenient opening hours**

The managers reported that HSP from public health facilities are work from Monday to Friday, 8.00am-5.00pm, while some activities are better done during the weekend, such as outreach activities to the community and schools. Meru youth centre manager was concerned about the facility not being able to operate during weekends and public holidays due to the shortage of staff.

**Inadequate maintenance of equipment**

The majority of managers reported that replacement of equipment, games and other recreational items was a major concern. The facility managers expected financial support from partners or NGOs for procuring and maintenance of damaged equipment. This was because they were unable to get financial allocation from the hospital management. Sustaining supplies at the youth centre was also said to be a problem since young people do not often pay for services.

“..I want a motorbike, to do mobilisation; Chuka [district hospital] now they expect us to do [construct] a separate small building where they can put the games, pool table, and many others...they are asking us to build a smaller structure, which is not within our budget, which is a very good idea but I would expect the hospital to do that. In Laikipia [youth centre] even a ball game, they can’t supply the nets, they still ask Save the Children [Canada] to do it. So there are all those kind of requests. They are good but in the agreement it was for the Ministry to take over”, (KII Programme manager, SCC)

**6.2 SRH service delivery model strengths and weaknesses**

Broadly, two models of SRH service provision for young people were examined in this study, youth centres and integrated facilities. Table 38 gives a summary of the responses on the strengths and weaknesses of integrated facilities and youth centres. This has been derived after consolidating the responses from FGDs and IDIs with young people, health service providers, facility managers and programme managers.

The majority of managers reported that youth centres had the advantage of being facilities that serve only young people, have friendly staff and have other resources for use by young people to increase
their knowledge on SRH as well as improve their life skills. The majority of managers also reported youth centres to be heavily reliant on donor funding and also experience implementation challenges such as lack of clinicians to provide the services. In addition, some managers perceived facility-based youth centres as parallel health structures, encroaching onto the merge hospital resources.

With regards to integrated facilities the managers reported the facilities to be able to offer affordable and a wide range of SRH services to young people. Integrated facilities were said to have an in-facility referral mechanism, between departments, and availability of clinicians during official working hours. Weakness of integrated facilities identified mainly revolved around lack of privacy and anonymity, long waiting time, staff shortages and lack of youth-specific activities.
### Table 38: Strengths and weaknesses of SRH service delivery models: integrated facilities and youth centres

<table>
<thead>
<tr>
<th>Service model</th>
<th>delivery</th>
<th>Strengths</th>
<th>Weaknesses</th>
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| **Integrated facilities** |          | - Wide range of services available: in-facility referral services available  
- Clinician always available (weekdays 9.00am – 5.00pm)  
- Services cheap and hence affordable  
- Some HSP are trained in provision of YFS and are friendly  
- Good linkages between community and facilities through community health workers and other resource persons  
- Good location – some facilities are within walking distance | - Young people receive services as part of the general public  
- Staff shortages  
- Long waiting time for clients, high workload for the staff  
- Poor staff attitude including support staff; some staff are unfriendly and elderly  
- Concerns about clients’ privacy, confidentiality, anonymity, in some cases consultations are not private as there are other clients and staff in the consulting room.  
- No youth specific counselling sessions apart from VCT; health talks available but also not youth specific  
- No room for youth specific counselling sessions apart from VCT; health talks available but also not youth specific  
- No room for youth - lack of consultation space  
- Lack of essential supplies such as drugs  
- No system for maintenance of equipment and supplies (especially equipment for YFS - outdoor games, etc)  
- No active peer education system  
- No incentives for youth volunteers  
- No financial and logistical support for community outreach activities | |
| **Youth centres** | Facility-based | - Youth-only facility  
- In-facility referral: Young people receive specialised services by referral within the hospital  
- Good privacy during consultation  
- HSP are friendly and younger  
- Youth resources available: library, peer education  
- Outreach activities: availability of outreaches to schools and the community  
- Community acceptance: the community views positively the services offered by the youth centre. | - Limited range of services available: Provision of VCT, contraceptive pills, EC, general counselling: no laboratory services available  
- Lack of essential supplies and reagents  
- Inadequate clinical staff: affects service availability  
- Heavy reliance on donor funding  
- Educational resource materials available are outdated  
- Lack of ownership of the youth centre by the hospital management. Youth centre seen to belong to NGOs  
- Youth centre is seen as a parallel health structure  
- Conflicts of interest in utilisation of the youth centre - managers want to use the youth centre for meetings and training workshops)  
- Lack of prioritization of SRH services for young people | |
| **Youth centres** | Community-based | - Youth-only facility- offers services such as VCT, youth counselling, contraceptive pills, condoms  
- Supportive staff: facility has friendly youthful staff  
- Youth resources available:  
  - Availability of activities such as games gymnasium, library, cyber cafe, hairdressing  
  - Vocational training - computer training  
  - Active peer education system –  
- Good management support in terms of HSP training, procurement of equipment and supplies, community outreach activities | - Limited range of services available: only VCT services available on full-time basis.  
- Lack of clinical staff: affects clinical service availability, services may only be offered on particular days or hours of the week  
- Young people referred to neighbouring clinics or hospitals  
- Low turnout of female clients: males are more frequent visitors to the youth centre compared to females.  
- Heavy reliance on donor funding  
- Games like pool may only attract boys and scare away girls  
- Stand-alone services may be stigmatized by young people |
6.3 Development of SRH service delivery model for young people

As outlined in section 4.7 of the methodology chapter, the process of developing the model for provision of SRH services to young people in Kenya involved four processes:

i) Exploring the different models of SRH service provision and indentifying their strengths and weakness, through IDIs of facility and programme managers (section 6.1).

ii) Identification of key components of the SRH service delivery model through consolidation of findings from
   - Literature review on SRH interventions and development of health care delivery models
   - Examination of primary data responses from young people, community members, health service providers, facility managers and programme managers.

iii) Application of the research findings to the identified SRH service model components

iv) Review of the developed SRH service delivery model by obtaining stakeholders’ view on the model through a series of participatory workshops (see Figure 16).

6.3.1 Identification of key components of a SRH service delivery model

6.3.1.1 Literature review of SRH interventions and development of health care delivery models

In reference to the literature review findings on approaches to improving the SRH of young people (section 2.2), overall, SRH interventions targeting young people have largely taken the following approaches: i) facility-based (section 2.2.2a), ii) school-based (section 2.2.2b), iii) community-based (section 2.2.2c) and iv) multi-component or combination of approaches (section 2.2.2a). The literature review showed that interventions that used a combination of approaches were likely to produce positive results, with regards to the SRH behaviour outcomes and increase in service utilization by young people. Studies have recommended the implementation of facility-based interventions, with linkages to schools and the community, accompanied by a strong process and impact evaluation (Dick et al. 2006). The SRH service provision model that is designed in this study is primarily facility-based with linkages to both the community and schools. The purpose of adopting a combination approach is to reach out to the different groups of young people who are either in-school or out-of-school.
The literature review of health service delivery models resulted in the identification of 12 key interrelated elements essential for the development of health service delivery models (see Table 12). This included: goal or purpose of the service; service delivery mechanism; staffing; supplies and equipment availability; institutional infrastructure; financial sustainability; organisational structure; networking; communication channels; evaluation; community participation and the political environment.

As previously discussed in section 2.5.1 on key components of health care delivery models, Girard (1993) asserts that in developing nursing care delivery models, one needs to identify three key components which are essential for the design of a health service delivery model. These include: enabling or assistive factors, barriers and boundaries. With the model developed in this study, identification of the above three components was done by reviewing the strengths and weaknesses of available SRH service models (described in section 6.1), as well as examining the primary data of the four categories of respondents who took part in this study namely: young people, community members, health service providers and facility managers.

6.3.1.2 Examining primary data of young people, community members, HSP and facility managers

To begin with, enabling factors were identified by reviewing respondents’ positive views of the available SRH services, their suggestions on strengths of available SRH service delivery models and how available SRH services could be improved. Likewise, barriers were identified by examining the negative views on the available SRH services, barriers and SRH service model weaknesses respondents gave towards available SRH services. Details of this synthesis are presented in Figure 23. Both enabling factors and barriers identified were related to the following aspects of SRH health care: SRH service delivery, health service providers, young people, supplies and equipment, health management, leadership or governance, financial support and community perceptions. The enabling factors and barriers showed some similarity with the 12 elements essential for the development of a health service delivery model, previously identified in the literature review section. These elements therefore formed the building blocks upon which the provisional development of an SRH service delivery model was anchored (see Figure 24). The SRH service delivery model developed was categorised in two main aspects: supporting structures and the service delivery mechanism.
**Supporting structures** are the inputs that are required to be in place for the effective implementation of SRH services and include six components: addressing health service providers’ concerns, the need to have essential supplies and equipments, ensuring financial sustainability, having good leadership and governance, effective information flow and monitoring and evaluation, and community and youth participation. These supporting structures also form components of an effective health service system. Details of the requirements of each component are listed in Figure 25.

**The service delivery mechanism** defines the core services, additional resources, the service delivery process and expected outcome. The core services address the SRH problems of young people while the service delivery process outlines mechanisms needed to improve access and availability of SRH services. The expected outcome of this model is increased access and utilization of SRH services. Triangulation of responses from young people, community members and HSP led to the identification of the SRH problems of young people. These formed the core services of the model and included the following (also shown in Figure 24):

1. Screening services: pregnancy tests, HIV, STIs,
2. Treatment services: syndromic management of STIs, sexual violence, abortion complications
3. Provision of contraceptives: COCs, condoms, injectables, EC
4. Drug and substance abuse education and counselling
5. SRH Counselling and Education, general counselling
6. Outreach activities to schools and the community and social support services

Respondents also made suggestions regarding having “additional services”, or activities, which could provide non-health benefits to a young person, as well as motivate young people to develop an interest in visiting the health facility. Suggestions made of these additional services by respondents included: recreational activities such as games, educational resources, training on life skills, vocational training, and establishing income generating activities (IGAs) through support to youth groups. The provisionally developed SRH service model was then presented to stakeholders through a series of stakeholder workshops and key informant interviews; the results of which are presented in section 6.4. For clearer presentation of the developed SRH service model to stakeholders, the model was presented in the form of a house with the expected outcome forming the roof of the house, while the core services formed the pillars of the house (Appendix II). The supporting structure formed the foundation of the house or base of the model with recreational resources forming an arch over the house.
Figure 23: Identification of key components: enabling factors, barriers and boundaries

Identification of Key components of SRH service delivery from interviews with young people, community members, HSP, facility managers and programme managers

Identification of enabling or assistive factors
- Service delivery related
  - Affordable services
  - Wide range of services within the facility (within-facility referral)
  - Short waiting time
  - Facility location – distance from residence, public transport
  - Full-time services
  - Facility improvement initiatives such as having youth-only rooms
- HSP related
  - Improving staffing needs such as numbers, skills and competencies, training, proper deployment, motivation, incentives, selection criteria for training in YFS
  - Improving staff attitude, approach or teamwork
- Young people
  - YP regard of the services or the youth centre such as good, place of encouragement, confidence builder, enhance self-esteem
  - Youth-related activities or availability of resources such as library, community outreach activities- schools and community
- Equipment and supplies
  - Availability of essential supplies, drugs and equipment

Identification of Barriers
- Service related factors
  - Limited range of services,
  - Lack of awareness of available services
  - Long waiting time
  - Limited service hours
  - Lack of privacy, confidentiality and anonymity
  - Uncomfortable health seeking environment
  - No proper directions to service areas
  - Inaccessible facility location
- HSP or staffing related
  - Inadequate staffing needs - training, competencies, numbers
- Young people related
  - Fears, lack of honesty
  - Type of games at facility
  - Negative peer influence – discourage one another against using certain services
  - Girls social responsibilities
- Supplies and equipment
  - Procurement – inadequate supplies, drugs and equipment
  - No system for maintenance of equipments
- Health management
  - Lack of health management support and ownership
- Financial
  - Inadequate funding
  - Lack of financial and logistical support for community outreach activities
- Leadership and governance
  - No proper planning, monitoring and evaluation system

Identification of boundaries:
- Facility type:
  - Targeted - Youth- only facility
    - Health facility based within hospital compound
    - community-based
- Integrated-facilities
  - services provided within general health care system
  - infrastructural design
- Managing authority
  - government managed facilities, faith-based, NGO, private for profit
- Facility location
- Policy environment and legal framework

Financial support and advocacy
- Community perceptions
  - Parental, community, societal support and appreciation of the services
- Awareness of the available services
Figure 24: Model for delivery of SRH services: the key components

### Core SRH services
1. Screening services: pregnancy tests, HIV, STIs,
2. Treatment services: syndromic management of STIs, sexual violence, abortion complications
3. Provision of contraceptives: COCs, condoms, depo, EC
4. Counselling on drug and substance abuse
5. SRH Counselling and Education, general counselling
6. Outreach activities to schools and the community; initiation of social support services; mobile services

### Additional resources and services
- Provision of sanitary towels
- Educational resources, life skills training, link to community and school based programmes
- Recreational activities

### Service delivery process
- **Availability:** Client-centred working hours, full-time services, availability of clinical staff, staff motivation and incentives
- **Accessibility:** facility location, distance, short waiting time, service directions, service affordability
- **Acceptability:**
  - Service integration at health provider level
  - Infrastructure: Facility improvement initiatives to enhance anonymity, privacy, cleanliness, set up youth-only rooms, clean
- **Referral mechanism** specialised services such as laboratory services, ANC, PNC, PAC, comprehensive care for HIV+ clients, general medical and specialized SRH services
- **SRH information updates**
  - establishment of health social networks, online counselling system, SMS information service
  - Awareness and demand creation of the available services

### Core SRH services
1. Screening services: pregnancy tests, HIV, STIs,
2. Treatment services: syndromic management of STIs, sexual violence, abortion complications
3. Provision of contraceptives: COCs, condoms, depo, EC
4. Counselling on drug and substance abuse
5. SRH Counselling and Education, general counselling
6. Outreach activities to schools and the community; initiation of social support services; mobile services

### Additional resources and services
- Provision of sanitary towels
- Educational resources, life skills training, link to community and school based programmes
- Recreational activities

### Supporting structures
- Addressing health service providers' needs
- Continuous health care provider training: in-service and pre-services
- Adequate number of staff, proper deployment
- Appropriate skills mix, attitude and approach
- Set up a criterion for selection of health service provider training

### Availability of essential supplies and equipment
- Drugs for STI treatment, contraceptives,
- Testing kits for Pregnancy, VCT,
- Supplies of ARVs,
- Procurement of sanitary towels
- Procurement of in-door games, TV, DVDs

### Financial sustainability
- Advocacy for:
  - Budgetary allocation for SRH services for YP advocacy
  - Establishing public-private partnerships
  - Adoption of youth centres
  - Tapping into locally available resources such as CDF

### Good leadership and governance
- Advocacy for:
  - Prioritization of ASRH services: Supportive policies, clear guidelines and minimum standards
  - Facility management support
  - Partnerships between government, partners, NGOs, and CBOs

### Effective information flow, monitoring and evaluation
- Definition of Monitoring and evaluation indicators: standardization of the M/E system
- Designing scientific and methodologically sound interventions
- Development and maintenance of an updated SRH information system

### Community and youth participation
- In service provision through peer education and peer counselling
- Participation in management committees of youth centres
- Participation in development of annual plans

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The above model outlines the key components and processes involved in delivering SRH services effectively. It emphasizes the importance of good leadership and governance, accessibility, acceptability, and financial sustainability. The supporting structures, availability of essential supplies and equipment, and financial sustainability are integral parts of this model. The diagram visually represents the flow and components, while the text provides a detailed explanation of each aspect.
6.4 Stakeholders views on the SRH service delivery model

A total of 15 key informant interviews were conducted with programme managers and programme officers. They were drawn from both government line ministries, NGOs and development partners. The government line ministries represented included MOPHS (4), (DRH, Family health and NASCOP), NCAPD (1) and Ministry of youth affairs (1). The NGOs/development partners represented included JHPIEGO (1), NOPE (1), Population council (1), FHOK (1), SCC (1), PATH (1), FHI (1), WHO (1) and UNFPA (1). Three stakeholders’ workshops were conducted with programme managers and officers from government line ministries, NGOs, development partners and medical training (Table 39).

The stakeholders’ workshops and key informant interviews aimed at eliciting views and reactions to the provisionally developed SRH service delivery model. The process involved eliciting stakeholders’ views on the core SRH services, service delivery process and the supporting structures needed for effective SRH service delivery. Stakeholders were also asked to identify enabling factors, barriers to SRH service provision, SRH service model acceptability and sustainability. Four key thematic areas emerged from stakeholders’ views on the provisionally developed model; these are: i) model positive aspects, ii) model core services, iii) model weakness, and iv) suggestions on model improvements.

Table 39: Details of respondents who took part in the three stakeholders’ workshops

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<tr>
<th>Workshop No</th>
<th>Total number of stakeholders</th>
<th>Representation of the stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop I</td>
<td>22</td>
<td>MOPHS- DRH, NASCOP, Family health - 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teaching institutions – (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NGOs/ development partners (13)</td>
</tr>
<tr>
<td>Workshop II</td>
<td>23</td>
<td>MOPHS senior managers and heads of departments</td>
</tr>
<tr>
<td>Workshop III</td>
<td>28</td>
<td>MOPHS – 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NGOs / development partners (10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training institutions (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provincial managers (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>District managers (10)</td>
</tr>
</tbody>
</table>

6.4.1 Model positive aspects

Model positive aspects described the benefits of having an SRH service provision model for young people. The majority of stakeholders described the model that was presented as being integrated, workable, doable, relevant, inclusive and comprehensive. They indicated that the model provided an operational framework within which the SRH problems of young people could be addressed, with the end product being the development of minimum SRH service and information packages.
One manager from MOPHS stated that integration of services was the approach the government had embraced, as a way of ensuring that a wide range of services was available and accessible to young people, at the point of contact with a HSP. The manager from SCC described the idea of developing the service delivery model as an effort to bring order and organisation to SRH service provision, based on the SRH problems of young people, instead of what organisations felt comfortable providing.

“.....as it were now...each youth centre decides this is a youth friendly centre but we can choose what we want to provide or what is feasible for us to provide, and what is difficult or what is stressing us then, that one we will leave it, the youth will go and find someone else to provide that…” (07-KII programme officer)

A policy advisor from the Ministry of Planning reported that the model would provide a guide for defining minimum service and information packages for SRH service provision to young people.

“So I like this model because this model will go a long way to set up some guidelines for the youth centres, they can set up minimum guidelines and tell them okay, if you are setting up a youth friendly centre, what do we need? We need the minimum. You can use this one [the model] to come up with the minimum...under services we can have minimum packages...” (05-KII Policy Advisor)

### 6.4.2 Model core services

Although core services of the model presented were said to be comprehensive, suggestions were made for inclusion of other services in the model. The majority of stakeholders felt that aspects of drug and substance abuse had not been explicitly stated in the model. Other aspects such as adolescent pregnancy, disaggregation of services by age and sex, were also not well highlighted in the model. Stakeholders also suggested having counselling on life skills as a specific pillar of the model. The majority of stakeholders also noted that though a very noble idea, provision of sanitary towels would be unsustainable. Table 40 shows a compiled list of other additional services that were suggested by the stakeholders.
Table 40: Additional services suggested by stakeholders

- Pre-conceptual care which includes counselling on when to start childbearing, micronutrient supplementation – iron and folate
- Counselling on
  - life skills, adolescence, relationships, personal hygiene, careers, FGM, mental health, gender based violence (GBV)
- Support services for HIV positive youth
- ANC services and post natal care

- Treatment services
  - anaemia
- Counselling on dangers of drug and substance abuse and referral for treatment
- Training in youth empowerment and livelihood skills
- Treatment of minor ailments

During in-depth interviews, stakeholders expressed their opinions on what they would personally do within their routine practice, as service providers, with regards to contraception, irrespective of the policy framework. Although contraception was mentioned as one of the core services of the developed service delivery model, a minority view from stakeholders was that hormonal contraceptives should not be encouraged among younger adolescents, especially those below 15 years old.

“Still if you are dealing with very young adolescents...like below 15, personally I would not recommend the hormonal methods because they are still, they are still setting their body clock, and many times when we put them on hormones, it disrupts their body clock and they will end up having irregular menses. That’s just my practice, I know many people still put them on that; but the younger the adolescent, the more the adverse effects”, (01-KII Programme manager)

It was acknowledged by the majority of stakeholders that the Kenyan society was still very conservative with regards to discussions around SRH. Discussions around sex, sexuality and sexual health were said to be regarded as a taboo, and hence prohibited by some cultures and religions. Stakeholders were aware of the dilemma health service providers experienced with regards to choosing between their traditional, religious and cultural values and honouring a young person’s right to accessing SRH services.

“....yet on the other hand, the rights of the patients for family planning, one of them is privacy; so it puts the health worker in a dilemma, are you going to give a 13 year old a contraceptive method without parental consent, especially if it a long acting one, let’s say an implant? ...and those are things that will have to be worked out by society. The society has to reach a stage where it is acceptable to the society to do that. And then that releases the service provider to do it”, (01-KII programme manager).
6.4.3 Model weaknesses

Model weaknesses mentioned were varied and included what stakeholders’ viewed as basic assumptions the model had with regards to addressing SRH problems of young people and aspects of youth participation. Marginalised or vulnerable young people who are deaf, blind, and on the streets, were said not to be reflected in the model.

One stakeholder noted that the developed model had inherent assumptions such as; the SRH services for young people were designed around the traditional medical model where a young person was sick and required health services, and the information needs were also largely focused on illness. It was suggested that addressing SRH of young people needed a broader approach of looking at both the social as well as the economic growth and development of the young person.

6.4.4 Suggestions on model improvement

This thematic area lists suggestions made by stakeholders on how to improve on the model presented. Re-organisation of service delivery components, segmentation of services and service customisation, to fit local community concerns, were some of the improvements that were mentioned by stakeholders.

Re-organisation of service delivery components: some stakeholders indicated that the SRH service delivery model presented should be modelled around three key service delivery components: biomedical services: behavioural interventions and contextual or structural issues. In so doing indicators for monitoring progress should also be identified around the same service delivery components.

The need to have a structured sexual health education component was also mentioned by the majority of stakeholders. It was indicated that the contact time HSP or other health educators such as peer educators, had with young people should be maximised by putting in place guidelines on basic or minimum information package that should be passed on to young people at any given opportune contact time. This was to prevent having ad hoc health education sessions from which young people may not get maximum benefits. One stakeholder noted that sometimes peer education sessions may deviate to discussion of topical issues such as football and politics.

“…..so the health care provider who for example, interacts with the young people should have a checklist of....the basic minimum information, that when I interact with this young person at least this information needs to have been shared within a minimum package and within the minimum time that is allowable and possible, so that young
people have adequate, reliable and accurate information at every other interaction with either, service providers or their peers, because that is where peer education has been limited” (02-KII programme manager)

Segmentation of services: the majority of stakeholders noted that services should be segmented so as to target different categories of young people. These include

- Having age specific SRH information
- Targeting forums where young people are (in-school and out of school)
- Targeting young parents, especially with contraception

Service customisation to community needs: the design of SRH services that address the problems of the local population was emphasised by the majority of stakeholders. It was noted that generic service delivery guidelines, which have been developed at the national level, may not work well because rural community health problems may be different from urban community health problems. The need to undertake local studies that identify local community health priorities and problems and hence facilitate community buy-in and participation of local projects was said to be of paramount importance, especially with regards to ensuring service sustainability.

“I don’t think any local studies are done of the community needs and we cannot just have generalized arrangements, because communities to communities are totally different, an urban community, a rural this tribe community compared to a rural another tribe community will have totally different needs and therefore the “one-type-fits-all” type of thing cannot work” (13-KII Programme manager)

6.5 Barriers and constraints to model implementation

Stakeholders were asked to identify barriers that would hinder the successful implementation of the developed model. The majority of stakeholders mentioned the following as some of the barriers that negatively affected SRH service provision to young people: limited finances, lack of prioritization of SRH services for young people, health service provider inadequacies, weak linkages between the different sectors, poor infrastructure, unfriendly operating hours, changes in national level management structure, lack of a monitoring system, and cultural beliefs and practices and religion (Table 41).

Limited finances: the majority of stakeholders reported that limited finance was a major barrier to the provision of SRH services to young people. Lack of budgetary support to these services implied that SRH activities were largely donor dependent at all levels of health care. Donor dependency, coupled with donor fatigue and donor dictation, meant that programme
implementation was limited in scope and coverage. Setting up YFS was also said to be a costly endeavour. For development partners and NGOs who provide or receive funding within the framework of results based programming; investing in adolescent or youth SRH presents a challenge, because the expected results may not be seen within a short period of time. Such partners’ shy away from venturing into the SRH programmes, leaving the programmes devoid of the much needed resources. Dissemination of policy documents and guidelines was also said not to be effective as this was tied to the availability of financial resources.

“.....these three types of models have financial implications and therefore implementing some of them may be a tall order because of the high capital input that it requires” (04-KII, programme manager)

“...the only problem that maybe has led to youth friendly services to be weak is mostly issues of health system because the health system is not going to change here and now, one because of the limited resources” (08-KII Programme manager)

“So our finances are limited, a big chunk of our finances are sponsored by development partners......we do not have a budget line for youths or adolescents or whatever definition you want to call it; youth reproductive health services provision and management of the program........if my partner decides to pull the rag under my feet then I will be drowning... ”, (10-KII programme manager)

“...then another barrier or constraint is the donor dependency aspect, where you have most of those services are provided because there is a donor supporting....so we think this is a constraint because when the donor leaves or the donor stops supporting then you are out of business, the dictation part is that some of the donors will give you the money and tell you, okay, you want to offer your friendly services, we cannot offer the comprehensive package as you wish but we would like you to offer only like HCT (HIV Counselling and Testing) or we would like you to talk to young people about abstinence. So that brings a lot of issues”, (Stakeholder workshop III)

Lack of prioritization of SRH services for young people: it was noted that there were competing priorities within the health sector and sometimes activities targeting the SRH of young people were relegated to the back during the agenda setting process. Though YFS have been recognised as a priority area within the health sector, this was not reciprocated with financial allocation; finances allocated to SRH are minimal or negligible. The programme manager for MOPH noted that lack of prioritization of youth activities could be due to lack of understanding among policy makers and planners of the importance of addressing the SRH problems of young people and allocating specific resources for the same,
“Of course finances are always limited and despite that we need to prioritize and the problem is that the list of priorities is really long, and whatever you look at will always be the most important thing to do at a certain particular time......for the other policy makers who do not deal with the youth directly and they hold a big chunk of the budget, they may not see it as a priority...”, (08-KII Programme manager)

At the district level, lack of understanding of the importance of YFS by the management resulted in the services not being given the needed support. One programme manager who had previously worked in a management position at the district level indicated that lack of understanding of YFS by the management contributed to them not receiving adequate support. With regards to facility-based youth centres, sometimes the staffs at the youth centre were seen to be idle, especially during the afternoons due to lack of clients. In such instances, the management would decide to allocate the empty and idle space in the youth centre for other services or convert the space into offices. More emphasis was placed on the need to make sure that administrators were more aware of the benefits of the youth centres, the specific indicators the services were addressing and how this translates to improving the health of the district or catchment area.

“But that idleness of the place [youth centre] in the afternoon ....would make people want to use it...for other [activities]...since you are busy just in the morning then why don’t you just use these rooms and let’s give out some of these rooms .... so that they become office(s)...” (13-KII Programme manager)

Health service provider inadequacies: The majority of stakeholders noted that there was a general shortage of staff within health facilities, on a national level, which had negative effects on the implementation of interventions and quality of services provided. There were also concerns about negative health provider attitude, limitations in knowledge and skills, language, age and gender of HSPs.

“ we are talking about this model which is quite integrative including all these components that need to be addressed but then, when you reach there [at the health facility], maybe you have a very rural area where we have only one nurse working in a facility, you expect this nurse to provide post abortion care, to provide HIV testing and counselling, to provide family planning services, treat the youth for STIs and then at the same time TB and Malaria programme come, the HIV programme come and they want this same person to do all that, with long queues outside, so there is a big issue about quality of services” (10-KII Programme manager)

Weak linkages between the different sectors: the majority of stakeholders were in agreement that the linkages between the different line ministries, development partners and NGOs involved
in providing SRH services were poor. For example, although there was an adolescent reproductive health task force at the MOPHS which had meetings on a quarterly basis, the Ministry of Youth Affairs representatives had never attended these quarterly meetings.

“We have a technical working group that [the] Ministry of Youth affairs is part of but unfortunately we have not been able to really work closely together currently because personally I am new in the programme and we haven’t been able to establish very close working relationships...” (10-KII, Programme manager)

**National level management structure changes:** The majority of stakeholders were concerned about the split of the Ministry of Health in Kenya into two; MOPHS and MOMS in the year 2008, as this had created confusion and duplication of roles between the two ministries. In some instances stakeholders were not sure of whom to collaborate with, between the two ministries.

**Lack of a monitoring system:** The majority of stakeholders indicated that there was a lack of a system for monitoring YFS and, as such, effects of SRH interventions were not documented. Indicators for YFS were not part of the national health information system and hence SRH programmes, targeting young people, were not documented in the national annual health reports.

“...monitoring of youth health services, and talking particular for reproductive health it is not captured very well and the indicators are not captured in the reporting...the hospital reporting tool....”, (10-KII, programme manager)

Youth friendly services were also said not to be available in the rural areas as available services were mainly urban based.

“...the other thing which the youth friendly services also have a problem with is that at the moment they are essentially located in the urban centres; hardly do we see a spread of youth friendly centre or services being provided in the rural population”, (12-KII, programme manager)

The need to have the service conform to the cultural and religious norms was stated as being important by some of the stakeholders

“In providing youth friendly services we need to ask the following questions; is it friendly to the culture? Does it take into consideration the religious background and other cultural issues? (Stakeholders’ workshop II)
Table 41: Identified barriers for YFS provision

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of funding for YFS</td>
<td>o Donor dependency</td>
</tr>
<tr>
<td></td>
<td>o Donor preference/ dictation</td>
</tr>
<tr>
<td>Lack of prioritization of YFS</td>
<td>o Lack of ownership at the district level</td>
</tr>
<tr>
<td>Health provider inadequacies</td>
<td>o Numbers, knowledge, skills, age, language, negative attitude</td>
</tr>
<tr>
<td></td>
<td>o YFS needs a multi-skilled service provider</td>
</tr>
<tr>
<td>Lack of proper infrastructure</td>
<td>o Lack of space and privacy</td>
</tr>
<tr>
<td></td>
<td>o Lack of equipment including furniture</td>
</tr>
<tr>
<td></td>
<td>o Lack of commodities and supplies</td>
</tr>
<tr>
<td>Unfriendly operational time or hours</td>
<td></td>
</tr>
<tr>
<td>MOH management structure changes</td>
<td>o Spilt of the MOH into MOPHS and MOMS</td>
</tr>
<tr>
<td></td>
<td>o Poor dissemination and implementation of national policies</td>
</tr>
<tr>
<td>Weak linkages between the sectors</td>
<td>o Lack of proper coordination at all levels</td>
</tr>
<tr>
<td></td>
<td>o Inadequate linkages between line ministries, NGOs, CBOs, private sector</td>
</tr>
<tr>
<td>Lack of an effective monitoring system</td>
<td>o YFS not captured in the national grid</td>
</tr>
<tr>
<td></td>
<td>o YFS not available in the rural areas. Services are mainly urban based</td>
</tr>
<tr>
<td></td>
<td>o Culture and religion</td>
</tr>
<tr>
<td></td>
<td>o Poor accessibility / facility location</td>
</tr>
</tbody>
</table>

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6.6 Enabling factors for SRH service delivery for young people

A sound financial base, health service provider training, advocacy for ownership and prioritization of youth SRH, multiple sectors involvement, infrastructural improvement, timely dissemination of policies and national guidelines, instituting a monitoring and evaluation system were mentioned by the majority of stakeholders and KII as some of the enabling factors that would facilitate the successful implementation of SRH services for young people. Meaningful youth participation and community ownership were also mentioned as important enabling factors.

Stakeholders noted that youth friendly services needed to be provided by health service providers who had received specific training as were sensitive to the sexual health problems of young people. For sustainability, this training needed to be infused in the pre-service training curricular.

""The model can be successful if we have well trained service providers in youth friendly services.....we have to work on retaining the trained staff until we have enough capacity build in the clinics before we can re-deploy the trained staff”, (stakeholder workshop III)

"There are providers who have been serving the for a very long time which is the big group so if you are talking about training, it’s more of in-service or continuous training ....... but we also have the in terms of the [HSP] who are in pre-service training, both in government and other sectors....we can have two components – in-service and the pre service training”, (05-KII, policy advisor).

Stakeholders noted that one of the reasons that youth friendly services was not highly prioritized was because the management had not been fully involved in the design of the services

".It is important to train health managers to bring them on board and we thought most likely that we are failing because we’ve not involved the managers. If we have the management from all the levels, from the national, the provincial and district and health facilities, we will get their support in establishing these clinic-based centres” (Stakeholders workshop III)

Timely dissemination of policies and guidelines was said to be important in creating awareness among HSP at the service delivery points of the national policy direction (Table 42).

Some KII stated that having services that target specific community health priorities was essential for community recognition and ownership
“.....the “one-type-fits-all” type of thing [model], cannot work...... so that the community buys into this [model]; whatever the community does not buy into, to me it will never work. So I feel in order to get community buy-in you must promote the services, advocate for them and have [local] living testimonies of their benefit, and if you are starting a new in one a place you can always borrow the living examples from another neighbouring youth facility”, (13-KII, programme manager)

“It looks like there is no one-size-fit-all kind of youth friendly services it looks like it has to be tailored to the circumstance for the particular youth population that one needs to target, but there are some general perceptions among the youth about what they need as services”, (12-KII, programme manager)

Table 42: Summary of enabling factors for SRH service delivery for young people

<table>
<thead>
<tr>
<th>Sound financial base</th>
<th>Commodity security (contraceptives, STI drugs, ARVs)</th>
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</thead>
<tbody>
<tr>
<td>Resource mobilisation</td>
<td></td>
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<tr>
<td>Lobby for budget line and resources for research and preventive and promotive activities related to youth SRH</td>
<td></td>
</tr>
<tr>
<td>Health service provider training</td>
<td>Timely dissemination of national policies and guidelines</td>
</tr>
<tr>
<td>both pre-service and in-service training:</td>
<td>At all levels of health care; to service delivery areas</td>
</tr>
<tr>
<td>Training of health care workers and managers at all levels</td>
<td></td>
</tr>
<tr>
<td>HSP should be multi-skilled. Meeting the staffing requirements of a comprehensive youth friendly centre</td>
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<tr>
<td>Advocacy:</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>Ownership of YFS by health mangers</td>
<td>Strengthen the supervision process to bring out adolescent health as a core area of supervision</td>
</tr>
<tr>
<td>May lead to prioritization at all levels</td>
<td>Standardize the data collection tools and reporting tools</td>
</tr>
<tr>
<td>For increased budget allocation</td>
<td>Clarify the reporting line</td>
</tr>
<tr>
<td>Raising awareness on the health problems of young people and highlighting the social and economic consequences of not doing so</td>
<td>Integrate ASRH core indicators the HMIS system</td>
</tr>
<tr>
<td>Multiple sectors involvement</td>
<td>Youth participation</td>
</tr>
<tr>
<td>Establish strong linkages between the different sectors: Line ministries; NGOs</td>
<td></td>
</tr>
<tr>
<td>Strengthen or broaden the National Technical Working Group</td>
<td>Community ownership or and buy-in</td>
</tr>
<tr>
<td>Support to the school health programme</td>
<td>Service customisation</td>
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<tr>
<td></td>
<td>Strengthen community outreach services</td>
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<tr>
<td></td>
<td>Use of media technology in information dissemination. Develop short documentaries, short clear messages for use by media houses during morning shows</td>
</tr>
<tr>
<td></td>
<td>Use of role models, media champions</td>
</tr>
<tr>
<td>Infrastructural improvement</td>
<td></td>
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<tr>
<td>Must ensure privacy</td>
<td></td>
</tr>
<tr>
<td>Facility set-up and arrangement should be serene, comfortable, attractive and clean especially the waiting area, bathrooms, examination rooms</td>
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</tr>
</tbody>
</table>
6.7 Model Sustainability

Resource mobilisation, multiple sector involvement, establishment of strong partnerships, service integration, health management support and community participation and ownership were some of the areas that were mentioned that could enhance sustainability of the SRH service delivery model (see Table 43)

Resource mobilisation: A sound financial base was said to be the cornerstone for sustainability of SRH service provision. Resource mobilisation through advocacy for government budgetary allocation to youth related health activities was said to be essential for sustainability. One programme officer noted that young people were “net consumers” and did not pay for services and, as such, the cost implications for setting up services to address their SRH problems were high.

“....resources is very key; if this model has to be effective it requires resources, so resource mobilization is also one area that needs to be looked into both human and financial and any other resource that pertains to operationalization of this model” (06-KII programme officer)

Multiple sector involvement: Involvement of multiple sectors as a way of enhancing sustainability was raised by majority of stakeholders. This was out of the recognition that addressing the SRH problems of young people was more than a health issue; it was said to be a social issue which other line ministries or sectors, such as, youth affairs, education, sports, labour, and social services, needed to make their contribution. It was reported that all these line ministries have, within their strategic plans, components addressing youth issues with accompanying budgetary allocation and so synergism among them would be essential for programme sustainability and continuity.

“For you to sustain this kind of an approach or this kind of a model you must involve stakeholders and once you involve them, you [should] clearly spell out their roles but after you have spelt out their roles.......then find out are they doing what is expected them? (06-KII programme officer)

“....how can we come into the ministry of education as a health ministry to support the young people in school and out of school? So if we are able to identify, at a higher level, the linkages how we can fit into the youth ministry, education ministry and work together so that it can be beneficial to the youths” (Stakeholders workshop III)

For example stakeholders stated that the Ministry of Youth Affairs (MOYA) was establishing a comprehensive youth empowerment centre (YEC) in each constituency. The purpose of the
YEC was to provide appropriate services and information that can help mitigate youth
development concerns in the areas of entrepreneurship, unemployment, education and training,
health and recreation. The centres are intended to provide one stop-shop youth-friendly forums
for information and other services addressing youth health and developmental needs. This was
said to be an opportunity which the health sector could exploit in reaching out to young people
with SRH information and services.

**Establishing strong partnerships:** Promotion of public-private partnerships was mentioned as
an innovative way for resource mobilisation to enhance sustainability. Stakeholders said that it
was necessary to anchor some of the youth centres on community resources and corporate
companies, which have strong social responsibilities, and could even adopt youth centres. One
KII gave an example of where Mukuru youth centre which had been adopted by General Motors
Company. Stakeholders also noted that some of the community-based youth centre models, run
by NGOs, failed to link their activities to already existing government processes and projects
and hence they ended up dwindling away as soon as donor funding came to an end.

“When you look at community models of which the trend has been to try and set up
community models, a lot of community models fail to be linked to other service delivery
points, which are already anchored on government processes. The challenge for that is
that it becomes unsustainable as soon as a particular donor funding ends. However, the
thinking and some of the most sustainable youth centres have developed public-private
partnerships. So through public-private partnerships we begin to see private sector
engagement including adopting centres”, (02-KII programme manager)

Stakeholders noted that meaningful youth participation could also generate income through
encouraging young people to be involved in the creative economy. Use of educative theatre and
performing arts were said to be some of the structural interventions that could generate income
for young people. One programme officer noted that, in designing youth programmes, one
requires to pay cognisance to the fact that young people want to grow career-wise and not just
be consumers of services. Hence the growth path for young people should be infused in service
delivery models that target them.

**Service integration:** integrating SRH services within the existing systems and processing was
reported to be essential to SRH service sustainability. With the perennial shortage of health
service providers experienced in Kenya, service integration was said to be a feasible form of
service delivery. Stakeholders noted that this would involve conducting training of health
service providers at both pre-service and in-service levels. Integration of SRH in pre-service
training curricular was identified as one of the avenues where a large number of health care
providers could be reached.
“...there is the issue of integration even though integration of youth services sometimes has been quite difficult it would be easy for the health sector to integrate the youth services with other services and at the same time ensure that there are trained health providers who can be able to deliver youth friendly services...” (08-KII Programme officer)

“If we are now creating a whole parallel system it can’t work, even the government would not have those type of resources”, (13-KII Programme manager)

Bringing out young peoples’ SRH as a core area of supervision, integrating SRH indicators within the national health information system and having SRH indicators as set targets during performance contract planning and rapid results initiatives at district and facility levels were mentioned as ways of strengthening service integration and sustainability.

“Strengthen supervision systems at all levels, this is specifically to bring out adolescent health as a core area for supervision, because most of the time when we talk of the reproductive health, we are looking at maternal and other reproductive health aspects and adolescent health does not come out strongly even in our supervision tools....”. (Stakeholders workshop III)

“[we need to] have youth friendly services as set targets. In the performance [contracts], we set targets. We have facilities offering youth friendly services but we have not really picked out to have targets for the district, for the facilities. We need to have targets and even set RRI[s] [rapid response initiatives] to meet those targets in the facilities and in the districts”, (Stakeholder workshop III)

**Health management support:** Stakeholders took note of the fact that SRH programmes for young people were failing in some areas because they had not adequately involved the health managers at all levels of health care and this resulted in them getting limited support. Health managers’ sensitization to the importance of addressing SRH problems of young people at all levels of health care was mentioned as a way of enhancing acceptability and sustainability.
Table 43: Suggestions of SRH service model sustainability

<table>
<thead>
<tr>
<th><strong>Resource mobilization</strong></th>
<th><strong>Service integration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy for government budgetary support</td>
<td>Within existing health services</td>
</tr>
<tr>
<td><strong>Multi-sector involvement</strong></td>
<td>Continuous health service provider training</td>
</tr>
<tr>
<td>Youth health is not only a health issue it is also largely a social problem</td>
<td>Integration of SRH in pre-service training curricular</td>
</tr>
<tr>
<td><strong>Promotion of the establishment strong partnerships</strong></td>
<td><strong>Health managers support</strong></td>
</tr>
<tr>
<td>Public – Private partnerships</td>
<td>Ownership and Prioritization</td>
</tr>
<tr>
<td>Private sector engagement with companies that have a strong corporate social responsibility</td>
<td>Infuse in the national and district health plans: set targets that are specific for YFS</td>
</tr>
<tr>
<td>May include adopting youth centers</td>
<td><strong>Community ownership and buy-in</strong></td>
</tr>
<tr>
<td>Anchor programmes on existing government processes</td>
<td>Community participation</td>
</tr>
<tr>
<td>May be useful in provision of sanitary towels</td>
<td>Use of local community resources</td>
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<tr>
<td></td>
<td>Youth participation</td>
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<tr>
<td></td>
<td>Sustained demand creation</td>
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<tr>
<td></td>
<td>Initiation of Income-Generating Activities: (IGAs)</td>
</tr>
<tr>
<td></td>
<td>Promote creative economy among young people such as educative theatre, performing arts</td>
</tr>
</tbody>
</table>

6.8 Revised model after consideration of stakeholders’ views

As shown in Appendix II, SRH service delivery model presented to stakeholders had the following seven core services which were presented as pillars of the model; treatment of STIs, HCT/positive living, contraception, PRC/PAC, provision of sanitary towels, updated SRH information and Counselling – both SRH and general. Structural support to the SRH model included: skilled and motivated workforce, financial sustainability, leadership and governance, youth participation and a standardized monitoring and evaluation (M and E) system. The model included recreational resources which included vocational training, life skills training recreational activities and linkages to school-based and community based education programmes.

As discussed in section 6.4.2 on model core services, stakeholders made suggestions of additional services they felt could be included in the model. ANC, PNC services and treatment of minor ailments, though identified by stakeholders as additional services that need to be provided to young people were not included as pillars in the revised model. This was due to the cost implications and human resource requirements that could be incurred by the health system.
if such services are provided to young people separately. Stakeholders had also warned against setting up a parallel health system which was bound to be unsustainable. The revised model provides a referral linkage where young people are referred to other clinical departments for specialized and general health care. This line of thought is also informed by the fact that from the primary data obtained in this study, pregnant girls accessing ANC services regard the available SRH as appropriate and meeting their health problems (section 5.1.3.4). Counselling on drug and substance abuse was an additional service that was included as a pillar in the service model as a suggestion from stakeholders.

There was disagreement among stakeholders on the sustainability of the provision of sanitary towels which was in the initial model. One KII stated that the private sector could be engaged in providing such services. Another KII noted that the government should have a policy where sanitary towels are provided to girls especially those in primary schools. Nonetheless it was noted that innovative ways should be identified to help address the menstrual needs of young people, especially those in the rural areas.

After the stakeholders’ workshops, a few amendments were made on the model. The pillars of the SRH service model were reduced from seven to six to reflect the following core service areas,

1. Screening services: this involves provision of screening services for pregnancy, HIV and other sexually transmitted infections
2. Treatment services: this involves the provision of treatment services for sexually transmitted infections including sydromic management of sexually transmitted infections, sexual violence, and complications from unsafe abortions.
3. Provision of contraceptive services
4. Counselling on drug and substance abuse
5. Provision of SRH counselling and information
6. Outreach activities to schools and the other community-based programmes.

Having sound linkages is an aspect of referral networking that has been included in the new model. Establishing networking mechanisms which can facilitate young people to have access to the general, as well as specialised health care was said to be of paramount importance by stakeholders. This was because young people also need of general health care and other specialised services such as ANC, delivery, postnatal care and HIV treatment, care and support.

Specific to the Kenyan context, stakeholders indicated that it was important to establish networks with Youth Empowerment Centres (YEC), school-based programmes and community-based education programmes. This was because YEC and community-based programmes would
provide an opportunity to implement structural interventions addressing the underlying factors affecting the SRH of young people.

There were areas of disagreements that were not addressed by the model. This included the need to have services that were culturally and religious friendly. There seems to be a thin line between what is cultural and what is religious as they seem to be quite intertwined. Religious and cultural values advocate for “no sex before marriage”, and “no use of contraception before having given birth”. These socially prescribed values fail to accept the fact that young people, even those who are religious, are sexually active. The failure by the social system to recognise that young people are sexually active denies young people the opportunity to get the SRH information they need and subsequently the skills to protect themselves from the adverse RH outcomes.

Confidentiality was also discussed and there were tensions among stakeholders with regards to at what point a parent would allow their child to go to the health facility unaccompanied. This was bearing in mind that parents accompany their children when going to school and the church and so on.

“At what point do we separate the child from the parent? At what point does the child now go to the health facility alone for services? Because this children when they go to school we take them? ....how does a young person go to the clinic alone?” (stakeholder’s workshop III)
Figure 25 presents the suggested SRH service delivery model after review by stakeholders. The model is supported by a strong base of a skilled and motivated workforce, essential supplies and equipment, financial sustainability, supportive leadership and management, standardized monitoring and meaningful youth and community participation. The model is also linked to a referral system for specialised care and other community resources such as YEC, school and community based education programmes.

6.9 Summary of chapter 6

Broadly two models of SRH service delivery available in Kenya are discussed in this chapter; the integrated and youth centre models. Youth centres offer SRH services designed for young people only while within the integrated model, young people receive services as part of the general public. Although the youth centre is the preferred model among young people and healthcare providers, its sustainability is not guaranteed. Moreover, the range of services it is able to provide is limited due to deficiencies in staffing, essential medicines and supplies and supporting equipments.

There is a supportive policy environment in Kenya with regards to the provision of SRH services to young people; however, this is not reflected in the financial allocation. Youth participation in SRH service provision varies from one facility to another and is heavily reliant on donor funding (see section 6.1.2). Supervisory, monitoring and coordination structures at both the national and district levels are weak with inadequate resources. Lack of prioritization of YFS, lack of management support, conflicts in youth centre utilisation, deficiencies in staffing and financial resources are some of the challenges faced by youth friendly service provision. This study proposes an integrated SRH service delivery model with six core services essential for the SRH problems of young people (see Figure 25). A sound financial base, multiple sector involvement and establishing partnerships with the private sector, service integration, and health management support were identified as avenues through which sustainability of youth friendly service provision could be enhanced.
Figure 25: Suggested model after stakeholders' input
Chapter 7: General discussion

7.0 Introduction

This study explored ways in which SRH services could best be provided to young people in Kenya’s economic and socio-cultural setting. This was achieved by exploring experiences and perceptions of young people, community members, health service providers, facility managers, programme managers and policy makers on the following: i) the SRH problems of young people, ii) the available SRH services, iii) strengths and weaknesses of available models of SRH service provision, and iv) through consultative process, developing and recommending an SRH service delivery model for young people based on evidence provided by these experiences. The development of the SRH service model was also informed by the literature review on effectiveness of ASRH interventions in other settings (sections 2.2 to 2.4) and other models of health care delivery (section 2.5). The literature review resulted in the identification of 12 essential elements needed for the development of a health service delivery model (see Table 12). Taking into account the perceptions and experiences of young boys and girls, community members and health service providers, these 12 elements were used as the building blocks upon which an ideal SRH service delivery model for Kenya was conceptualised. The proposed model was then presented to stakeholders through a series of stakeholder workshops to obtain their views, opinions and suggestions on SRH service delivery. Stakeholders who participated in the workshops included policy makers and programme managers from NGOs and development partners involved in the implementation of SRH programmes for young people in Kenya.

7.1 The gendered nature of sexual and reproductive health

7.1.1 The gendered nature of SRH problems among young people

The findings in this study showed that the SRH problems young people experience were similar across the study sites as expressed by young people themselves, community members and HSP. These included early sexual activity, unwanted pregnancy, unsafe abortion, STI/HIV/AIDS, sexual violence, inadequate RH information and problems concerning relationships and growing up. Reported underlying factors that contribute to these problems were also similar among respondents and included the following: lack of proper parental guidance, poverty and unemployment, poor living conditions, drug and substance abuse, peer pressure and media influence. Poverty and unemployment leads young people into idleness and create feelings of hopelessness, which in turn lead them into drug abuse as well as risky sexual behaviour.
Young people, community members and health service providers in this study reported that sexual initiation among young people, especially girls, occurs at an early age; as early as between 9-15 years. Early and unprotected sex predisposes adolescents to early and unwanted pregnancy and STI/HIV infection. As earlier stated in the introduction Chapter, section 1.1, the proportion of young people aged (15-24) who have had sex before age 15 is an UNGASS behavioural indicator for monitoring progress of HIV/AIDS prevention (United Nations 2011b).

Current national population-based surveys for Kenya (KDHS) indicate that young girls and boys initiate sex at much older ages of 18.2 and 17.6 years respectively. However, young people and community members reporting that young people begin having sexual intercourse at ages 8, 9-10 years could be a dramatic way of emphasising that sexual activity begins early. This finding could also have been influenced by differences in the demographic characteristics of respondents in this study and those in the KDHS. Young people who took part in this study were from urban poor backgrounds, less educated and living in urban slums. In contrast young people taking part in KDHS are largely of rural residence (over 70%) and in school (over 71%). Other studies conducted in Kenya with young people from different social backgrounds have also reported different results on sexual initiation. A population-based longitudinal study conducted among two slum and two non-slum settlements in Nairobi reported that transition to first sex occurred at 15 years among boys and girls from the slums compared to 18 years for girls and 17 years for boys in non-slum areas (Kabiru et al. 2010). A survey using a structured questionnaire among high school students in Nairobi reported the median age at first sex to be 15 years for females and 13 years for males (Kabiru and Orpinas 2009b). In a school-based survey conducted in Nairobi, 4.1 percent of girls were found to have initiated sex by age 10, although some girls reported experiencing sexual violence (Lema 1990). Similarly Magadi and Agwanda (2009) also reported that young girls from households with lower socio-economic status and those with lower education initiate sex, marriage and pregnancy at an earlier age than their counterparts from households of higher socio-economic status and with higher education (Magadi and Agwanda 2009).

Girls also report not being well prepared for puberty especially with regards to menarche and more often menarche finds them unawares, leaving them in great shock. A study among urban Kenyan primary school girls found a mean age of menarche of 12.5 years with 10 percent of the girls experiencing menarche by age 11 years (Ogeng’o et al. 2011). Lack of proper preparation for menarche coupled with lack of access to sanitary wear, water and sanitation facilities contributes to school absenteeism among girls. In an effort to look for money to purchase sanitary wear, some girls especially those from poor families engage in transactional sex hence exposing themselves to unwanted pregnancy and STI/HIV/AIDS infections. Other studies have shown similar findings. In Sri Lanka, problems relating to the menstrual cycle were reported as being common among adolescent girls (Agampodi et al. 2008). In rural Malaysia, out of 1295
adolescent girls, 76 percent reported experiencing dysmenorrhea which in-turn led to poor concentration in school, absenteeism, poor school grades and reduced girls’ participation in social events (Wong 2011). Pain and discomfort and waist pain were reported by secondary school girls in Nigeria as being common problems experienced by secondary school girls in Nigeria (Adinma and Adinma 2008). In addition, over half of the girls reported using unsanitary absorbents such as tissue paper (41.3%) and clothes (14.4%). Adolescent girls reported discussing their menstrual problems with their mothers, teachers or both (Adinma and Adinma 2008; Wong 2011). Consultative stakeholders workshops carried out in Kisumu, Kenya, with the aim of identifying public health issues linking water/sanitation and sexual and RH among females in Kenya have singled out lack of water and poor menstrual management as negatively affecting girls school engagement (Phillips-Howard et al. 2011b). There is therefore need for more research to identify sustainable innovative and culturally acceptable ways of helping girls manage their menstrual problems effectively. The feasibility study conducted in Kenya on use of menstrual cups in the management of menstruation among poor girls has shown some positive results although more evidence is needed to ascertain its acceptability and appropriateness (APHRC 2010a). The pilot study evaluating the impact of menstrual cup and sanitary towel use among school girls, being conducted in western Kenya, will help inform menstrual management and its impact on school attendance (Phillips-Howard et al. 2011a).

The results presented in this study suggest that early and unwanted pregnancy is a SRH problem affecting young girls. Both boys and girls gave an indication that young girls may get pregnant due to six main reasons: i) engaging in early sex without having a clear understanding of the consequences of early and unprotected sex, ii) lack of discussion on contraceptive use among young sexual partners, iii) engaging in sex for material and financial gain due to poverty, iv) dropping out of school due to lack of school fees, v) peer pressure, and vi) negative perceptions, myths and misconceptions young people have against condom use or use of hormonal contraceptives.

Early and unwanted pregnancy leaves many girls with very little or no other options other than early marriage. Young people reported that once young girls become pregnant they are forced into early marriage due to lack of alternative options; if they are in school they often drop out. In some cases school girls with unwanted pregnancy seek abortion services to be able to continue with their education. Girls with an unwanted pregnancy may end up being disowned by their partners, parents and ridiculed by the community in general. Similar findings have been reported in Uganda where pregnant adolescents were said to be disowned by their sexual partners and subjected to physical and psychological violence by their parents, sexual partners and the community in general (Atuyambe et al. 2005).
Transactional sex, which is sexual relationships for material and financial gain, was reported to occur among both girls and boys in this study. Poverty is one of the factors that drive girls into engaging in sex for money with sexual partners who are older. Transactional sex has been reported to occur mostly among women aged 15-19 years (Chatterji et al. 2005) and its meaning is complex as in some cultures giving girls gifts or money also symbolizes worthiness, love and appreciation. Some girls even feel offended if their sexual partners do not give them money or gifts. Whether young girls are aware that transactional sex exposes them to risky sexual behaviour is uncertain, while in communities where poverty levels are high, young girls may be forced by sheer necessity to engage in unsafe sexual practices especially if their sexual partners give them more gifts and money. This may in turn expose them to unwanted pregnancy and STI/HIV/AIDS. A study conducted among males in urban Kisumu, a region with the highest prevalence of HIV in Kenya, found that both monetary and non-monetary gifts were negatively associated with condom use (Luke 2006). Previous studies conducted in Kenya on transactional sex have mainly been done within the context of commercial sex work (Ferguson et al. 2006; Robinson and Yeh 2011). The association between transactional sex and risky sexual behaviour is not well understood and more research is needed to explore the nature of this association and inform the design of targeted interventions.

7.1.1.1 Pregnancy prevention and gender

Findings from this study reveal aspects of gender dynamics associated with taking responsibility for pregnancy prevention between young sexual partners. Young men tend to dissociate themselves from use of family planning and regard it as the responsibility of the girl. Most boys suggested that pregnancy prevention was the girl’s responsibility and perceived contraception as a woman’s domain. They also found difficulty in initiating discussion with their girlfriends on contraception. Similar findings have been reported by Nzioka (2001) where boys considered pregnancy prevention the responsibility of girls and not their own (Nzioka 2001). Early pregnancies occurring among adolescent girls can however also take place within marriage or mutually acceptable unions. Both boys and girls reported that while some girls become pregnant unexpectedly, other girls get pregnant out of their own will so as to get commitment from their boyfriends or to belong to a certain social class or a peer network. Boys reported that some girls become pregnant intentionally if they were interested in a particular boy such as one who was smart in class or had a steady job. Girls also opted to get pregnant if their peers also had children and they wanted to fit into the peer group. Studies have shown that out-of-school girls and those with lower education, peer pressure and lack of parental guidance, all pre-dispose young girls to early pregnancy (Were 2007). In a community based survey conducted in rural Nyanza, Kenya, the majority (70.8 percent) of adolescents aged 16 and below reported that their
first pregnancy was unwanted and most (94.7%) of those pregnant were not in school (Taffa et al. 1999).

7.1.2 Girls and boys views about available SRH services

Girls and boys views of available SRH services were not uniform and showed variations between the two genders and also with regard to the model of SRH service delivery.

7.1.2.1 Girls’ views about available SRH services

Girls gave conflicting views with regards to available SRH services. Young girls who were service users and attending ANC and FP service clinics within integrated facilities described available SRH services good, helpful and cheap. Young girls in this category gave an indication that the services they were receiving adequately addressed the SRH problems they experienced in relation to pregnancy prevention, contraception and ANC. According to the girls who were accessing services for ANC and FP, they regarded the services fine as they were cheaper and accessible in terms of location. This could have been a biased view since the girls who expressed this view were already service users and were being interviewed at the health facilities. They might have felt obliged to give a favourable opinion. Another possible reason for this view could be that the girls might not have been aware that the services they were receiving could be better. Similar findings have been reported in Mozambique where an evaluation of youth-friendly health services (YFHS) located within public health facilities reported that young women found the services to be meeting their SRH problems with regards to contraception and ANC. Facility staff treated clients with respect, but it must be noted that the majority of clients who visited these facilities were young women who had began childbearing (Hainsworth and Zilhao 2009). On the other hand, girls who were non-service users and also some service users also expressed concern about the negative attitude of health service providers, lack of essential supplies, gender of the health providers, and that there was corruption in the facilities.

According to girls’ views, friendliness of services meant having HSP who are friendly, respectful, welcoming and approachable. Friendly services also included services that were cheaper, within walking distance, involved a short waiting time and offered a wide range of services within the same facility compound. Girls felt that the facility environment should be clean including the waiting area and toilets. On the other hand, girls did not seem to additionally value having youth-only facilities or recreational activities at health facilities. This finding is in agreement with evaluation results of adolescent friendly health services (AFHS) conducted in Mongolia among 10-19 year olds, where more females than males (76 percent vs. 66 percent) reported being satisfied with the services; service satisfaction was linked to the health care
provider’s attitude, facility environment, being able to receive appropriate counselling and information, and having adequate privacy during consultation (Sovd et al. 2006).

7.1.2.2 Boys’ views about available SRH services

In contrast to the girls, boys perceived the service delivery environment within public health facilities to be unfriendly or uncomfortable. For boys, available SRH services at health centres and district hospitals were described as having been designed for women and children. Boys from Nairobi who participated in the mixed users FGDs also stated that maternal and child health services provided at the health centres in Nairobi were “perfect” or “smart” where women and children were concerned. There seems to be an unmet need for SRH service provision for boys within the current public health facilities and hence boys’ preference for private facilities. The design of health facilities including the waiting area and service delivery areas (for example the MCH clinics) seems to favour women and children. The apprehensive feelings boys have towards using SRH services in public health facilities could be due to the fact that most services offered within these clinics are more “receptive” to women as they constitute the majority of clients at these facilities. In addition to features mentioned by girls on service friendliness, boys preferred having youth-only rooms and youth activities such as games at the health facilities. This was to keep them busy while waiting to be served.

7.1.2.3 Availability of games and recreational activities

Generally this study has shown that the presence of games such as a pool table at health facilities elicits mixed reactions. While having games at health facilities is supported by most respondents, (young people, community members and HSP), a few young people were of the opinion that such games could scare away some girls. Available games at health facilities seem to mainly favour participation of boys who may turn the health facility into a meeting base, hence making girls feel less comfortable. Although boys favoured having games at health facilities, the positioning of these games within the facility seemed to be very important. Young people indicated that games should not be placed at the facility entrance. Moreover, young girls would not like to be seen going to a place that is frequently visited by boys. The purpose of having games at health facilities is mainly to encourage young people to visit the facilities and subsequently access the available SRH services. Evidence supporting the association between games and other recreational activities at health facilities and increase in access and utilization of SRH services is weak. There have not been enough studies conducted to ascertain this association, instead, young people who use games are said to be much older and those not seeking health services (Erulkar et al. 2006). There is limited evidence showing that young people who are associated with sporting activities have a slightly higher chance of consistently
using condoms (Delva et al. 2010). There is need for more research to assess the importance of games within health facilities and their impact on use of SRH services by both girls and boys.

7.2 Social norms and vulnerability of adolescents

Social meanings, norms and values placed on the sexuality of young people by the society greatly influence young people’s ability to access SRH services. Young people are concerned about what “other people”, (their peers, parents and other community members) think about their sexuality. The myths and misconceptions young people have towards use of condoms and contraceptives are similar to those expressed by community members. If the community associated SRH services with immoral behaviour, then young people would not want to be seen going to such a facility.

7.2.1 Conservatism and sexuality

The social expectations and complexities around boy-girl relationships seem to have a major influence on young people’s ability to have protected sex and access SRH services. Boys are socialised to know that it is okay to have girlfriends and even be engaged in sexual intercourse while girls’ interaction with boys is often restricted and discouraged. The social constructs around adolescent sexuality brand girls who are sexually active as “spoilt”, while sexually active boys are regarded as “men”. The net effect is that both boys and girls end up having secretive sexual relationships and sexual activity tends to occur by chance without proper planning and discussion around contraception or condom use. Open discussion about sex is limited in Kenya and discouraged by most social structures such as schools and churches (Kamaara 1999). Sex before marriage is regarded as an immoral act and as such the consequences of unsafe sex such as teenage pregnancy and STI/HIV/AIDS infection are also viewed by the society through a “moral lens” instead of being seen as a public health problem. This is unlike the view in some western countries where lower teenage pregnancy rates are experienced and adolescent pregnancy is regarded as a public health problem (Moore 2000).

There is need to engage social structures such as schools and religious institutions in encouraging open discussion about adolescent sexuality. More research is also needed to explore ways of opening up discussion about sexuality and RH between young people, community members and such social institutions.

7.2.1.1 Condom use among young people

Findings from this study show that condom use among young people is encouraged within the context of prevention of pregnancy, HIV and other STIs among sexually active young people. On the other hand myths and misconceptions such as lack of sexual satisfaction, condoms
having holes, condoms being laced with the HIV virus, and condoms being associated with increased promiscuity or increased sexual activity leads to non-use. Inconsistent condom use among young people was also reported to occur as a result of young people “trusting” one another after being in a relationship for a few months. Young people also reported receiving conflicting messages on condom use from health promoters who say condom is not 100 percent effective. This is in line with findings from a qualitative study conducted in South Africa, which showed that condoms were being promoted as second best to abstinence because they were only “80 percent effective in preventing transmission of HIV infection during sexual intercourse” (Nixon et al. 2011). Generally scientific evidence shows that condoms are between 80-87 percent effective in preventing HIV transmission (Cayley 2004; Davis and Weller 1999). This line of argument is not strong enough because other public health preventive interventions are not 100 percent effective, but their use is not questioned in the same manner by health promoters and the general population. Interestingly, promoting “abstinence” is also used here as a “moral” rather than health prevention concept. The focus on condom ineffectiveness reinforces the notion among young people that they can still get infected with HIV while using condoms and hence they opt for non-use. In the course of this study, there were media reports in Kenya that a certain brand of condom which had holes in it was on the Kenyan market. Such media reports tend to reaffirm young people’s concerns about condom safety and ineffectiveness and therefore discourage their use. There is evidence indicating that condom use at first sex increases the chance of subsequent consistent condom use by over eight times (Yotebieng et al. 2009). Consistent condom users are also more likely to begin sexual activity at an older age than non-users (Kabiru and Orpinas 2009a). The above findings may provide a possible explanation as to why the proportion of young people using condoms at last sex is low in population based surveys.

Although several studies have demonstrated that sex education and condom promotion do not result in increased sexual activity among young people, in this study, young people and community members believed otherwise. Both young people and community members believed that encouraging young people to use condoms was synonymous with providing them with a licence to engage in sexual activity. Currently, condom promotion is seen by the Kenyan society as a way of encouraging young people to engage in sexual activity because of the “safety cushion” of preventing HIV and pregnancy condoms bring along. This seems to be contradictory because despite there being no rigorous sex education, young people are still engaged in sexual activity. On the other hand, there is sufficient evidence to indicate that educating young people on contraceptive use does not increase sexual activity among young people (Gallant and Maticka-Tyndale 2004; Kirby, Laris and Rolleri 2007; Michielsen et al. 2010). There is therefore an urgent need to create dialogue forums to educate the community and demystify myths on the use of condoms with regards to HIV prevention. Other strategies of
dispelling myths and rumours can also include using the mass media, community role models, champions, and social marketing.

7.2.1.2 Vulnerability to sexual violence

This study identifies sexual violence as one of SRH problems affecting young people in Kenya. Although sexual violence was not extensively explored in this study, relatives and friends were mentioned as being perpetrators of coercive sex and rape of young girls. Cases of rape of young boys and small children were also mentioned by a few young people. Girl’s mode of dressing and walking at night were said to increase their risk of experiencing rape. Idleness, use of drugs and alcohol and peer pressure were mentioned as contributing factors to rape. Other studies have also reported girls’ mode of dressing as a contributing factor to rape (Kilonzo 2007).

Among young girls, sexual coercion has been documented as a risk factor for STI/HIV infection and unwanted pregnancies. The social constructs around sexual coercion connotes that girls are expected not to initially agree to having sex and that the boys have to use some tricks, deception and even force for the girl to agree to have sex (Maticka-Tyndale et al. 2005). The “blurred boundaries between forced, coercive and consensual sex” in the Kenyan social context negatively affects access to SRH services (Kilonzo et al. 2008). Because of this social acceptance, cases of dating rape and even marital rape are often underreported in surveys (Jewkes and Abrahams 2002). Young people may also find difficulty in reporting coerced sex experiences (Birungi et al. 2011). The social acceptance of sexual coercion and sexual violence propagates the practice. In this study, men presenting themselves as “lions”, which is synonymous with having “uncontrollable sexual desires” reflect a picture that sexual violence is unavoidable. This is a relatively surprising but a finding that has huge implications with regards to advocacy for women’s sexual health rights. A review of the literature has shown that discourse linking men’s sexual experience with their masculinity often encourages the social construct that men’s “sexual desires are uncontrollable” and once aroused, require immediate attention and that rape occurs as a “biological” phenomenon rather than a “sociological” phenomenon; being a tool for controlling women’s sexuality (Jewkes et al. 2005; Ricardo and Barker 2008). In addition, women who experience sexual violence especially from intimate partners are more often exposed to other forms of violence (Jewkes et al. 2006b). There is therefore need to engage young people themselves, community leaders and other social structures such as religious organisations in educating the public about the risk factors of sexual violence and the need to seek health services. Health services providers and providers within the criminal justice system also need to be sensitised on how to identify and handle victims of sexual violence and the role of multi-sector response in the search for justice (Kilonzo et al. 2009b). The sexual offenses act of Kenya (2006) protects children and women against any form of sexual offense and details the punishment prescribed by law to perpetrators of sexual
offenses; this ranges from five years for attempted rape cases to life imprisonment for rape, upon conviction (GOK 2006b).

7.2.2 Values and attitudes towards SRH services for young people

The majority of respondents in this study did not approve of the use of hormonal contraceptives (family planning) by young girls. Young people themselves, community members and HSP were of the opinion that young girls, especially those who have never given birth, should not be allowed to use hormonal contraceptive methods. This was because of the perceived side effects and especially the belief that hormonal contraceptives affect young girls’ future ability to conceive. Contraceptives were also given a moral tag and were believed to lead to an increase in young people’s sexual activity. In addition, HSP expressed concerns that non-hormonal contraceptives such as the IUCD would increase transmission of STIs. All respondents were of the opinion that contraceptives should only be used by married women or girls who have had at least one child. Contraception was thus construed by the society to be used mainly within the context of “child spacing” as opposed to preventing unwanted pregnancy or delaying childbirth. Other studies have reported similar findings where contraceptive use by young girls was not approved by young people, community members and health service providers because it was considered to affect young girls’ fertility (Ajayi et al. 1991). In Brazil young people also reported being concerned about potential side effects of contraceptives on future fecundity (Goncalves et al. 2011). Despite the societal moral connotation given to modern method contraceptive use by sexually active unmarried women, statistics indicated that modern method contraceptive use is higher among unmarried young girls than their married counterparts. For example, among sexually active unmarried girls aged 20-24 years in Kenya, 58.9 percent use any modern method, while only 30.4 percent of currently married girls the same age use any modern method (KDHS 2008-09).

7.2.3 Values and attitudes of health service providers regarding SRH service provision

During interviews, HSPs described young people in terms that were reflective of negative attitudes and prejudices they have towards young people. HSPs’ difficulty in SRH service provision for young people could be presumed to originate from their inability to deal with young people at a personal level. This could reflect their poor understanding about adolescent psychology, their limitations in adolescent counselling and interpersonal communication skills. This could also be reflective of deficiencies in the content of the SRH training curriculum with regard to the practicality of addressing the SRH problems of young people. Similar views have been reported by a study among health care providers in Turkey, where the majority of nurses
acknowledged that responding to the sexual health problems of adolescents was an integral part of their routine nursing care. However, health care providers faced difficulties in initiating these discussions and felt that discussions around sexuality with adolescents should be the responsibility of the parents (Rana et al. 2007).

The results of this study show that irrespective of training in YFS provision, the majority of HSPs are still conservative with regard to provision of SRH services to young people. Although some HSPs have received contraceptive training updates (CTU), where they are informed not to deny young people any SRH service, their personal values and societal norms sometimes take precedence. HSPs have reservations in providing SRH services to young people because of cultural, religious and perceived eligibility reasons. There is currently tension and contradiction between HSPs’ cultural and traditional values, existing policies and young people’s right of access to SRH services. Although HSPs are supportive of policies that allow provision of SRH information and services to young people, at a personal level they are not comfortable providing SRH services such as contraceptives to young people. HSPs seem therefore torn between their personal feelings and cultural norms, values and practices and health care ethics of respecting young people’s rights of access to SRH services. Possibly HSPs feel and behave more as parents when dealing with adolescents and make their judgement from the perspective of their parental instincts and identity. Previous studies have found that HSPs’ cultural and religious values may hinder them from providing SRH services to young girls. The Swaziland study (Mngagi et al. 2008) produced similar results where culture, values and beliefs played a key role in the provision of SRH services to young people; for instance, emergency contraception was only provided to girls who had been raped, and only if they were brought in by the police (Mngagi et al. 2008). Although HSPs have great reservations in providing contraceptives to young people, they are generally supportive of young people receiving other SRH services such as SRH education, HIV/AIDS related services, pregnancy-related services, treatment of unsafe abortion complications and treatment after sexual violence.

More research therefore needed to explore how socio-cultural and religious beliefs may act as either barriers or promoters of SRH service provision by health service providers. There is also need for more research to evaluate knowledge and the technical competencies of HSPs in providing YFS provision and identify how improvements in the curriculum can be undertaken to meet the identified gaps in knowledge and skills.

7.2.4 Parental role regarding SRH education

This study shows that young people recognize and appreciate the role parents can play in their upbringing, including SRH education. Young people perceive parents to be important in laying their foundation of knowledge with regards to SRH. To most young people’s
disappointment, parents have not lived up to this expectation. Young people from all study sites reported that parents had failed in their responsibility of educating young people on SRH issues and particularly on expectations during the adolescent period. For girls, the need to be informed by their mothers about monthly periods, use of sanitary towels, personal hygiene and consequences of early sex was emphasised. Boys expressed the need to be informed about voice changes, sexual feelings experienced and dangers of unprotected sex. Lack of proper communication channels between parents and young people, coupled with some traditional practices were reported as major barriers to this interaction. Young people were also concerned about their parents not being able to listen, talk to, or offer advice to them appropriately because of being too busy with work, being afraid, shy or uncomfortable discussing sexuality issues. Some parents were also reported to be too harsh and unapproachable and this made young people apprehensive in approaching them for advice.

In support of this view, community members admitted to having failed in their role as parents in nurturing and educating their children on sexuality and RH issues. This could be a cycle repeating itself since parents also reported not having been taught by their own parents on SRH issues. While parents assumed that young people learn about SRH in school, it was also acknowledged that teachers themselves have their own deficiencies in passing SRH information to their students. Young people emphasized that learning biology in school was not to be regarded as a replacement of parental guidance and teaching and that it was their parents’ responsibility to give them appropriate information on SRH. The assumption that someone else is doing the teaching leaves young people without the needed SRH information and hence, they turn to their friends to fill this knowledge gap and, if unlucky, they may receive the wrong information. Similar findings have been documented in rural Mwanza, Tanzania, where both young people and community members pointed out that parents had collectively failed in their responsibility of being good role models and providing proper advice to their children; instead some parents encouraged their daughters to engage in transactional sex so as to meet the family financial needs (Remes et al. 2010). In her study about sex and HIV-education among 17-19 year old high school students in Nairobi, Mbugua (2007) reported that educated Christian mothers do not feel comfortable giving SRH education to their daughters as this conflicted with their traditional, cultural and Christian values (Mbugua 2007). In the same article, Mbugua (2007) notes that educated mothers may resort to buying sex-education text books and giving these to their daughters without taking time to discuss and explain the contents.

Although young people want their parents to educate them on their SRH, parents (both educated and illiterate) find difficulty in taking up this responsibility because of traditional, cultural, and religious norms and values. An example is that of the educated AIDS activist in Uganda who was unable to talk to her girls about sex education and opted to leave a box of condoms in the
girls’ bedroom “assuming” that the girls would interpret and understand the meaning of her action (Mbugua 2007). This illustrates the fact that education does not eliminate the traditional value systems people have. This also highlights the importance of intergeneration dialogue in facilitating the communication of SRH issues between young people and their teachers, parents and community members and breaking the traditional barriers that hinder discussions of sexual issues and access to services. More research is therefore needed to identify ways in which parents could be involved, supported and encouraged to pass SRH information to their children and how existing religious and cultural barriers could be addressed to facilitate this interaction.

7.3 The medical model of SRH service provision

This study shows that young people seek health care when in need of the following health services: contraception, pregnancy-related services, abortion services, STI and HIV-related services, post-rape care, counselling on sexuality, SRH information and general health care. The identified SRH problems are similar to what was agreed upon by 179 governments in Cairo, during the International Conference for Population and Development (ICPD 1994; UNFPA 2007). These SRH problems are also similar to what has been outlined in national policy and strategic documents for reproductive health in Kenya such as the Adolescent Reproductive Health and Development policy (2003) and National Guidelines for Provision of Youth Friendly Services in Kenya (MOH and DRH 2005; NCAPD and MOH 2003). Previous studies have also shown that the majority of young people access health facilities when in need of contraceptives, ANC, treatment of STIs and HIV related services; other services sought include abortion services as a result of unwanted pregnancy and laboratory services for pregnancy testing (Kiapi-Iwa and Hart 2004; Mngagi et al. 2008). SRH interventions therefore must at a minimum, ensure that young people have access to the above mentioned services and where the stated services are not available on site, an appropriate referral system should be available. Although illegal in Kenya, this study shows that young people visit health facilities when in need of abortion services. There is a need for safe abortion services among young people in Kenya but this need is not being met because of the existing legal framework. However, young people who visit health facilities with complications as a result of unsafe abortion, receive appropriate medical post-abortion care.

7.3.1 Models of SRH service provision

This study examined broadly two models of SRH service provision; integrated health facilities and youth centres. The results presented in this study do not point to one single model as the best SRH service provision model because the two models provide a different range of services and are each able to reach different categories of young people; each specific model has its own strengths and weaknesses.
There seems to be a gender dimension in access to SRH services by young people depending on the model of service delivery. Integrated facilities seem to constitute a promising model for providing SRH services to pregnant girls but are unlikely to meet the SRH problems of boys due to the barriers related to organisation of health services at the health facilities. Boys find the service delivery environment uncomfortable for them to access and are concerned about the health facility set up and design which they perceive to be only suitable for women and children.

7.3.1.1 Integrated SRH service delivery models

Integrated facilities have the advantage of offering a wide range of SRH services that are affordable and benefit from availability of clinical staff on a fulltime basis, although such staff are generally only available during weekdays and official working hours (9.00am-5.00pm). SRH services are not offered in one room but clients are referred between departments within the same facility. A special arrangement that was present in all integrated facilities was training of HSPs in youth-friendly service provision. Recreational activities were rare at integrated facilities visited in this study but when present, only comprised of games, such as a pool table, that were linked to VCT clinics. The above findings are similar to other integrated models that have been implemented in other countries, for example in Jinja district, Uganda, implementation of adolescent friendly services within public health centres comprised of training of HSP, establishing recreational activities and involving parents and young people themselves in the design of the services. An evaluation of the intervention showed increased access and utilization of RH services, which included ANC, maternity, contraception, treatment of STIs and laboratory services; although the intervention was constrained with an erratic supply of contraceptives and STI drugs (Mbonye 2003). The Geracao programme in Mozambique also uses public health facilities, conducts training of HSP in providing SRH services to young people and has resulted in an increased number of young people accessing SRH services although a significant increase has only been observed among girls (Hainsworth and Zilhao 2009). The NAFCI in South Africa also uses public health facilities and improved SRH service provision to adolescents through quality assurance mechanisms such as setting standards and ensuring accreditation by external assessors (Dickson-Tetteh et al. 2001). Evaluation of the NAFCI has shown an improvement in the quality of services provided, although this has not directly lead to an increase in service utilization and reduction in the incidence of HIV and pregnancy rates among young people in the catchment population (Dickson, Ashton and Smith 2007).

The main weaknesses of integrated models of SRH service provision as identified in this study revolved around long waiting times, a high workload for HSP, inadequate staff numbers, poor
HSP attitude, low staff morale, lack of anonymity and privacy during consultation, lack of essential drugs and lack of youth-specific activities such as peer education. Other studies have also documented that these barriers do influence young people’s access to SRH services (Molla et al. 2009) as well as access to general health service delivery (Opwora et al. 2011). This implies that the SRH problems of young people cannot be addressed in isolation but have to be addressed as part of wider efforts to improve health service delivery within the context of the general health system. Cost as a barrier to accessing services did not feature prominently in this study. This could be because the cost of services at public health centres is low because they have been subsidized.

**7.3.1.2 Youth-only SRH service delivery models**

Youth centres or youth-only facilities have the advantage of offering SRH services for only young people and can either be located within a main hospital compound (facility-based) or within the community (community-based). Youth centres have the potential of offering both clinical and non-clinical services. Although set up with an aim of providing comprehensive SRH services to young people (James-Traore et al. 2002; Pathfinder 2001), youth centres visited in this study only offered a maximum of four services: i) contraception (oral contraceptives, EC and male condoms), ii) VCT, iii) information and counselling on SRH, including drug abuse and occasionally, iv) pregnancy testing. A key service that was needed by young people, but was not offered in the youth centres visited, was treatment of STIs. This was reportedly due to lack of full-time clinical staff and lack of essential supplies, reagents and equipment to offer these services. None of the youth centres visited in this study had the necessary resources to run laboratory services.

Youth centres have the potential of providing adequate privacy during consultation, having HSP who are friendlier and younger and having youth specific facilities such as resource centres, a variety of games, life skills training, vocational training, active peer education and conducting outreach activities that are youth specific to schools and the community. Availability of youth related activities was heavily dependent on the financial resources such youth centres had access to. HSP working at youth centres are recruited or deployed on the basis of being passionate about working with young people and hence are bound to show sensitivity to the SRH problems of young people.

The results presented in this study show that facility-based youth centres located within district hospitals, face challenges with regards to support and ownership by the district hospital management. In some instances youth centres that have been established within public health facilities with the support of NGOs may not be recognised by the management as part of the hospital, but may be seen to be belonging to the supporting NGOs. Lack of management
recognition and ownership of these youth centres results in these not being staffed with the essential staff required and also not being allocated financial resources to run youth related activities in the absence of NGO support. In some instances equipment purchased for use at the youth centre is relocated to the main hospital. In extreme cases youth centres have closed down. In addition there may be conflicts of interests in youth centre utilization between the hospital management and young people. Youth centres are generally designed to have ample space and good privacy and hence the hospital management may find it convenient to use the youth centre as a venue for other meetings such as week-long staff trainings. Some of the rooms within the youth centre may even be turned into administrative of staff offices. This is likely to happen in situations where the management has not been fully involved in the design and implementation of the programmes and hence do not fully understand the purpose of youth centres. Sustainability of such youth centres is questionable when the facility management is asked to take over the running of the youth centre once the NGO funding comes to an end. It is therefore imperative to ensure that during the establishment of facility-based youth centres, the hospital management are fully involved in the decision making process right from inception. With adequate participation of the management in the implementation of youth activities health managers taking-over of the running of the centre should not arise but rather continuation of service delivery should be a better term to use. This may therefore require a clear Memorandum of Understanding between NGO and MOH authorities at project inception.

Community-based youth centres with limited resources are not able to maintain clinical staff on a full-time basis and hence clinical services may only be available during specific days of the week. Community based youth centres tend to operate as stand-alone facilities and are likely not to anchor their services within the available government health structures and processes. Their heavy reliance on donor funding implies that their activities dwindle away as soon as the funding comes to an end; the youth centres may even close down due to lack of financial resources. A case in point is the FHOK NGO (formally FPAK) in Kenya which closed down a number of its youth centres countrywide as a result of the Global Gag Rule (Zielinski and Dreweke 2011). On the other hand, anecdotal reports from Tuungane youth centre show that it is one of the stand-alone community-based youth centres in Kenya that has documented success in reaching out to young people with HIV prevention information. The youth centre was established in 2004 with the aim of involving young people, parents, teachers and religious leaders in HIV prevention efforts, using the “abstinence” and “being faithful” strategy. Based on need, the centre has expanded its services to include provision of other RH services such as VCT, treatment of STIs, care and treatment for HIV positive youth, post-rape care and treatment, paediatric care for infants of HIV positive girls and referral for contraception. Unfortunately the youth centre is wholly donor dependent (Agot and Onyango 2009).
Establishing youth centres seems to be popular within developing countries but evidence for their effectiveness is limited (Speizer, Magnani and Colvin 2003; Speizer et al. 2004). Setting up youth centres is a costly affair (Pathfinder 2001) and most are heavily reliant on donor funding. Studies have shown that young people who visit youth centres are much older and mainly come for recreational activities rather than for health services per se (Speizer et al. 2004). However, in Jinja Uganda, an increase in the number of young people accessing RH information and services at youth centres were reported (Mbonye 2003). In the international literature, evidence for the effectiveness of youth centres is weak and there seems to be no well designed comparative or analytical studies that have been done to evaluate effectiveness.

7.3.1.3 Access to SRH information

Findings in this study suggest that adolescents, especially younger adolescents, do not have adequate information on SRH. For instance, girls aged 10-14 were not fully aware of the use of condoms and indicated that they had not received specific education. They also believed that condoms were only used by older youths. Younger adolescents who were in-school were also not accessing available SRH services due to lack of time as they were in school most of the time, even during school holidays. The study by Mashamba and Robson (2002) in Zimbabwe reported similar findings where younger adolescents (10-14 years) reported not being aware of the nearby youth centre, were reluctant to discuss contraception and associated the youth centre with STDs and hence did not want to be seen going to the centre. Conversely, the majority of older youths were satisfied with the services offered at the youth centre (Mashamba and Robson 2002). It is therefore important to reach out to younger adolescents with age specific SRH information so that they become aware of the SRH risks they are exposed to. Those who are in school can be reached by taking information and services to the schools. The KDHS (2008-09) report indicates that over 95 percent of young adolescents aged 10-14 are in-school (UNFPA and Population Council 2010). School-based sex and HIV education programmes have been found to be successful in improving SRH knowledge and attitudes among young people (Shepherd et al. 2010). In addition, sex education programmes have been found to be more effective if introduced at a younger age, before young people begin engaging in sexual activity (Poobalan et al. 2009).

7.3.1.4 Sexuality and relationship education

Sexuality and relationships education is a service that is not currently provided to young people in integrated health facilities in Kenya. HSP mentioned having “health talks” every morning for all clients who visited integrated facilities, but these talks were not youth specific. Although these talks addressed SRH issues such as prevention of pregnancy and STI/HIV infections, they seemed to be ad-hoc with no structure and with the content being HSP dependent. There seemed
to be no clear guidelines on how HSP should conduct these health talks or what minimum information is needed to be passed onto clients during each session. This is likely to encourage HSP to only discuss topics they are familiar with or are comfortable talking about. There is need to establish clear guidelines on how such health talks should be conducted and the minimum information package needed to be covered during each health talk session. Young people may also not feel comfortable being talked to together with other community members. Integrated facilities have to devise innovative ways of conducting youth specific health talks and counselling sessions at the health facilities so as to meet the SRH information needs of young people. Use of peer education, conducting youth-specific group discussions and having information sheets or leaflets which young people can read and carry away may be alternative options that can be used to pass on SRH information to young people. Use of the mass media, mobile telephone text messages, internet, self directed computer-based learning programme, positive messaging educational films in health facilities are also other avenues young people can be reached with SRH information.

There have been concerns about the effect of sex education in schools especially with regards to the decision of young people to initiate sexual activity but evaluation studies to date have shown that these programmes do not significantly increase sexual activity. On the whole, the evidence suggests that some of the sex education programmes actually delay sex and lead to an increase in condom and contraceptive use (Kirby 2002; Ross et al 2007). Young girls who have had formal instruction about pregnancy prevention and contraception are more likely to talk to their parents about these issues. They are also more likely to have ever used a contraceptive method, and adolescents who receive instruction prior to first intercourse, are more likely to use an effective contraceptive method (Kirby 2002).

Provision of sex education in schools would therefore provide an opportunity to reach the younger adolescents with SRH information before they begin engaging in sexual activity. There is therefore a need to establish strong collaborative links between schools and health facilities to be able to reach out to young people with SRH information at a younger age, before they begin sexual activity. In Kenya there is also a need to develop age specific SRH information so that young people can receive information that is appropriate for their ages. This information should be translated to relevant local languages if necessary.

### 7.3.1.5 Personal development and youth friendly services

The findings in this study indicate that young people describe youth-only facilities or youth centres within the context of the biomedical services they receive as well as the non-health benefits the youth centres accords them. Most importantly they value the personal benefits they receive by participating in available youth related activities at health facilities. Apart from
receiving SRH services young people regard youth centres as a place for passing time as well as gaining other skills such as life skills and employability skills. Youth centres are seen within the context of building young people’s self-esteem and confidence, improving communication and interpersonal skills, bridging the health knowledge-information gap, and as a stepping stone for career progression. However, this study did not explore whether availability of these non-health benefits led to an increase in the number of youths accessing SRH services or whether the youth centres visited met young peoples’ expectations with regards these non-health benefits. There is therefore need for more research to evaluate how this non-health benefit translates into improved SRH of young people.

7.3.2 Constraints of the medical model

The medical model of SRH service provision discussed in this thesis has some limitations in addressing the SRH of young people. The medical model mainly focuses on offering health care to the SRH problems young people face, with little attention being paid to the structural drivers that make young people more vulnerable to adverse SRH outcomes; such as social norms and values and the economic context. Going back to the basics, WHO defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Callahan 1973). Addressing the social-wellbeing of young people is therefore imperative for health to be said to have been provided comprehensively to young people. As stated in Chapter 2, (section 2.1.1e page 25), the law status of women in society and their lack of negotiation power to safer sex and monogamy makes them vulnerable to HIV and STI infections. In the Taegtmeyer et al (2006) study, married women were less likely to carry home a pack of condoms after a counseling session. Young people from poor families engage in transactional sex for material and financial gain and young girls are at risk of sexual coercion and rape; and therefore being exposed to unwanted pregnancies and subsequently unsafe abortion practices. Failure to recognize these social and cultural factors and only dealing with medical conditions fails to address the root cause of the SRH problems young people experience.

Only one stakeholder gave the suggestion that the SRH service delivery model for young people proposed in this study should move away from the illness driven model, but detailed suggestions on how this can be achieved were not made. The health system is basically concerned with providing health care to persons who have health problems. Previous health sector plans have largely been driven by the disease burden but more recently there has been a paradigm shift whereby the current National Health Sector Strategic Plan (MOH 2005) focuses on disease prevention based on the human life cycle through the Kenya Essential Package of Health (KEPH) framework; also discussed in section 3.3.1 (page 80-81).
Moving away from the illness driven model implies that the SRH problems of young people have to be addressed in a comprehensive manner, to include their educational, social and economic developmental needs. This, the health sector cannot achieve on its own but will require collaboration with other sectors of the social fabric. As stated in section 7.4.3, the SRH service provision model proposed in this study expressly recognises the need for strong linkages between the core services and other behavioural interventions within schools, the community and other government initiatives such as the Youth Empowerment Centers (YECs).

### 7.3.3 Barriers to accessing SRH services

Young people report fear and discomfort as reasons why they do not access SRH services. For example, young people appreciate the importance of VCT services but the inherent fear and stigma associated with HIV overshadows the benefits of the services. Young people report not having the personal confidence to handle HIV positive results. The thought of being HIV positive instills intense anxiety and fear in them that eventually deters them from accessing the services. Fear of having an HIV test, embarrassment of being asked personal and intimate questions by HSP, fear of explaining their problems to non-clinical staff, being seen going to a health facility associated with HIV or known to offer treatment for STIs make young people shy away from visiting such health facilities. Previous studies have also shown fear, shame and embarrassment, lack of privacy and confidentiality and long waiting time to be major barriers of access to SRH services by young people (Bankole and Malarcher 2010; Biddlecom et al. 2007; Kipp et al. 2007; Lindberg et al. 2006; Molla et al. 2009). Similar barriers have also been identified among urban black male adolescents in the United States of America (USA). Using a qualitative methodology male adolescents identified stigma, shame, embarrassment, disrespectful providers, lack of privacy and confidentiality and challenges within the health system as barriers to accessing SRH services (Lindberg et al 2006).

In Kenya a lot of effort seems to have gone into educating the public on the importance of going for HIV counselling and testing but not enough has gone into educating the public on individual risk perception and how to handle HIV positive results. This could explain why recent population-based data has shown that the majority of Kenyans who are infected with HIV (84 percent) do not know their HIV status (KAIS 2009) and that over 50 percent of young women and 66 percent of young men aged 15-24 have never had an HIV test (KNBS and ICF 2010). Education efforts need to go a step further to inform young people how to deal with a positive HIV test results, and if possible use living examples. Anecdotal reports from Tuungane youth centre in Kisumu indicate that young people who are HIV positive and on ARV treatment counsel other young people on HIV/AIDS. An approach that is highly appreciated by young people as expressed in the following excerpt,
“Being counselled by someone my age and who is positive and on ARVs is the best thing about Tuungane [youth centre]” 19-year old female client, (Agot et al. 2009).

SRH services in Kenya have largely focused on HIV which is associated with fear and stigma. There is therefore need to refocus efforts of addressing SRH of young people in a comprehensive way and this may involve including social, cultural and economic factors that shape sexual behaviour, instead of addressing HIV/AIDS as a stand-alone problem.

Lack of awareness of available services, negative peer influence, and distance of facility from the community are also barriers young people report experiencing when seeking health care. Knowledge among boys regarding available services at both integrated facilities and youth centres seems to be limited. In Nairobi, boys reported that they were not aware of the full range of services available at the health centres. At the districts some boys also reported that the youth centre would not be their first choice of seeking care since they were unaware of the services available at the facility. Lack of awareness of available SRH services could also mean that the interventions are not reaching the target audience. If young people are not aware of the available services, they will not visit the health facilities and similarly they will be unable to refer their friends to the same facility for services. Evaluation studies have shown that very few young people are directly being reached by SRH interventions. For example in Ethiopia, an evaluation of coverage of the existing youth programmes, (eight peer education programmes and six youth centres) found that only 12 percent of adolescents (20% boys; 7% girls), had visited a youth centre within the past one year and only 20 percent (27% boys; 15% girls), had come into contact with a peer educator within the same period. Boys and especially older boys were significantly more likely than girls to have had access to a youth programme and girls who worked longer hours and were more isolated were less likely to come into contact with the programme (Erulkar et al. 2006). Other studies in Sri Lanka (Agampodi et al. 2008) and Nepal (Regmi et al. 2010) similarly reported lack of awareness of available SRH services, especially by boys. There seem to be some contradictions whereby boys report not being aware of the available services but evaluation studies report more boys than girls being reached by SRH interventions. Nevertheless, more operations research need to be undertaken to identify effective ways of reaching both young boys and young girls with SRH interventions to ensure increased service use.

7.3.4 Increasing access to SRH services

Increasing availability of SRH services, creating awareness of available SRH services, improving the attitude of HSPs, instituting facility improvement initiatives and ensuring availability of essential supplies were mentioned by young people, community members and
HSPs as approaches of increasing access to SRH services. Other ways of improving access mentioned by young people included having up to date educational materials at the health facilities, increasing operational hours and reducing the waiting time.

Suggestions on how to increase availability of SRH services included setting up more youth centres especially in the rural areas or initiating mobile youth clinics to the rural areas in order to reach large numbers of young people and eliminate barriers related to distance and transportation costs. Setting up more youth centres has been documented to be a costly endeavour and may not be sustainable in developing countries where resources are limited (Pathfinder 2001). On the other hand, mobile services are cheaper and capable of reaching a large number of people. In a study conducted in Kenya assessing utilization and cost-effectiveness of two models of HIV counselling and testing (HCT): stand-alone and mobile services, more clients were found to attend the mobile services (76%) compared to the stand-alone services (24%). Persons with no previous history of HIV testing were more likely to attend the mobile services (88%) than the stand-alone services (58%) while more couples visited stand-alone services (18%) than the mobile services (2%). A significant proportion of persons were between the ages 15-24 years (42-47%) (Grabbe et al 2010). The provision of mobile HCT services was also found to be cheaper than stand-alone HCT services as the cost per individual tested was USD 14.91 for mobile-HCT compared to USD 26.75 for the stand-alone HCT (Grabbe et al. 2010). Mobile services are therefore cheaper and able to reach more young people especially those in the rural areas.

The SRH service model proposed in this study has an outreach activities and support services pillar. This pillar is inclusive of outreach services provided to schools and the linkages that can be created with other community based programmes as well as the provision of mobile services. Mobile services are therefore part of the core services proposed in the service model (also reflected on core service No.6 on Figure 24). Although recognised as a way of reaching out to the rural population mobile services do not receive specific government financial allocation. Often mobile services operate under the support of NGOs and donor funding which is often for a short period of time. Efforts should be put in place to promote their availability by ensuring the needed resources are available for their promotion. While embracing service integration, Mobile HCT services should also be expanded to include other components of SRH in order to address the SRH problems of young people in a comprehensive manner.

Creating awareness of available SRH services through use of the mass media in addition to conducting outreach activities from the health facility into the community, schools and churches by HSPs and youth peer educators are ways of increasing awareness of available SRH services among young people and community members. Other studies have also suggested the use of mass media and community outreach activities in increasing awareness of health services. Mass
media campaigns have been shown to be effective for increasing utilization of VCT services in Kenya with the radio and billboards being the most cited sources of information (Marum et al. 2008). In Nigeria mass media campaigns which included educational messages led to a significant increase in the number of new clients accessing family planning clinics (Piotrow et al. 1990). There is need to therefore include aspects of mass media interventions in the provision of SRH services to young people.

Multi-purpose centres such as YEC (described in Chapter 3, section 3.4) provide an opportunity for reaching out to young people with SRH information and services in a place where they socialize and are involved in other economic and education activities.
7.4 Political and financial context

7.4.1 Health service providers’ understanding of YFS, policies and guidelines

The findings in this study show that majority of HSP are aware of the concept of YFS provision but not of the supporting national policies and guidelines. A few HSP are aware of available policies and guidelines but are not sure of their content or the specific details. Lack of awareness of the existing policies and guidelines could either be as a result of unavailability at the health facility level or documents and information not being shared by facility managers or HSPs who attend training updates or dissemination workshops. The available guidelines have not been well disseminated, and the format in which the guidelines are presented may not be user-friendly. Some of the HSPs questioned why the focus on “friendliness” of services should be on young people alone when everyone else needed “friendly services”. Lack of proper understanding and internalisation of the YFS concept may explain the low priority YFS are currently accorded at different levels of health care.

These findings are in agreement with those reported in a study conducted in Swaziland among 56 HSPs, where most HSP (45) reported that YFS service provision guidelines were not available at their health facilities, while few HSPs (9) reported having guidelines but not using them (Mngagi et al. 2008). There is need for wide dissemination of available policies and guidelines at all levels of health care and to ensure that all HSP are aware of and understand the guidelines informing service delivery. In addition, the content of these guidelines should be disseminated in a format that is easy to use by HSP such as via job aids, flip charts, CDs and DVDs. The process of developing service delivery guidelines should be participatory and allow HSP from different levels of health care to help inform and develop such guidelines. This would enhance their familiarity with the content of the guidelines and ensure ownership.

7.4.2 Health service providers’ training and competency in provision of SRH services

HSP competency and confidentiality are essential elements of YFS (WHO 2002a). HSP training has been identified by WHO as one of the priority interventions for improving access to SRH services by young people (WHO 2001a). The findings in this study show that HSPs lack the ability to provide comprehensive SRH services to young people, especially in adolescent and youth counselling. HSPs indicated that sometimes they were unable to create a comfort zone during the counselling process where young people could open up and freely express their problems. HSPs with no training in YFS use their skills as parents and their experience of working in other clinical areas to provide services to young people. This view was re-affirmed by most young people who reported that HSPs talked to them in a motherly way.
Lack of selection criteria for HSPs who are eligible for training in YFS is a finding that has been emphasised by HSPs interviewed in this study. HSP are concerned that senior facility managers are often the ones privileged to attend such training sessions while HSPs who come into direct contact with young people on a daily basis are often left out. This has a direct effect on service provision as it demotivates hands-on HSPs at the service delivery points. This is in line with findings in Tanzania where HSPs reported that the existing selection criteria for HSP training favoured senior managers who worked in administration departments and had minimal contact with young people (Renju et al. 2010a). There is therefore a need to institute good and fair selection criteria for training HSPs in YFS provision at the health facility level. This has to be followed by, if possible, thorough scrutiny of the selected HSPs by organisers of the training to ensure that appropriate cadres of HSPs are included in such training.

This study suggests that friendly policies and HSPs training alone may not improve access to SRH by young people. There is need to address the cultural, religious and traditional value system which prevents HSPs from providing SRH services to young people. Training updates may not necessarily change personal attitudes but are necessary to enable HSPs to start evaluating their personal and cultural prejudices towards young people. HSPs trained in YFS have been known to be sensitive to the sexual health problems of young people and do not turn them away when they request services such as VCT, contraceptives and STI treatment (Mathews et al. 2009). There is therefore need to ensure that the HSPs’ training package is comprehensive to include theoretical and practical aspects of SRH service provision. The training package should also include participatory sessions where HSP are given a chance to examine their own values, cultural and religious beliefs which have a direct effect SRH service provision, and come out with practical solutions. HSP should be sensitized on the importance of paying special attention to young people compared to other patients.

HSP training in youth friendly service provision has been shown to result in a modest increase in service utilization for STI treatment especially by young males (Larke et al. 2010). HSP training has also been found to be positively associated with improved management of other RH concerns such as provision of good quality post-abortion care in the event of an unsafe abortion, post-partum haemorrhage and retained placenta (Olenja et al. 2009).

In Kenya the pre-service training curriculum for nurses has been revised to incorporate adolescent SRH concerns, but aspects of culture, the traditional belief and value systems may not have been adequately addressed. There is a need to strengthen the content of the training curriculum so as to effectively address SRH communication and counselling for young people, clarify the belief and value system HSPs have using practical examples and case scenarios. The Commonwealth Medical Association Trust (Commat) has developed a medical model curriculum on SRH to be integrated into undergraduate medical education and this could be
adapted for use during continuing medical education sessions (CME) (Haslegrave and Olatunbosun 2003). This curriculum highlights the need to include topics such as counselling and communication skills, disclosure of personal matters, health care provider attitude, and the influence of socio-economic and cultural factors on access to services (Haslegrave and Olatunbosun 2003).

Although the National Reproductive Health Training Plan for Kenya (2007-2012) advocates for the on-the-job-training (OJT) as an alternative way of improving the skills of HSP who have not undergone structured training, the effectiveness of this training methodology is open to discussion as there are no clear guidelines on how OJT should be conducted to ensure competency and subsequent certification of HSP in adolescent SRH (MOH and DRH 2008). Furthermore, HSPs who have received training may not be skilled in training their colleagues and HSPs who have undergone OJT may consider themselves untrained if they have not been certified. There is therefore a need in Kenya to identify the proportion of HSPs who have undergone training in YFS, the competency of these trained HSPs, whether these trained HSPs are actually providing services and whether they have participated in OJT of their colleagues. This would help in the development of guidelines for OJT and also assist in the planning of future training of HSP in YFS. Following in-service training HSPs do not necessarily put what they learned into practice. Follow up through supportive supervision to reinforce the newly acquired knowledge and skills from previous training may also be needed.

7.4.3 The proposed SRH service delivery model

Taking into account the views and experiences expressed by young people, community members, HSP and policy makers in this study, a multi-component SRH service delivery model, with six core services, for the delivery of SRH services to young people in Kenya is proposed. The proposed SRH service delivery model has also been informed by existing literature on ASRH interventions, and the development of health service delivery models, as described in sections 2.2 to 2.5 of this thesis. The literature outlined the need for identification of enabling or assistive factors, barriers and boundaries as pre-requisites for health care nursing model development. In addition, the literature review also identified 12 essential elements that need to be present in a health service delivery model (see Table 12). This is the first study to be conducted in Kenya, using a qualitative methodology, and result in the development an SRH service delivery model for young people, after triangulation of views and experiences of young people themselves, community members, health service providers and policy makers. Exploration of views of the stated respondents led to the identification of the SRH problems of young people, enabling factors, as well as barriers to SRH services provision for young people (Girard 1993). This views and experiences eventually informed the development of a new SRH service delivery model. This process is in line with the principles of client-centred model for
health care delivery where services are provided based on the needs of clients as opposed to the convenience of health care providers (Clarke 2004).

The six core services included in the proposed model for SRH service delivery in Kenya are:

1. Screening services - pregnancy, HIV and STIs
2. Treatment services - STIs, sexual violence, abortion complications, ARVs (re-supply)
3. Contraceptives service - injectables, COCs, EC, Male condoms
4. Counselling on drug and substance abuse
5. SRH counselling, information and education
6. Outreach services

These core services are essential services that address the SRH problems of young people and are basic services young people need to access. These services need to be easily accessible to young people and should be anchored within a strong support system or health care system for the process of service provision to be attainable. A strong support system would be able to mitigate barriers that hinder availability and accessibility of SRH services. As shown in the proposed model the support system has to be embedded within the concepts of a skilled and motivated workforce, sound financial sustainability, good leadership, management support and governance, a comprehensive, standardized monitoring and evaluation system, as well as meaningful youth and community buy-in and participation. This implies that SRH services for young people have to be embedded within an overall functional health system, even though it is recognised that in many low income countries, existing health systems are weak (WHO 2007d).

The SRH service delivery model for young people proposed in this study is consistent with the objective stated in the National Health Sector Strategic Plan (NHSSP II) in Kenya, which includes, establishing “youth-friendly services within existing health facilities” (MOH 2005). NHSSP II promotes the integrated model of SRH services delivery, a finding that is comparable to the SRH service model proposed in this study. NHSSP II also outlines four essential services to be provided to young people at the health facilities; this include provision of RH counselling, contraceptives, VCT and promotion of anti-tobacco and anti-drinking habits. The core services proposed in this proposed model are also consistent with the recommended essential service package for either youth centre-based or clinic-based models stated in the national guidelines for provision of youth-friendly services in Kenya (MOH and DRH 2005). The only difference is with regards to the provision counselling on drug and substance abuse which has been expanded, in the developed model, to include other abused drugs in addition to tobacco and alcohol.

Counselling on drug and substance abuse is recognised in the proposed model, as a core service, due to the magnitude of the problem among young people in Kenya. Current national reports in
Kenya indicate that eight percent of young people aged 10-14 have ever used alcohol, with the median age of having used alcohol and “bhang” being 11 years and 14 years respectively. Among those aged 15-24, nine percent currently use alcohol, six percent use tobacco, six percent use “miraa” (Khatt), while one percent use “bhang” (NACADA 2007). Studies have found significant associations between alcohol use and sexual activity (Anderson and Mueller 2008; Klein et al. 2007; Singh et al. 2010; Voglewede, Jr. 2011). In a cross-sectional survey among school children aged 11-14 years from North West England a positive association was found between alcohol use and sexual activity (Phillips-Howard et al. 2010). Recognizing the effect drug and substance abuse has on the SRH of young people is therefore essential to improving the SRH of young people.

Multi-component interventions have been known to produce desirable behavioural outcomes because young people are reached through multiple channels, especially when programmes combine BCC, YFS and outreach services (Williams et al. 2007). Exposure to SRH education interventions through multiple education channels, such as mass media and interpersonal communication, and where contraceptives are available, has been shown to result in improved attitude and preventive sexual behaviour among young people (Agha 2002). The proposed new SRH service model for Kenya recognises the need for strong linkages between these core services and other behavioural interventions within schools and, the community as well as existing government initiatives such as Youth Empowerment Centres (YEC) (MOYA 2007b). One possible limitation of YECs is that they are likely to be frequented mostly by boys who may also be older and out-of-school. Alternative avenues therefore have to be used in reaching out to young girls and younger adolescents particularly those in schools and by establishing partnerships with schools and existing community-based youth programmes. This is because adolescents are not a homogenous group, but comprise of different sub-groups, who are not necessarily reached by the same service model.

The results of this study emphasise the need to have a SRH service delivery model that is integrated, relevant and comprehensive. Service integration, especially at the health service provider level, would ensure that a wide range of services are available to young people at each contact time. This would require training of HSPs in multiple skills so that they can be able to provide the stated services effectively, with minimum referral to other HSPs. This would help avoid situations where young people have to repeatedly explain their problems to several HSPs; an action that is likely to result in poor compliance with referral and treatment.

One of the major advantages of the proposed new SRH service delivery model is that it provides a guide to stakeholders by defining the minimum service, information and education packages young people need based on research evidence. For example, the proposed model can guide the development of structured health talks and health education sessions at the health facilities.
Having structured sexual health education sessions for HSPs or other providers involved in educating young people such as peer educators would ensure maximisation of the contact time HSP have with young people and minimise adhoc health education sessions.

Having targeted services to address different categories of young people is an aspect of service delivery that has been emphasised in this study. Boys and girls opinions on available SRH services are derived from different perspectives. What girls consider as good services may not be seen in the same light by boys and hence service segmentation with regard to respecting the SRH problems of boys and girls need to be considered in the delivery of SRH services. Evidence shows that exposure to existing interventions is different for boys and girls, with older boys, being significantly more likely than girls to have access to a youth programme (Erulkar et al. 2006). Research has also shown that gender has a major influence on the sexual health of both boys and girls and that the social construction of sexuality expects boys and girls to express their sexual identity in different ways. While boys are expected to express their sexuality openly, girls are not expected to express their sexual feelings or desires and are supposed to keep them silent (Tolman et al. 2003). Evaluation of multi-component SRH interventions has shown positive outcomes for male but not female adolescents (Doyle et al. 2010; Larke et al. 2010) and vise versa (Karim et al. 2009; Williams et al. 2009). The systematic review on the effectiveness of HIV interventions of youth in sub-Saharan Africa showed that the interventions showed more positive impact among boys than girls especially with regards to condom use at last sex; ever had sex, and number of sexual partners (Michielsen et al. 2010).

This draws attention to the importance of developing interventions that use different approaches to target boys and girls given the different perspectives they exhibit on available SRH services and the gender specific outcomes that are observed in SRH interventions. Other aspects of service segmentation stakeholders in this study identified include having interventions that target in-school and out-of school young people; youth who are married; living in urban-poor or rural areas, young people who are deaf or blind, poor and street children.

There are a few SRH interventions targeting young people that have used public health structures for piloting and subsequently scaling-up interventions in developing countries. Majority of the interventions are anchored within NGOs or other partner organisations, which means more often, parallel management structures are set up to oversee implementation of these interventions. The adminstration and financial management of such projects is usually, solely undertaken by NGOs, while the government provides the infrastructure including human resources. For example in the MxV project in Tanzania (Obasi et al 2006) and the Geracao Biz programme in Mozambique (Hainsworth and Zilhao 2009), technical assistants (TAs) were employed by the projects at the different levels of health care. While this led to an increase in financial accountability, high coverage and ensured fidelity in the implementation process, it
prevented project ownership by the local health management. It also acted as a hinderance to service integration into the existing health system (Renju et al. 2010b). This was exhibited when HSP within project areas preferred reporting directly to the technical assistants instead of the health facility in-charges or managers. The primary school HIV prevention intervention in Kenyan schools is an example of an intervention that used the existing education structures for piloting as well as scaling-up and subsequently has reported sustainability; teachers trained at the time of project initiation were still delivering the intervention three years later (Maticka-Tyndale, Wildish and Gichuru, 2010). This may have been because there was a policy directing all schools to provide HIV education and hence teachers felt obliged to continue providing the education. There is therefore need for more research on how large-scale interventions can effectively be implemented through existing government systems and processes, how governance and financial management of such interventions can be infused within the existing government financial planning cycles, and how sustainability of the programmes can be enhanced.

Previous studies on SRH programmes have not produced positive results especially with regards to reducing the incidence of HIV and pregnancy rates. It may not be realistic to expect intervention programmes that mainly aim to advice and counsel young people on SRH to result in measurable and improved health outcomes such as reducing the incidence HIV and adolescent pregnancy. Perhaps, at best, outcomes to be considered in interventions should include those that strive to increase service utilization, enhance the picking up of more unrecognised STIs and treating them, rather than expecting to reduce the disease prevalence.

7.4.4 Policy environment, co-ordination and financial context of SRH services in Kenya

Kenya has a sound and explicit policy framework and accompanying strategic documents to address the SRH problems of young people. The National Health Sector Strategic Plan (2005-2010), the National Reproductive Health Policy (2007), National Youth Policy and all other national policies and strategic documents listed in section 3.4, all outline the importance of addressing the SRH problems of young people.

However, this study suggests that “a supportive policy environment” is not enough for the effective provision of SRH services to young people and hence, factors beyond this supportive policy environment needs to be taken into consideration, if the SRH problems of young people have to be addressed. This is the first study to conduct an in-depth analysis of implementation of SRH services for young people in Kenya, by exploring views of respondents representing the whole spectrum of SRH service provision, ranging from the national and policy level, to the service delivery points. This included examining views of policy makers, development partners
and NGOs, district managers, health service providers, and young people and community members. The outcome was the identification of a total of 10 contextual factors which shape the provision of SRH services to young people as illustrated in Figure 26.

The results in this study suggest that although ASRH has been identified as a priority concern by relevant ministries and stakeholders; however, there are large deficiencies in the implementation of these policies. The prioritization of ASRH has not been reciprocated by allocation of adequate financial resources. The SRH programme at all levels of health care is heavily reliant on donor funding and is only active in regions or health facilities where there is donor or NGO financial support. In regions where there is no donor or NGO support, youth SRH services, with the exception of HIV/AIDS related services, are non-existent. Furthermore, coordination, supervisory and monitoring structures at the national level are weak and also have inadequate financial and technical resources. Despite clear indicators for ASRH being available internationally, the Kenya Annual Health Sector Statistics Report does not present data in a format that reflects the proportion of adolescent clients accessing RH services, such as, the number of clients attending ANC, PMTCT, delivery, FP, PAC and STI services (HMIS 2008).

There seems to be a gap between the collection and utilization of data from facilities offering YFS since the current planning process does not seem to be informed by available service statistics. This is evidenced by the fact that facility managers are not sure of the reporting line structure.

Barriers that could hinder the implementation of the proposed SRH service model identified in this study and require further attention include: limited financial resources, shortage of HSP, weak coordination linkages between the different sectors and line ministries, national management level structural changes and lack of an effective monitoring system. On the other hand, model sustainability would be enhanced by having a strong and sound financial base, involvement of multiple sectors, establishing strong partnerships between the public-private-NGO sectors, service integration, supportive management and leadership and community buy-in and ownership.

Sustainability of most youth initiatives is therefore a major concern, especially with regards to financial resources. Since most youth initiatives currently rely heavily on donor funding, they dwindle away as soon as funding comes to an end. Aggressive resource mobilization initiatives such as leveraging resources from well funded programmes such as HIV/AIDS through service integration, shared funding initiatives of ASRH services between MOPHS and MOYA, tapping into locally available resources such as the Constituency Development Funds (CDF), fund raising through public-private partnerships, establishment of income generating activities (IGAs) including creative economy, and training of young people in micro-enterprise and business management skills may be important ways of enhancing financial sustainability. As
stated in section 2.5.3 on costs for health care delivery, evidence for establishing successful public-private partnerships especially in developing countries is limited, although in European countries these partnerships may reduce government spending, enhance greater efficiency in service delivery as well as health care management (Nikolic and Malkisch 2006). Previous PPPs have mainly focused on health facility infrastructural development but there is some evidence from Lesotho and Spain suggesting that having PPPs which also include a component of service delivery, at the same client cost, may result in better health care (Sekhri et al. 2011). Other innovative ways such as use of competitive vouchers may enhance PPPs AND also increase access to SRH services by poor young women. Government budgetary allocation would be an ideal way of ensuring financial sustainability of SRH services for young people. There is therefore need to advocate for budgetary resource allocation so as to enable institutionalisation of these services within the public health system; the implementation of the proposed new model will be reliant on this.

Factors shaping the successful provision of SRH services to young people in Kenya can be summarised as shown in Figure 26. Only one of the factors can be said to be in place, that is, the policy environment. Other nine factors are either partially available or represent major barriers to SRH service provision.

**Figure 26: Factors shaping access to and provision of SRH services to young people in Kenya**
7.5 Study limitations

This study has several limitations which must be considered while interpreting the results presented. This is a qualitative study which took place in eight facilities and hence the results presented cannot be generalised to the whole of the Kenyan population. The study health facilities and respondents were purposefully selected hence the views expressed may not be generalised to the whole population. It is possible that different health facilities and respondents would have been selected to participate in the study if random selection was used. Young people, community members, health service providers who took part in this study were from urban areas and therefore it is possible that different views would have been elicited if the study included respondents from purely rural areas where SRH services are not available. The study findings could therefore not be disaggregated to show rural and urban differences.

The lack of quantitative data meant that definitive conclusions from the findings could not be made. For example due to lack of time to collect and analyse service statistics, service utilisation trends by boys and girls over a period of time could not be assessed. Future research should consider assessing health service utilisation patterns, over a given period of time, for both girls and boys. This will enable one draw conclusions on whether available SRH services are being utilised or not.

Focus group discussions with young people were not disaggregated by age category (10-14, 15-19, and 20-24), but all FGDs consisted of young people between 15-24years. The views of young people in the FGDs were therefore not disaggregated by age groups 10-14, 15-19 and 20-24. This is a major limitation of this study because the SRH problems of young people in the different age categories vary. Due to time constraints, FGDs of young people aged 10-14 were also not conducted. Lack of time also hindered having a school component to the study. In addition separate approval by the school authorities would have been required. Schools would have provided a good avenue of getting young people aged 10-14 years bearing in mind that 95 percent of young people aged 10-14 years in Kenya are in school. Future research should consider selecting study respondents according to the above age categories and disaggregating the findings according to the specified age categories.

The study experienced financial constraints and hence a larger number of facilities could not be included in the study; only three youth centres were visited in this study. The study could have benefited from experiences of young people, community members and health service providers from other regions in the country such as Nyanza and Rift Valley Provinces, which also have functional youth centres. The limited time attached onto a PhD project meant that only a few facilities could be visited and assessed.
FGDs of young people from the districts were not disaggregated by service users or non-service users but were mixed. The groups consisted of young people who were both users and non-users of health services. Future research should consider also disaggregating the respondents according to service use status; service users and non-service users.

The study addressed more the SRH problems young people experienced and did not explore general SRH problems in detail. This was because the study FGD and IDI topic guide for young people focused mainly on probing more on SRH problems. The researcher’s medical background could also have influenced the direction of the research to mainly look at SRH problems instead of exploring more on the SRH problems young people experience. It could also have influenced the identification of thematic areas which tended to be more towards SRH problems.

Studying adolescent sexual health is a difficult area since young people are very sensitive to cultural and social norms and expectations. This study has relied mostly on self-reported data which is prone to recall bias and other biases linked to cultural sensitivity of young people’s sexuality. There is a continued debate with regard to the validity of self-reported sexual behaviour among adolescents especially in societies where it is essentially a taboo for young people to engage in pre-marital sexual activity. In such societies young people keep their sexual relationships as “a guarded secret” (Wight et al. 2006) and may only report what is socially acceptable (Plummer et al. 2004). In the Kenyan society girls are regarded as well behaved if they are not sexually active while sexually experienced girls are described as bad or immoral. This is likely to contribute to the under-reporting of sexual activity especially among girls during interviews. Nonetheless, in-depth interviews have been found to be effective in getting honest responses among females having STIs, (Plummer et al. 2004)

For example, FGDs with girls in two of the facilities, Woodley clinic and Langata health centre, needed a lot of probing. The girls were not able to articulate issues on sexual health very well and therefore a lot of effort went into probing so as to get some information from the respondents. The girls found it particularly difficult to talk about condom use and generally on issues regarding sex. They also did not seem to know very well the range of SRH services that were available at the facilities. This could also have been due to the fact that this particular group of girls had a lower education level (some or complete primary level) and hence could not articulate issues adequately. It has been shown that lack of confidence and low self esteem may prevent individuals from openly participating in group discussions (Rabies 2004).

Looking back at the data collection tools for young people’s FGDs and IDIs, these may have had some limitations especially with regard to being SRH problem-based rather than SRH needs-based. The topic guide may not have allowed for an in-depth inquiry on the SRH needs
but rather was directed at SRH problems. The topic guide therefore may not have allowed young people who had other needs and ideas other than SRH problems to freely express their views and opinions, for example, on relationships, sexual bullying, body image, stigma/fear, fear and those who felt that coming for services was the right thing to do.

The researcher’s medical background may have also influenced the direction of the research to mainly look at SRH problems instead of exploring the SRH needs of young people in more detail. Similarly the identification of thematic areas tended to more focus on SRH problems.

Community members who took part in the study were mainly community resource persons such as religious leaders, administrators, CHWs, CBDs and business women and hence they may be members of the community who were well informed compared to ordinary men and women in the wider community. Nonetheless, these are considered the gatekeepers of the community and their views are reflective of the social norms around SRH education and contraceptive use. Furthermore their lack of knowledge on the available SRH services could imply that the awareness level of the common man and woman in the community could be worse.

It was difficult to get programme managers and policy makers together for the sole purpose of discussing research findings and hence the researchers had to adapt to their schedule to fit the research activities onto their routine programmes. The reality on the ground is that policy makers may not have time for research and if they are to participate in the research process, researchers have to actively reach out to them within their normal working routine and make research part of their agenda. The research findings also have to be presented in a format that is easy to understand and internalize. In this study, the proposed model for SRH service delivery was presented to stakeholders in the format of a house which was a concept liked and easily understood by stakeholders. In the first two workshops with programme managers and policy makers’ insufficient time was allocated to plenary discussion of the research findings and this was compensated for by getting feedback from the stakeholders individually. It is possible that some stakeholders who would have wished to make their views known during the plenary session were not able to do so. However, stakeholders who volunteered to be interviewed further made this known and were interviewed individually at a later date.

Coming into this research process as a programme manager and policy maker within the public health sector may have resulted in some bias and influenced the manner in which respondents answered the questions. Some health care providers felt that I was asking questions to which I already had answers and sometimes challenged me to provide an opinion by asking some questions along with their responses. For instance, HSP would ask questions like: “what would you do if faced with a similar situation?” or, “how would you react if your 16 year old girl came
home and told you “Mum, I have inserted an implant?”

Being mother of adolescent girls may have also influenced my sensitivity to addressing the SRH problems of adolescents in general.

The inexperience of the researcher may have affected the systematic nature of the research process in terms of planning, development and application of the research tools before and during the research process. Future research by the researcher will ensure that the process is more systematic, planning is more rigorous, resources are in place, and that the key sectors to be involved (such as education) are contacted and approval is sought at an early stage.

The participants who took part in the stakeholder’s workshop were mainly from the field of health and health services and may therefore not have given many divergent views on the core services of the proposed model. They could also not have had much insight or discussed in detail how to move away from the illness driven model of health care provision.

7.6 Summary of discussion

The discussion chapter highlights the gendered nature of SRH problems young people experience with regards to early sex, puberty, transactional sex and the gender dynamics associated with pregnancy prevention. Girls and boys views of available SRH services and the importance of games at the health facilities are discussed. The social norms, conservatism, adolescent sexuality and their relationship to views about condoms use, contraceptive use and young people’s vulnerability to sexual violence are discussed. The values and attitudes young people and health service providers have towards available SRH services are also discussed. Views on the models of SRH services, barriers and mechanisms of improving access to SRH services by young people are presented. The proposed SRH service delivery model for young people is presented together with the political and financial context.
Chapter 8: Conclusions and Recommendations

8.1 Conclusions

This chapter examines whether the research process has answered the research questions and met the objectives the study set out to achieve. The chapter also outlines some of the recommendations the study proposes and areas for future research.

The SRH problems of young people remain a major public health problem in Kenya today. Early and unprotected sexual activity, infection with HIV/AIDS and other STIs, unwanted teenage pregnancy, unsafe abortion and sexual violence are major SRH problems young people experience. Lack of accurate and timely information about SRH increases young people’s vulnerability to the stated SRH problems. Lack of parental guidance, poverty, unemployment, drug and substance abuse, peer pressure and the influence of the media are major underlying factors that predispose young people to adverse SRH outcomes. Poverty and unemployment are major driving forces identified by young people. Currently young people in Kenya are more than ever concerned about unemployment and link adverse SRH outcomes to poverty and unemployment. Programmes addressing the SRH problems of young people have to take this into consideration. Other SRH needs young people have and require more information include concerns around relationships, menstrual problems, physical body changes and psychological changes that are age specific.

Addressing the SRH service problems of young people remains a big challenge for the health sector in Kenya. There still exists a large gap between policy formulation and the implementation process. Some progress has been made towards creating a friendly policy environment for SRH service provision; however, the major challenge is implementation of these policies. The SRH services of young people still take a back seat with regard to allocation of resources. The sustainability of the current youth SRH health initiatives in Kenya is questionable as these are heavily donor dependent.

Programmes designed to address the SRH problems of young people need to include interventions addressing structural issues such as gender inequality, poverty and economic empowerment as well as social norms and values such as normalcy of sexual coercion, community disapproval of contraceptive use by young unmarried girls and myths and misconceptions about condom use. Designing interventions that aim to change the socio-cultural context, including the community’s attitude, norms and values are essential for sexual behaviour change. Currently, most health education is directed at changing individual behaviour but, individual behaviour is also determined by the socio-cultural and economic context in which young people live.
A multi-component and integrated SRH service delivery model, with six core services, is proposed in this study. This is a facility-based SRH model with linkages to schools and the community. The proposed model is embedded within six supportive structures which include: a skilled and motivated workforce, essential supplies and equipment, financial sustainability, good leadership and governance, a standardized monitoring and evaluation system and community and youth participation. This proposed model can serve as a guide for stakeholders in outlining a minimum SRH service package for young people.

The Kenyan society is still very conservative with regards to discussion around sex and sexual health because of existing religious, social and cultural norms and values. Young people wish to receive SRH information and education from their parents, but parents have limited experience and are not sure on how this can be done. Cultural norms and traditional practices also hinder free discussion of sexual health between parents and children.

Schools provide an excellent opportunity for provision for age-specific SRH education to younger adolescents (aged 10-14) in Kenya, since the majority of adolescents in this age bracket (over 95%) attend school. SRH education has been shown to be more effective when given at a younger age (e.g. before initiation of sexual activity).

The design of SRH programmes in Kenya needs to take into consideration that sexual initiation among young people occurs early, below 15 years, and by age 18, the majority of young people are already sexually active. Programmes also need to consider that 12 percent of adolescents aged 15-19, and over half (56 percent) of young girls aged 20-24 are already married.

Use of modern contraception is not supported among the Kenyan society especially for young girls who have never given birth due to community perceived negative effect on subsequent fertility. Contraception is also mainly construed within the context of “child spacing” and “family planning” as opposed to delaying childbirth or preventing unwanted pregnancy. The use of contraceptives is approved for girls who have begun childbearing but not for those who have never given birth.

Young people are aware that condoms can effectively prevent pregnancy. It might be more acceptable to promote condom use as a pregnancy prevention tool than solely link it to HIV as is currently most often done. This link to HIV leads to stigmatization around condom use. Inconsistent condom use among young people is still common. Myths and misconceptions, “blind trust” and negative media reports discourage consistent condom use. Rigorous health education and harmonisation of condom education messages is needed to dispel these myths and misconceptions.
Young people are not a homogenous group and their SRH problems as well as perceptions about available SRH services are diverse and show variation between boys and girls. Public health facilities offering integrated services seem to receive approval from the majority of young people with regards to SRH service provision for young girls and women. However, boys find the environment within integrated public health facilities uncomfortable leading to problems with access to services. There is therefore an unmet need for SRH services among young boys as a result of infrastructural design and organisation of health services at integrated public health facilities.

Providing SRH services to young people through the public health system (integrated model) presents an opportunity that can be exploited because a large number of public health facilities are in place and geographically spread out nationally. In addition, public health facilities serve the poor, including those in rural and remote areas. Integration of SRH services for young people within this existing public health services system would enable a large number of young people, especially girls to be reached by the services. However, the integrated model of SRH service provision still faces challenges that are linked to an overall weak general health system.

The results of this study suggests that the youth centre is the preferred model of SRH service provision by young people, community members and HSP; however, its sustainability is questionable and it is only able to offer a limited range of services. Setting up youth centres is an expensive endeavour that may not be sustainable in developing countries.

The evidence linking the presence of recreational facilities to increased access and utilization of ASRH services is insufficient. The role and importance of games and other recreational activities at health facilities is still not well understood. Where games are available this seems to only attract boys, and in the long run, may scare away girls. Maintenance and replacement of these games also presents a challenge.

Community members are not fully aware of the range of SRH services currently available to young people in Kenya but they are supportive of services which are preventive and educative in nature.

Irrespective of training in YFS, health service providers are still conservative with regards to providing SRH services to young people, especially with regard to contraception. Friendly policies and health service provider training alone may not improve access to and utilization of SRH services by young people. Cultural, religious and traditional values play a major role among health service providers regarding whether and how they provide SRH services to young people.
HSPs competency in providing SRH services to young people is limited by their understanding of adolescent psychology and by their interpersonal communication skills. HSP seem to provide motherly, rather than professional advice to young people seeking SRH services and this acts as a hindrance to young people in accessing SRH services.

Currently SRH programmes have focused on training HSPs. This training has however been sporadic or opportunistic without taking into consideration follow-up or supportive supervision to see whether HSPs are putting the acquired knowledge and skills into practice. This coupled with de-motivated HSPs, means that managers and HSPs do not go the extra-mile to ensure that SRH problems of adolescents within the catchment area are being addressed.

Conducting outreach services from the district hospital to rural health facilities as well as mobile services to the community could provide an opportunity where more young people could be reached with SRH information and services. Extending SRH services to rural areas also presents a challenge due to health systems deficiencies such as lack of staff, lack of space to service young people and lack of essential supplies.

There exists a supportive policy framework for providing improved SRH services to young people in Kenya; however there exists gaps in implementation. Effective dissemination of existing policies and guidelines is essential for the harmonisation of service delivery at all levels of health care.

The design of alternative models for provision of SRH service provision for young people should be explored and scientifically evaluated in order to identify best practices and ascertain their effectiveness.
8.2 Recommendation

SRH service delivery model

- This study recommends a multi-component SRH service delivery model, with six core services, addressing the SRH problems of young people in Kenya. The model should be implemented through the existing health systems, and establish linkages with schools, Youth Empowerment Centres and other community based programmes. This proposed SRH service delivery model should be scientifically “tested” in selected health facilities and evaluated to measure its effectiveness, using both process and outcome evaluation procedures.

- Policy makers should ensure that the core services stated in the proposed model are available to young people irrespective of age, gender and marital status, by putting in place explicit service delivery guidelines or revising the already existing ones. Special attention should also be given to young people who are more vulnerable to adverse SRH outcomes such as those who are poor, living in urban slums, rural areas and are married.

- The public health system should be strengthened to address the SRH problems of young people in a more effective and integrated manner, rather than create parallel health structures focusing only on young people. This should be done by training HSPs on how to be respectful, friendly and maintain client’s confidentiality. The service delivery environment should be devised such that it provides adequate privacy and anonymity to clients. The facilities should maintain cleanliness, offer a wide range of SRH services and operate within flexible working hours. The waiting area and service delivery units should be designed to offer comfort to both young girls and boys.

- Within the inter-sectoral collaboration framework, SRH programmes that retain young people in schools should be promoted, for example, subsidizing some aspects of education costs such as school uniform, tuition fees and providing sanitary towels. This is based on the evidence that young people, especially girls with a higher education are less likely to face adverse RH outcomes, such as teenage pregnancy, than their less educated counterparts.

- Age-specific, school-based, SRH education programmes should be designed in order to reach young people with SRH information and education before they begin to engage in sexual activity.

- SRH programmes that include and support parents in providing education and information should be designed, implemented and evaluated for their effectiveness. Parents should also be empowered with skills on how to pass SRH information to their children.
Young people are in need of abortion services but are unable to get these services because abortion is illegal in Kenya. Young girls can receive treatment when they visit a health facility with complications of unsafe abortion. Bearing in mind that abortion is illegal in Kenya, there is therefore a clear need to intensify advocacy campaigns for pregnancy prevention initiatives, such as increasing access to a wide range of contraceptives for young people (including emergency contraception), increasing access to comprehensive sex education for both in-school and out-of-school youths and creating strong linkages between schools, religious organisations and other community based organisations. There is also a need to have more operational research to document the situation of unsafe abortion among young people in Kenya as well as identify lessons learnt on safe abortion and prevention of unsafe abortion in other countries.

There seems to be a gap between unmarried young people who need contraception to avoid unwanted pregnancy and the use of the phrase “family planning”, signifying staring a family within the confines of marriage but planning this. The notion among young people is that they cannot use “family planning” choices since they are not married and/or starting a family. The Division of Reproductive Health is in the process of revising the national guidelines for provision of youth friendly services in Kenya. This process involves extensive stakeholder consultation and hence presents an opportunity where a renewed emphasis can be placed on the use of the term “contraception” as instead of “family planning”.

The use of the media (radio and print) and internet-based social networks to pass SRH information to young people should be strengthened and evaluated.

The design of SRH programmes should include interventions that address the underlying causes of SRH problems young people experience, such as poverty, sexual coercion/violence, gender inequality and transactional sex. SRH programmes education should also strive to change community social norms that have a negative effect on young people’s sexual behaviour and SRH outcomes.

Community dialogue and discussions forums should be encouraged between community members and young people, using existing community structures such as local administration (chiefs’ barazas), men and women’s groups, as well as youth groups. These dialogue meetings should aim at enhancing communication between young people and their parents, and demystifying the social and cultural barriers around adolescent sexuality.

National policies, guidelines and capacity of HSPs

The Ministry of Health should ensure that there is timely dissemination of available national polices and guidelines, up to the lowest level of service delivery, so as to standardize SRH
service delivery. The national guidelines should also be presented in a format that is easy for reference and use by health care providers, such as posters and job aids.

- The Ministry of Health should develop selection criteria for training health service providers in youth friendly SRH service provision. The capacity of HSP to provide SRH services to young people after training should be reinforced through regular supervision and follow-up after the initial training.
- In providing health services to sexual violence victims, a multi-sectoral response in required to ensures that survivors of sexual violence receive both medical care and justice
- The technical competencies of HSPs in providing YFS provision should be evaluated on a large scale, and improvements in the content of the curriculum for training HSPs undertaken to meet the gaps in knowledge and skills, especially with regards to adolescent psychology, adolescent counselling, and interpersonal communication.
- The training curriculum for HSPs should be revised to include aspects of culture, religion and traditional practices, with the aim of understanding their influence on HSPs’ decision making process, especially in the provision SRH services to young people. This should provide an opportunity for health service providers to be sensitised to their own values, cultural and religious beliefs, and how these beliefs could be used positively during the counselling process.

**SRH service coordination and monitoring**

- The coordination of SRH services at the national level should be strengthened and widened to include all relevant stakeholders from the different line ministries, such as education, health, youth affairs, social services, development partners and NGOs. This is to ensure that all the relevant stakeholders are part of the decision making process, they consolidate their efforts, encourage leveraging of resources and avoid duplication of service delivery efforts.
- The Ministry of Health should organize an Annual National SRH Conference where stakeholders with an interest in SRH for young people are given an opportunity to share their experiences in SRH service provision, and also share research findings.
- A minimum SRH education package for use by HSP and other providers who come into contact with young people such as peer educators should be developed to ensure that the provider-client contact time is maximized. This should be done through participatory consultation with stakeholders from key sectors of education, health and social services, so as to ensure standardization of the SRH information young people receive.
- There is a need to strengthen and standardize monitoring and evaluation indicators for SRH service provision to young people and integrate these indicators within the National Health Information Management System (HMIS). A standard daily activity register, to be used at all youth centres, should be developed and made available at the youth centres. Monthly
reporting summary sheets should be designed to show the disaggregation of clients visiting health facilities by age and sex. The reporting line by the facility managers should also be clarified. In facilities providing integrated services, health statistics of clients assessing SRH services should be summarized to reflect age and gender differences.

- MOPHS and MOMS are in the process of developing a new District Health Information System (DHIS) where all the data will be disaggregated by age and sex. Suggestions have been made for the inclusion of indicators related to SRH of young people such as number of facilities providing YFS services and number of youth accessing YFS services. It would be important for the DHIS to also include indicators related to the number of young people accessing specific SRH services such as contraception, STIs, PAC, post-rape care, and delivery.

- Lack of financial resources and donor dependency are threats the ASRH programme faces. SRH service integration with other services such as HIV/AIDS, tapping into locally available resources such as the Constituency Development Fund (CDF) and mobilising resources through public-private partnerships are some of the initiatives suggested by stakeholders to improve financial sustainability of SRH services. Most importantly, there is need to intensify advocacy activities for the creation of a budget line for SRH services through government funding so as to ensure that funding for the provision of SRH services for young people is earmarked and guaranteed.

8.3 Future research

Although there was a stakeholder’s workshop to review the SRH service model, there was no opportunity to get young people’s views on the developed model. In addition, few participating stakeholders were from outside the medical field. In taking this research forward, consultative meetings will be organised with both young people and other stakeholders so as to get their views of the developed SRH model. Young people will be recruited through youth centres, public health facilities, the community and schools. This will be done to ensure wider consultation of young people who are both service users and non-service users. Other stakeholders will also be drawn from sectors such as education, social services and youth affairs. We intend to approach the WHO-Kenya country office for financial support to facilitate these consultative meetings.

The MOPH is in the process of assessing the implementation of the ARH&D policy (2003) together with its plan of action (2005-2015). MOPHS also intends to review the national guidelines for provision of youth friendly services in Kenya as well as develop a youth strategy. Working in consultation with the national ASRH technical working group, it is anticipated that the findings of this thesis will inform the national policy and guidelines review process. Since the policy review process often involves having stakeholder consultative meetings, policy briefs
derived from this thesis will be developed and made available to stakeholders for reference during these meetings. In addition, a PowerPoint presentation of the research findings will be made available to stakeholders and this will inform the decision making process with regards to youth-friendly service provision. The policy briefs made from this thesis will also be posted on the DRH website with a copy of the full thesis being made available at the DRH resource centre. NGOs and other development partners supporting sexual and reproductive health research and the ASRH programme in general will be approached to financially support the design and printing of the policy briefs. Publication of these research findings will also be made in peer reviewed journals.

It is possible that the same stakeholders who took part in the review of the proposed SRH service model will also take part in the consultative meetings that will review the adolescent RH plan of action and the national guidelines for provision of youth friendly services. Their previous participation in the research process will encourage reference and facilitate ownership and adoption of the research findings.

Working in collaboration with other researchers, partners and NGOs, the model proposed in this study will be refined and tested in selected health facilities and evaluated using both qualitative and quantitative methodology. The results presented in this thesis will form the basis for the development of a structured questionnaire for young people, community members and health service providers which will then be used to conduct population-based surveys.

Evidence for the effectiveness of SRH interventions targeting young people is still weak. Current systematic reviews on effectiveness of HIV and sex education interventions in developing countries have shown that interventions are effective at improving SRH knowledge and attitudes, but not on reported sexual behaviour. Meta-analysis has shown increased reported condom use only among males. Unfortunately most SRH interventions only focus on HIV/AIDS as a precursor for change in sexual behaviour. The literature review of this study identified only four studies that reported the use of biological markers, pregnancy rates and incidence of HIV, in the evaluation of SRH and HIV interventions for young people in sub-Saharan Africa. In all four studies there was no significant effect on the incidence of HIV or pregnancy rates. Lack of inclusion of interventions addressing the social and cultural norms, values and beliefs of the target population has been cited as one of the reasons these interventions may have failed to produce more positive results. In addition, other factors such as poverty and unemployment, gender inequalities, drug and substance abuse have been identified as drivers of the sexual behaviour of young people, but have not been addressed in most interventions. Future research should therefore involve the design, implementation and evaluation of structural interventions addressing the social, cultural and economic drivers of sexual health of young people.
Future research should focus on exploring how socio-cultural and religious beliefs hinder or promote SRH service provision by health service providers. More research should be also be undertaken to evaluate the knowledge and technical competencies of HSP in providing YFS. Operation research should be undertaken to explore ways in which improvements in the training content of youth friendly service provision can be undertaken to meet this identified gaps in knowledge and skills. At the community level, there is need for operations research to explore culturally sensitive approaches that can be used positively, to overcome social conservatism with regards to discussion around adolescent sexuality.

No study has been designed and evaluated on a large scale to inform the delivery of SRH services to young people in Kenya and hence evidence informing SRH service delivery for young people in Kenya is insufficient. As discussed in section 2.3 of the literature review, only seven small-scale studies from Kenya have been published in peer-reviewed journals, with a focus on provision of SRH information and services, including HIV education in schools. This is the first study to be conducted in Kenya exploring views and perceptions of adolescents about available SRH services using qualitative methodology. Previous studies have mainly used quantitative methodology or focused on assessing reported adolescent sexual behaviour. No large scale multi-component SRH intervention, using biological outcomes to measure intervention effect, has been implemented in Kenya and hence there is a huge knowledge gap. Although previous studies of multi-component SRH interventions have not shown any significant effects on the incidence of HIV and pregnancy rates the interventions faced implementation challenges which have been documented and can be used to inform the design of a large scale multi-component intervention in Kenya. Possible research should also include designing and evaluating interventions that promote condom use as both a pregnancy and HIV prevention tool as opposed to HIV prevention only. Future research should also focus on more rigorous analytical studies, such as RCTs, and cost effectiveness studies of the proposed SRH service provision model and establish the effect on service utilisation and subsequently health outcomes.

There is also the need for research to identify effective SRH service provision models to reach young people in rural areas with SRH services as well as their cost effectiveness. Future research should also focus on identifying approaches where boys can better be reached within an integrated SRH service model.
## Appendix I: Study timeline and data collection tools

### Table 44: Study timeline

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<td>Proposal writing</td>
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<tr>
<td>Application for ethical approval from LSTM and KNH ethical committees</td>
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<td>Data collection at the district level</td>
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<td>Data collection at Nairobi health facilities</td>
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<td>Data analysis for young people, community members, health service providers, facility managers or in-charges and programme managers</td>
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<td>Development of proposed SRH service delivery model for young people</td>
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<tr>
<td>Stakeholders workshops and Key Informant interviews; to get their views on the proposed SRH service delivery model</td>
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<tr>
<td>Thesis writing</td>
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Topic guide for FGD and IDIs with young people

FGD/ I.D. No...............Date of FGD/ IDI..............Place of interview..........................
District.................................Province..................................Name of Facility..................
Model of youth service provision: ..........Managing authority..........................
Male / Female FGD/IDI...............Name of the moderator/Interviewer..........................
Name of the recorder / note taker..............Number of participants .................

Background information

Get an overall picture of the demography of the adolescents the group in terms of the following
Age: .........................................Marital status: Single  /  Married
Education level: ...........................Employment: Yes/NO ......................

Exploring SRH problems of adolescents / young people

- What SRH problems do adolescents / young people experience in this community?
  - probe for lack of information about, human reproduction, treatment and prevention
    of STIs and, HIV/AIDS, teen-age / unwanted pregnancy, coerced sex, rape, school
    dropout,
- How can these problems be addressed (teen-age/unwanted pregnancy, rape, STI/HIV) :
  - Probe for possible ways the mentioned SRH problems can be dealt with? Use of
    contraception – condom use, modern FP, dual methods, counselling, sex education
    etc?

Exploring health seeking behaviour

- What are some of the common SRH problems that make adolescents seek health care?
- When a young person has a SRH problem, what do they normally do? From whom or where
  do they seek care?
  - Probe for where they prefer to go for treatment for the following problems –
    pregnancy, contraception, STIs, post rape care, counselling on issues related to
    sexuality: services required most? etc)

Exploring adolescents / youths views and uptake of SRH services

- What type of SRH services does the youth centre / health facility provides for adolescents /
  young people?
  - Probe further to find out how the available services the participants can identify
- What are your views/opinions about the available services?
  - what is good, what is bad, incidences where it has been useful, any personal
    experiences, expressed fears, community members views about the available services
- How can you describe the relationship or the interaction between adolescents and health
  providers?
  - Probe on how the providers maintain privacy and confidentiality
- Can you describe some situations or instances where service providers have been helpful to
  adolescents?

Reasons for not seeking SRH services

- What are some of the reasons that make adolescents not seek care from the health facility/
  youth centres?
  - Probe for factors which act as barriers by adolescents, the health providers, the
    facility infrastructure, the community including cost, time, their fears
- What SRH services do you feel should not be provided to adolescent and why? Which ones must be provided?

How to improve access

- How can adolescents be encouraged to access SRH services more?
  - Probe for measures to be put in place by the community, health facility, health providers and others.
- How can the existing services be improved or made acceptable to everyone both the youth and community members?

Topic guide for community members FGD

I.D Number............. Date of FGD .....................Place of FGD.........................
District.....................Province....................Name of Facility.........................
Model of youth service provision: ....................Managing authority.......................
Male / Female FGD...............Name of the moderator.................................
Name of the recorder / note taker.....................Number of participants. ...........

Background information

Marital status: Single / Married / divorced / Widow (er)
Education level: .............................................................
Work: .............................................................................

Community adolescent sexual reproductive health problems

- What are the common SRH problems young people experiences in this community?
  - Probe for the existence of RH problems (early marriage, teen-age pregnancy, STI/HIV, sexual abuse, unsafe sex, no access to contraceptives, lack of knowledge on SRH and the order of priority, early marriage, prostitution, school dropout).
- How can these problems be addressed?

Perception of available SRH services

- What types of SRH services are available at the facility / youth centre for adolescents/ youths?
  - Such as contraception, emergency contraception, treatment of STI/HIV, provision of condoms, post-abortion care, pregnancy tests, SRH information & counselling, post-rape care)
- What are your views and feelings about these services
  - Probe whether they feel these services are useful and important
- Would you recommend your child to visit the youth centre to receive these services
- What SRH services do you feel should not be provided to adolescent and why? Which ones must be provided?

SRH service improvement

- How can young people be encouraged to access SRH more?
  - Probe for measures to be put in place by the community, health facility and other
- What measures can be put in place to improve service delivery to adolescents in general?
Table 45: Thematic framework for community members

<table>
<thead>
<tr>
<th>SRH problems faced by young people in the community</th>
<th>SRH problem preventions</th>
<th>Perceptions of available SRH services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>Youth counselling and Education</td>
<td></td>
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<tr>
<td>Abortion</td>
<td>Parental Education and Advice</td>
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<tr>
<td>STI/HIV</td>
<td>Jobs / Reduce idleness</td>
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<tr>
<td>Sexual violence and FGM</td>
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<tr>
<td>Lack of parental guidance</td>
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<td>Poverty/ Poor living conditions</td>
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<tr>
<td>School drop out</td>
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<tr>
<td>Peer Influence</td>
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<tr>
<td>Media Influence</td>
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<tr>
<td>Drug and alcohol abuse</td>
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</table>

Health provider’s in-depth interview guide

Identification of the interviewee..............................
Date of interview: ................................................Place of Interview.................................
District......................................Province....................................................
Name of Facility........................................................................................................
Model of youth service provision......................Managing authority...............................
Name of the researcher ...........................................

Background information

Can you please tell me some information about yourselves e.g.
- Age ---------------Sex: M / F:
- Staff cadre ---------------
- Service provision department / clinic
- No. of years in providing sexual and reproductive health services to adolescents / youth.......

Knowledge of policies and guidelines

- Can you please describe what is meant by the term youth friendly services?
- Are you aware of some of the guidelines the Ministry of Health has put in place to guide the provision of SRH to adolescents and youth? Can you briefly describe what some of this guidelines outline?
- Can you describe some of the reproductive health rights adolescents and young people have if they have to seek services?

Presenting problems / availability of SRH services at the facility

- What are the most common SRH problems adolescents / young people present with to this facility
- What SRH services are you able to provide to adolescents in this facility?
Facility sexual health educational activities

- Does this health facility /youth centre provide SRH education and counselling to adolescents?
  What topics are mainly addressed?
- Is there another system where clients can access information while off site, e.g. telephone call-ins, website, e-mail?
- Does the facility have educational materials for use by providers during counselling? Are other educational materials also available for clients to carry away?

Perceptions and experiences towards providing SRH services

- What are your views and opinions about providing SRH services to adolescents/ youths?
  - Probe views about provision of contraception, HIV/AIDS services
- Do you feel as a health provider you have the necessary skills and training required to effectively provide SRH services to adolescents/ young people?

Barriers to SRH service provision

- What are some of the challenges you face when providing SRH services to adolescents / young people?
- Can you describe some of the weaknesses this facility has with regards to SRH service provision to adolescents / young people?
- What are some of the reasons that make adolescents not come for SRH services from this health facility? And how can each reason be addressed?

Improving SRH service provision

- From your experience what can you say about improving SRH services to adolescents?
- What are some of the improvements / recommendations the clinic management should put in place in order to make the working environment more favourable or to both the adolescents and the health providers?
Table 46: Thematic framework for Health service providers

<table>
<thead>
<tr>
<th>Knowledge of policies and guidelines</th>
<th>Facility sexual health education</th>
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</thead>
<tbody>
<tr>
<td>▪ HSP understanding of YFS concept</td>
<td>▪ Health talks /counselling</td>
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<tr>
<td>▪ HSP knowledge of national guidelines</td>
<td>▪ Call in services</td>
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<tr>
<td>▪ HSP knowledge of SRH rights</td>
<td>▪ Educational materials</td>
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<tr>
<td><strong>Presenting SRH Problems</strong></td>
<td></td>
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<tr>
<td>▪ Contraception - FP/ EC</td>
<td><strong>HSP views and perceptions of available services</strong></td>
</tr>
<tr>
<td>▪ Pregnancy-related services</td>
<td>▪ Provision of contraception</td>
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<tr>
<td>▪ Abortion services/ complications (PAC)</td>
<td>▪ Provision of HIV related services</td>
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<tr>
<td>▪ STIs/ HIV/VCT</td>
<td>▪ HSP competency</td>
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<td>▪ Sexual violence</td>
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<td>▪ Counselling</td>
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<td>▪ General health</td>
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<tr>
<td>▪ Drug abuse</td>
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<tr>
<td>▪ Maternity / suicidal tendencies</td>
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<tr>
<td><strong>SRH Services available at facility</strong></td>
<td>How to improve access</td>
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<tr>
<td>▪ Contraception – FP, condoms</td>
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<tr>
<td>▪ ANC</td>
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<td>▪ STI treatment</td>
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<td>▪ VCT/ CCC</td>
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<td>▪ Post rape care / PEP</td>
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<tr>
<td>▪ Outreach activities</td>
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</table>

**Facility managers’ topic guide**

**Supportive policies**

▪ Does the facility have clearly written guidelines on how adolescents should be handled and served? Please describe this in detail?
▪ Does the facility have written guidelines on how to protect adolescents’ privacy and confidentiality?
▪ Does the storage of records ensure confidentiality?
▪ Does the facility charge a fee to adolescents for services provided? Can you explain this in detail? What happens to clients who are unable to pay?
▪ Can you describe the referral mechanism that is in place?

**Location and operating hours**

▪ How do you feel about the location of this facility with respect to accessibility by adolescents? *(Probe for distance from public transportation)*
▪ Does the facility have separate operating hours for adolescents?
▪ Do you think adolescents have times that are convenient for them to seek services?
▪ How do these times relate to the facility working hours?
Privacy and confidentiality

- Does the counselling and examination area provide both visual and auditory privacy?
- Does the facility have a separate waiting room for adolescents?
- How do you feel about the friendliness of the clinic set up?
- Please give suggestions on how services can be improved for adolescents?

Staff preparedness

- Do you feel the health providers are well trained to serve adolescent clients in SRH?
- What additional skills and training do they need to provide SRH services to adolescents?
- How can these problems be addressed?
- Can you please describe how group discussions are conducted among adolescent clients?

Youth involvement

- Are adolescents currently involved in the decision making process on how the facility should be run?
- Can you give some examples of where adolescents have been involved in the decision making process?
- What other roles can adolescents play in the running of this facility?
- How can adolescents be encouraged to be involved in the decision making process at this facility?

Challenges

- Can you describe some of the challenges the facility encounters while providing services to adolescents? How can these challenges be addressed?

Strengths

- In providing services to adolescents, what can you say is the strengths or the advantages this facility has?

Table 47: Thematic framework for facility in-charges and programme managers

- Supportive policies
- Location and operating hours
- Privacy and confidentiality
- Staff preparedness
- Youth involvement
- Pragmatic issues
  o Challenges/ weakness
  o Strengths
- Planning, supervision and monitoring
- Recommendations for services improvement
Stakeholder's workshop and KII discussion topic guide for review of the proposed SRH service delivery model

1. What is the purpose of YFS provision?
2. How and where should such services be provided?
3. What is your overall reaction to the model presented? (general comments)
   - What is positive or good about the model? What is negative about the model? What is missing in the model?
   - What do you think about the core services? Are they adequate? What needs to be added? Or removed? What is your opinion on the recreational activities? (Wrap around services?)
4. For the model suggested, what would be the enabling factors that would contribute towards the successful implementation of the model?
   - Model improvement suggestions?
   - Opportunities the model can take advantage of?
5. What are the barriers and constraints that would prevent the successful implementation of this model?
   - What are the weaknesses of the model?
6. How can the identified barriers and constraints be addressed?
7. How acceptable is this model to youth-friendly service provision?
   - Model acceptability
8. How sustainable is this model?

List of key informants participating in the review of the proposed SRH service delivery model

<table>
<thead>
<tr>
<th>No.</th>
<th>Organisation</th>
<th>No of participants</th>
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<tbody>
<tr>
<td>1</td>
<td>Program Manager JHPIEGO: (formally WHO)</td>
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</tr>
<tr>
<td>2</td>
<td>Program Manager NOPE: (National Organisation of Peer Educators)</td>
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<tr>
<td>3</td>
<td>Program Officer Population Council</td>
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<tr>
<td>4</td>
<td>Program Officer FHOK (Family Health Options of Kenya)</td>
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<tr>
<td>5</td>
<td>Policy Advisor NCAPD: National Coordinating Agency for Population and Development</td>
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<tr>
<td>6</td>
<td>Program Manager – Ministry of Youth Affairs</td>
<td>1</td>
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<tr>
<td>7</td>
<td>Program Officer SCC (save the Children Canada)</td>
<td>2</td>
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<tr>
<td>8</td>
<td>Program Officer DRH</td>
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<tr>
<td>9</td>
<td>Program Officer PATH</td>
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</tr>
<tr>
<td>10</td>
<td>Program Manager DRH</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Program officer WHO</td>
<td>1</td>
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<tr>
<td>12</td>
<td>Reproductive Health Advisor FHI</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Acting Head – Family Health.</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Program officer UNFPA</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>Organisation</td>
<td>No of participants</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>15</td>
<td>Program officer NASCOP</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>UNICEF</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>
In-depth Interview Consent Form

Identification of the interviewee
Date of interview: …/……../………… Place of Interview
District..........................Province..........................
Name of Facility..........................
Model of youth service provision: .........................Managing authority.............
Name of the researcher..........................

I have read the information sheet for the study / or the information sheet about the study has been read and explained to me. I fully understand that if I decide to be involved in the study I will have an individual in-depth face- to-face interview with a trained researcher for 1-2 hours. I understand that I am free to withdraw from the study at any time. I am also aware of the fact that if I decide not to participate in the study it will not have any adverse affects in any way. I also understand that the interview will be tape-recorded.

Any questions or concerns about the study will be answered at any time by the research team leader.

I agree to take part in this study

Name / Identification ..........................................
Signature ..................................Date ..................................

Interviewer:

Name ..........................................................
Signature ..................................Date .................
Focus group discussion consent form

*Only one consent form for the focus group discussion will be signed by the researcher to show that all that participants have accepted to take part in the study*

Identification of the Focus Group discussion..........................................

Number of participants in the FGD............................................................

Date of FGD: ....../........../......... Place of FGD.................................

District..................................................Province..................................

Name of Facility..........................................................Managing authority..........

Moderators Name..........................................................Note-takers name.............

Each of the participants has either read the information sheet or I have explained to the participants the information contained in the information sheet. They have assured me that they fully understand that if they agree to participate in the study, they will have a group discussion of between 8-10 persons, which will take almost 1-2 hours. They understand that they are free to withdraw from the discussion at any time and this will not have any adverse effect. The participants also understand that the discussion will be tape-recorded.

Any questions or concerns about the study will be answered at any time by the research team leader through the given contact.

The participants have agreed to take part in the study.

Name of researcher ..........................................................

Signature .......................................Date ...........................................

Parent / guardian consent form for young people less than 15 years old

I have read the information sheet for the study / or the information sheet about the study has been read and explained to me. I fully understand the nature of the study and how my daughter / son will participate in it. By signing this form, I will be giving my permission for my daughter / son to take part in the study. I understand that participation is voluntary and I can change my mind and withdraw at any time. My daughter / son will also be requested for her / his assent and is also free to decline. The information collected during the study will be confidential and will not be linked to any individual participant.

Any questions or concerns about the study will be answered at any time by the research team leader.

I agree for my son / daughter to take part in the study.

Name / Identification of guardian..................................................

Signature........................................Date...................................................

Researcher

Name ..........................................................

Signature ........................................Date ...........................................
Adolescents / minors assent form

The information about the interview has been explained to me. I fully understand the nature of the study and how I will participate in it. I fully understand that if I agree to participate in the study, I will either have an individual in-depth face-to-face interview with a trained interviewer or be involved in a focus group discussion for a period of between 1-2 hours. I understand that participation is completely voluntary and I am free to withdraw from the study at any time. I am also aware of the fact that if I decide not to participate in the study it will not affect the services I receive from the facility. I also understand that the interview will be tape-recorded. By signing this form, I will be accepting to participate in the study.

Any questions or concerns about the study will be answered at any time by the research team leader.

I agree to take part in this study

Name / Identification of minor/adolescent…………………………………………

Signature……………………............ Date.....................................................

Researcher

Name …………………………………………………………………

Signature ………………………………………Date …………………….
Appendix II:  Model presented to stakeholders and workshop schedule

Suggested model for provision of SRH services for review by stakeholders
## Workshop schedule

<table>
<thead>
<tr>
<th>Session /Time</th>
<th>Workshop activity</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30-9.00am</td>
<td>Registration and objectives of the workshop</td>
<td>DRH</td>
</tr>
<tr>
<td>9.00-9.10am</td>
<td>The context – Policy and strategic framework - for ASRH in Kenya</td>
<td>DRH</td>
</tr>
<tr>
<td>9.10 - 9.45am</td>
<td>Presentation of study findings</td>
<td>Pamela Godia</td>
</tr>
<tr>
<td>9.45 – 10.15am</td>
<td>Guided discussion on the study findings</td>
<td></td>
</tr>
<tr>
<td>10.15-10.30am</td>
<td>Introduction of group work</td>
<td>DRH</td>
</tr>
<tr>
<td><strong>10.30-10.45 am</strong></td>
<td><strong>TEA BREAK</strong></td>
<td></td>
</tr>
<tr>
<td>10.45-11.45am</td>
<td>Group work- Part I – questions 1-3</td>
<td>DRH</td>
</tr>
<tr>
<td>11.45 – 1.00 pm</td>
<td>Plenary presentation – Part I</td>
<td>DRH</td>
</tr>
<tr>
<td><strong>1.00-2.00 pm</strong></td>
<td><strong>LUNCH</strong></td>
<td></td>
</tr>
<tr>
<td>2.00 - 2.45pm</td>
<td>Group work – Part II; Sustainability</td>
<td>Pamela Godia</td>
</tr>
<tr>
<td>2.45 - 3.30 pm</td>
<td>Plenary presentation- Part II; Sustainability</td>
<td>Joyce Lavussa / WHO</td>
</tr>
<tr>
<td>3.30-4.00 pm</td>
<td>DFH/ DRH- how is DRH going to use this information :</td>
<td>Programme Manager ASRH</td>
</tr>
<tr>
<td></td>
<td>• Review of the National guidelines for provision of YFS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review of the national plan of action</td>
<td></td>
</tr>
<tr>
<td>4.00pm-4.15pm</td>
<td><strong>TEA AND DEPARTURE</strong></td>
<td></td>
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</tbody>
</table>
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