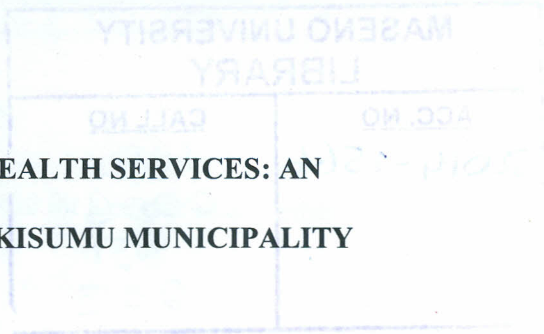

YOUTH FRIENDLINESS OF REPRODUCTIVE HEALTH SERVICES: AN ASSESSMENT OF HEALTH FACILITIES WITHIN KISUMU MUNICIPALITY

BY

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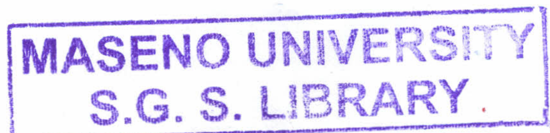
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ABSTRACT

The need for reproductive health services for youth is critical because of their high numbers, reduced age at first sex, multiple sex partners and other risky sexual behaviour leading to the possibility of unplanned pregnancies and sexually transmitted infections (STIs), including HIV. The provision of youth friendly health services plays a key role in the promotion of health and wellbeing in youth. The main objective of this study was to assess the youth friendliness of sexual and reproductive health services in health facilities within Kisumu Municipality. The specific objectives were to: identify the youth-friendliness of the reproductive health services provided at the various health facilities, assess youths' perceptions towards youth friendly services and compare the uptake of services from health facilities within Kisumu Municipality. Quota sampling was used to identify health facilities which were further stratified into different categories and purposive sampling was used to identify eleven facilities. Service utilization and information on service quality was collected through in-depth interviews (twenty two managers and service providers) and reviews of monthly records and registers. A sample size of 246 youth was found to achieve the desired accuracy at 0.05% level and this number was proportionately distributed among the targeted health facilities. Observation was used to assess facility environment and quality of services provided. Qualitative data was analysed manually and emerging themes presented in narrative form. Quantitative data was analysed using SPSS to produce descriptive statistics presented in form of tables and figures. Findings indicated that only half of the 11 health facilities visited provided all 13 essential sexual and reproductive health services. HIV counselling and testing, pregnancy testing and STI treatment were the only services available in all the facilities. Only a quart25% of the health facilities had screening for sexually transmitted infection services while sexual abuse care services were only available in 40% of the facilities and similarly a low number of facilities (27%) provided life skills training which is key for youth. 54% of the responses defined youth friendly services as those that are provided for youth at hospitals, other organizations and youth centres to educate and treat them or services that are free or affordable. A quarter of the responses cited revealed that youth did not know what constitutes youth friendly services. When asked about health seeking behaviour, 23% of the responses cited reported that some youth did not visit health facilities because they had fear of the unknown or feared knowing their HIV status especially for those with multiple partners, inability to pay for services (21%) and ignorance or low risk perception (12%). The majority (62%) of youth reported that they go to hospital to seek medical attention when they are sick. Public health facilities recorded a higher frequency of youth clients (2401) compared to the privately-run facilities (1502). In terms of facility characteristics, the mean score of public health facilities is not significantly different from that of private health facilities (p=0.3065). For staff characteristics a paired t-test indicated that the mean score of public health facilities is significantly less than that of private health facilities (p=0.048) and similarly for management characteristics the mean score of public health facilities is significantly less than that of private health facilities (p=0.045). Private health facilities had higher scores (67%) in terms of satisfaction as compared to public health facilities which scored 47%. It is recommended that health facilities should provide a wider range of services and create awareness of services to promote uptake. Staff including non-medical staff should receive further training in reproductive health and how to communicate effectively with youth. In addition, structural factors such as privacy, facility hours, waiting areas, fees and youth involvement need to be addressed in order to improve uptake of services by youth. This evaluation will help inform the work of policy makers and programme planners in designing more friendly youth services.

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CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Youth today comprise the largest generation in number and proportion in history. In 2002, worldwide there were more than 1.7 billion youth aged 10 to 24 (WHO, 2002; 2000) and about 1.4 billion (more than 85 percent) lived in developing countries. Kenya has a young and rapidly expanding population. The population of Kenya is about 38 million, thirty six percent of who are youth between the ages of 10 and 24 (National Council for Population and Development *et al*, 2010). The youth, especially youth bear a large burden of HIV and are increasingly being perceived as the generation at risk because of the high rates of HIV infection observed in this population. Their needs are unique to those of adults and children. There is therefore an unmet need to improve the quality of health care service delivery to youth

The need for specialized reproductive health services for youth has over the past few years become critical because they have specific biological and psychological needs during adolescence. Puberty is occurring earlier while the age at marriage is rising. Thus, many youth have prolonged periods of premarital sexual activity. The age at first sexual intercourse is relatively lower than it used to be in the past and youth have more sex partners, leading to the possibility of more unsafe sex (Senderowitz *et al*, 2003) unplanned pregnancies, abortions, sexually transmitted infections (STIs), and infection with Human Immunodeficiency Virus (HIV). Youth are also at a disproportionately high risk of sexual abuse. Urbanization and modernization has led to the loosening of family ties and youth are unable to rely on intergenerational relationships for information and guidance about

responsible sexual behaviour. Youth are increasingly left to learn about sexual issues from their peers or the mass media (African Youth Alliance/Pathfinder International, 2005). For youth, concerns about sexuality and reproductive health are new in their lives although the major defining biological aspect of adolescence is the process of attaining sexual and reproductive maturity. Given most societies' reluctance to approach the subject forthrightly, it is not surprising that young people view these new feelings and needs with some apprehension—and are suspicious of where to find answers (Senderowitz, 1999).

Making health care facilities more accessible for young people is a recognized intervention for preventing unwanted pregnancy and HIV infection. The development of healthy youth requires supportive and caring families, peers and communities, access to high quality services (health, education, social and other community services) and opportunities to engage and succeed in the developmental tasks of adolescence (Adolescent Medicine Committee Canadian Paediatric Society, 2005). Youth provides an excellent opportunity for shaping behaviour among this group of the population through programmes that aim to develop a fundamental set of skills and competencies to deal with the challenges of health, development and sexuality (Evelia and Muganda, 2003).

Youth friendly services involve a conscious and systematic effort to ensure that the provision of reproductive health information and services to youth is an integral part of the service delivery system (Senderowitz, 1999; (African Youth Alliance/Pathfinder International, 2003). Youth friendly services need to be in the right place, at the right price (free where necessary) and delivered in a manner that is acceptable to young people, effective, safe and affordable. They should meet the individual needs of young people who return when they need to and recommend these services to friends (WHO, 2002)

Throughout the world, young people continue to face many hurdles in accessing sexual and reproductive health services. In the developing countries in particular, availability of sexual and reproductive health services for young people remains a challenge (Braeken *et al*, 2007). Even where services are available, young people face a combination of legal, social and economic barriers to accessing sexual and reproductive health services (Ross and Ferguson, 2006). Moreover, several aspects of sexual and reproductive health services such as the attributes of the setting in which services are provided; performance of the practitioner and interpersonal elements; and client satisfaction have been identified by young people as hindering their utilization of sexual and reproductive health services (Braeken *et al*, 2007, Erulkar *et al*, 2005, Tylee *et al*, 2007, Ross and Ferguson, 2006 and Agha *et al*, 2009).

A rapid youth needs assessment carried out in Nyanza province indicated that organisations are well aware of the problems that youth face. However, the majority of them have only recently identified youth as a special target group and most youth-targeted programmes that were started are still in an initial phase. Health facilities, especially from the public health sector, have so far not done much to ensure that the services they provide are friendly to youth (Njue *et al*, 2001).

1.2 Problem Statement

Despite an increasing number of reports on youth friendly guidelines, the needs of youth are often ignored by many health and development plans and program leaders and service providers fail to promote provision of youth-friendly reproductive health services. Whereas policy documents have been developed on the provision of sexual and reproductive health services, little is known about the extent to which these guidelines have been implemented in health facilities within Kisumu Municipality.

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While youth-friendly services have been initiated in some facilities, low levels of service utilization continue to be recorded meaning that youth lack the means to navigate the increasing range of sexual and reproductive health problems facing them. While attention to health provider skills is increasing, other aspects of clinic operations that could be made more youth friendly have remained unaddressed. More information is needed on how various program characteristics affect health seeking behaviour of youth. This study will provide information that will be used to bridge the gap between reproductive health services provided and youths' uptake of services in Kisumu Municipality.

1.3 Research Questions

The following research questions guided the study:

1. What are the characteristics of youth friendliness in the various health facilities?
2. What are youths' perceptions towards youth friendly reproductive health services?
3. What is the uptake of services from the services from the different facilities?

1.4 Objectives of the Study

The overall objective of the study was to assess the youth friendliness of reproductive health services in health facilities within Kisumu Municipality.

The specific objectives were to:

1. Identify the characteristics of youth friendliness in the various health facilities,
2. Assess youths' perceptions towards youth friendly reproductive health services,
3. Compare the uptake of existing services from facilities providing youth friendly reproductive health services.

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1.5 Justification

Health institutions and other reproductive health organizations are increasingly focusing their attention on youth and considerable resources have been devoted to implementing youth friendly services. Planning and management are also increasingly being recognized as key issues for the development of health programmes and for efficiency and control of activities that impact upon health. This study will help inform the work of policy makers, architects and planners in improving friendliness of health services for youth through the exploration of the relationship between the health institution structures and service provision. Other studies on youth friendly studies have focused on the entire Nyanza province but none has focused on health facilities within Kisumu Municipality.

This study is significant in filling the knowledge gaps on how far different health facilities have gone in implementing youth friendly reproductive health programmes according to the provided guidelines. It will also serve to input to the improvement and development of new programmes for youths' reproductive health.

1.6 Scope and Limits

The study was limited to youth aged 10 to 24 years who visited different health facilities providing reproductive health services within Kisumu Municipality and was limited to health facilities within the central business district and high density residential areas of the municipality. The assessment only focused on the youth friendly health services in the areas of infrastructure, staff and management and did not examine other issues related to youth friendly services such as nutrition, income generating activities or drug abuse. Youth who did not seek youth friendly services were excluded. It was also limited to staff who directly deal with provision of reproductive health services within the different health facilities.

1.7 Definition of Terms

Adolescents:	An adolescent refers to a person aged 10-19 years (WHO, 2002).
Youth:	Youth refers to persons aged 20-24 years (WHO, 2002) The term youth and adolescence is often used interchangeably, however adolescence applies to a much earlier age, about 10-19 years (who constitute 26% of population) and merges into youth so that viewed as one block (10-24 years), this population category would move to up to 36% of population (Central Bureau of Statistics *et al*, 2004). Therefore in this study youth refers to persons aged 10 to 24 years.
Reproductive health:	In this study, "reproductive health" is used to refer to a state of physical, mental and social well-being in all matters relating to the reproductive system at all stages of life
Youth friendly services:	The term "youth friendly services" is used to refer to availability, acceptability, accessibility, and satisfaction with services among young people. Such services meet certain standards which include policies and processes that support youth rights and help them meet their sexual and reproductive health needs in a friendly manner (WHO, 2002; Republic of Kenya, 2005)
Health facility:	This is used to refer to a hospital, nursing home, maternity home, health centre, dispensary, or other institution whether private or public, where health services are rendered

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CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

This chapter presents a critical review of existing studies describing evaluation of youth friendly health services. It provides background information on the epidemiology of youths' sexual and reproductive health. The literature review also attempts to show the existing knowledge gaps in characteristics of youth friendly services, youths' perceptions towards youth friendly services and comparison of uptake of youth friendly services from different health facilities. Finally this section presents the theoretical and conceptual framework that guided the study.

2.1.1. Epidemiology of Youths' Sexual and Reproductive Health

Young people remain at the centre of major sexual and reproductive health (SRH) problems globally. About 40% of all newly acquired HIV infections in the world occur in youth aged 15-24 years (UNAIDS, 2007). Sub-Saharan Africa is the worst HIV affected region in the world with two-thirds of all people living with HIV/AIDS (WHO, 2002; 2006). In 2004, UNFPA estimated that about 500,000 youth, mostly young women were infected with an STI including HIV (UNFPA, 2004).

In Kenya, the 2008 Demographic and Health Survey (Central Bureau of Statistics, 2010) found an HIV prevalence of 9.1% among women aged 15-24 years and 2.2% among men the same age. The situation is the same in Nyanza, the province worst affected by HIV/AIDS in Kenya, (HIV prevalence of 15.3% among adults aged 15-49 in Nyanza compared to the national estimate at 7.1 (National AIDS and STI Control Programme, 2008). Overall,

HIV/AIDS awareness is high, but knowledge remains superficial and personal risk perception low (Central Bureau of Statistics *et al,* 1999).

The proportion of teenagers aged 15 to 19 years who have begun child bearing is 18% and in Nyanza this figure rises to 27% ((National AIDS & STIs Control Programme, 2008). Whereas abortion cases are prevalent among in-school youth in Kenya, few young people seek help at health facilities for abortion-related complications [Gebreselassie *et al.* 2004, Ikamari and Towett, 2007; Mitchell *et al*, 2006].

The data above clearly demonstrate the urgent need for youth friendly health services that are sensitive to youths' unique stage of biological, cognitive and psychosocial transition into adulthood. Despite this urgent need for **youth-friendly facilities, only 12 percent of facilities in Kenya offer such services** (Central Bureau of Statistics *et al*, 2005).

The success of adolescent reproductive health interventions can be hindered by policy restrictions and religious and cultural barriers. In Kenya the lack of a clear policy on adolescent reproductive health issues has in the past created an uncertain environment for service delivery and information provision and service providers were unclear on how to respond to sexual and reproductive health concerns of youth. At the International Conference Population and Development (ICPD) in 1994, governments including Kenya recognized the substantial and largely unmet needs that youth have for sexual and reproductive health information and services and set themselves the challenge of meeting those needs and recognizing youth' rights. In doing this, they agreed that information and services should be made available to youth to help them understand their sexuality and protect themselves from unplanned pregnancies, sexually transmitted diseases and subsequent risk of infertility

(Kenya, Republic of, Ministry of Health, 2005). In response to International Conference Population and Development Plan of Action, concerns expressed in the National Population Policy for Sustainable Development, NPPSD, 2000, the National Youth Policy the Children Act 2001, and other national and international conventions on children and youth, the government adopted the Adolescent Reproductive Health and Development Policy (Kenya, Republic of, Ministry of Health, 2005). The policy made a commitment to meeting the health needs of young people and provides a framework to respond to the health and related concerns of youth in the country. It prioritises to address factors that affect accessibility and quality of care, such as provider attitudes, privacy, confidentiality and hours of service. It aims to ensure that adolescent health concerns are mainstreamed into all planning activities. Previously, services offered to young people had been fragmented and varied from one institution to another and had not been harmonized. These guidelines aim to rationalize the provision of SRH services to youth and ensure national uniformity in the provision of SRH services. The policy aims to improve the well-being and quality of life of Kenyan youth through provision of health information and services which are available, accessible, affordable and acceptable and in turn improve the utilization of health services by youth.

2.1.2 Characteristics of Youth Friendliness in Various Health Facilities

Using the Clinic Assessment Youth-Friendly Services Tool (Senderowitz *et al*, 2002), the African Youth Alliance (African Youth Alliance/Pathfinder International, 2005) conducted a needs assessment on youth friendly services in three districts of Dar-es Salaam. Interviews were held with facility managers, service providers and youth clients. Observation was used to examine facility environment, provider-client interactions and equipment. Policies and procedures and service records were also reviewed. The findings indicated that service

providers had no training in youth friendly services or even any basic reproductive health. Basic services were available in most facilities but were not geared towards youths' needs. Job aids on adolescent sexual and reproductive health were unavailable and providers relied on experience and personal bias. Majority of youth expressed dissatisfaction with the quality of services received and felt they did not spend adequate time with the providers, they felt they were not allowed to ask questions and the providers did not listen to them Nearly 80% said they did not spend adequate time with the providers, about 90% felt that the providers did not listen to them and did not allow them to ask questions, while another 80% were not happy with services at the reception.

In a study to describe youths' preferences regarding primary health care in South Africa, it was found that youth wished to be involved in the planning of the activities of the youth health service, and that friendliness and respect for youth were seen as desirable characteristics of an youth-friendly health care service. Youth preferred services to be available throughout the week and to be located at the school, youth centre, community centre, hospital, or clinic. Youth preferred that their health services be separated from adult services and that a male nurse is employed in the youth service in order to create a less feminine image. It was also recommended that all youth be educated about the types of services available (Richter and Mfolo, 2006).

In a study conducted in Kenya and Zimbabwe (Erulkar *et al,* 2005) to assess youths' preferences for SRH services, it was noted that the rating of youth friendly characteristics varied. The most important characteristics for Kenyan youth were short waiting times, free or low cost services, the "one stop approach" and friendly staff. Zimbabwean youth cited confidentiality, short waiting times, a nurse who takes her time, low cost or free services and

the "one stop approach" as most important. The least important characteristics reported across the two sites included youth-only service, youth involvement and young staff, suggesting that youth do not prioritize stand-alone youth services such as youth centres, or necessarily need arrangements particular to youth such as youth involvement. By offering other activities such as recreation and library services, centres attempt to be more attractive to youth. However, youth centres are often stigmatized by the community and youth themselves. Many youth, especially girls, do not want to be associated with family planning organizations because it suggests sexual activity or because young people brand them as places for those with sexually transmitted diseases.

A more detailed and comprehensive assessment of sexual and reproductive health services for young people was conducted by Agha and Do (2009) to assess the quality of family planning services and client satisfaction in public and private sectors in Kenya, facility inventory questionnaire was used to collect information on the availability of resources, support systems and infrastructure elements at facilities; a health provider interview was used to collect information on qualifications (training and experience) and perceptions of the service delivery environment; and exit interviews with clients to collect information on clients' understanding of the consultation and satisfaction with services provided. Some of the determinants of client satisfaction identified by this study include waiting time, availability of a wide range of services, cost of services and distance to facility.

Kamau (2006) in her research carried out in Muranga, looked at factors influencing access and utilization of preventive reproductive health services (PRHS) by youth particularly in Murang'a District. The study was conducted among high school youth, health providers, community based organizations (CBOs), non-governmental organizations (NGOs) and faith

based organizations (FBOs) and found that youth indeed have sexual and reproductive health concerns that require them to access and utilise preventive reproductive health services. It revealed that efforts by different health facilities to address these concerns, services offered were inadequate and incomprehensive and that there were no youth- friendly facilities in Murang'a and to a greater extent in Kenya.

The studies reviewed above provide strong justification for including interviews with exit or mystery clients as a way of assessing satisfaction with available services. However, the studies would have made stronger contribution to the understanding of youth sexual and reproductive health services had they employed a combination of designs and data collection methods. This is due to the complexity of assessing the provision of sexual and reproductive health services to young people. This study will therefore employ a combination of data collection methods in order to get a well-rounded understanding of youth friendly services by using several qualitative methods to gather data including perspectives from in-depth interviews, facility observations and youth interviews.

From the above literature, characteristics of youth-friendly sexual and reproductive health services can be summarised as defined as those that ensure availability of a range of minimum essential services including counselling, information and education, life skills training, counselling on and provision of contraceptives, screening and treatment of STIs and HIV, post rape care and referral services where necessary as shown in Table 2-1 ((Kenya, Republic of, Ministry of Health, 2005), that are easily accessible to youth in terms of cost, location and marketing of available services; that are delivered in an acceptable manner bearing in mind confidentiality and privacy issues; and those that youth clients report satisfaction with.

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Table 2-1: Minimum Package of SRH Services for Youth

YOUTH-CENTRE BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE)	CLINIC BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE)	SCHOOL BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE
1. Counseling Services on * Sexuality * Growing up * Relationships * Pregnancy, * Abstinence * Unsafe abortion and abortion Prevention * STIs and HIV/AIDS * Substance and Drug abuse * Contraception * Careers * Rape prevention * Nutrition * Male involvement in RH * Parenting * Ante and post natal care * Skilled attendance 2. Screening and treatment of exually transmitted infections 3. Voluntary Counseling and Testing (VCT) 4. Provision of information and Education on Reproductive Health. 5. Availability of IEC, audio/visual Materials. 6. Ante and post natal care 7. Comprehensive post rape care (see Annex) 8. Provision of contraceptives 9. Promoting community based and school based outreach activities 10. Recreational facilities (In and Outdoor) where possible. Linkage to school based and Clinic based model Refer where necessary	1. Counseling services on * Sexuality * Growing up * Relationships * Prevention of pregnancy, * Abstinence, consequence of unsafe abortion * STIs and HIV/AIDS * Substance and Drug abuse * Contraception * Careers * Rape Prevention * Unsafe abortion and abortion Prevention * Nutrition * Male involvement in RH * Parenting * Ante and post natal care * Skilled attendance 2. Provision of information and Education on Reproductive health 3. Training in livelihood and life skills 4. Availability of IEC, audio/visual Materials 5. Promoting community Based/School Based outreach IEC activities Working with peer youth educators 6. Provision of contraceptives 7. Recreation facilities (In and Out door games) 8. Screening and treatment of STDs, HIV/AIDS (Where possible) 9. Voluntary counseling and testing VCT 10. Curative services for minor illnesses including ante and postnatal care 11. Comprehensive post rape care (see Annex) Linkage to school based and Youth center based model Refer where necessary	1. Life skill training on * Goal setting * Decision making * Negotiation * Moral values * Assertiveness * Communication skills 2. Counseling Services on * Sexuality * Growing up * Relationships * Abstinence * Pregnancy, Abortion and their Prevention * STIs and HIV/AIDS * VCT * Substance and Drug abuse * Contraception * Careers * Self esteem Nutrition * Male involvement in RH * Parenting * Ante and post natal care * Skilled attendance 3. School health talks * Personal hygiene * Sexuality and growing up * Reproductive Health * STD-Prevention * HIV-AIDS Prevention * Rape Prevention * Communication skills 4. Post rape care (see Annex) Linkage to clinic based and Youth center based model Refer for management. 5. Refer for treatment and management

[Source: Kenya, Republic of, Ministry of Health, 2005]

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2.1.3 Youths' Perceptions towards Youth Friendly Services

A study on youth perception of reproductive health care services in was carried out in Sri Lanka. This study explored the perceived reproductive health problems, health seeking behaviours, knowledge about available services among a group of youth in Sri Lanka, in order to improve reproductive health service delivery. It was conducted through focus group discussions in a semi urban setting in Sri Lanka among youth aged between17 and 19. The study revealed that youth had poor knowledge about existing reproductive health services. On reproductive health matters, girls mainly sought help from friends whereas boys did not want to discuss their problems with anyone. Lack of availability of services was pointed out as the most important barrier in reaching the youth needs. Lack of access to reproductive health knowledge was an important reason for poor self-confidence among youth to discuss these matters. Lack of confidentiality, youth friendliness and accessibility of available services were other barriers discussed. In conclusion the study reported that youth friendly health services were inadequate and available services were not being delivered in an acceptable manner. Its recommendation was that proper training of health care providers on youth friendly service provision is essential and that a national level integrated health care program is needed for the youth (Agampodi et al., 2008).

In a baseline study carried out in 1998 in Uganda to identify and assess the adolescent sexual and reproductive health (ARH) training needs among the reasons given by adolescents for not seeking other reproductive health and family planning services were little knowledge of available reproductive health services, a perception of negative provider attitudes towards adolescent sexuality, inconvenient schedules at health care centres, lack of anonymity and confidentiality at heath centres, misinformation and myths surrounding the use of

contraceptives and embarrassment about disclosing sexually transmitted infections as well as fear of screening for HIV/AIDS (Matatu *et al*, 2001).

In a study conducted by Family Health International (Schueller *et al*, 2006) to assess youth friendly health facilities in 4 provinces in Kenya, youth who were asked to define what they considered to be youth-friendly reported that the most important thing was that the clinic not look like an actual clinic – it should be a disguised facility with other activities going on in order to draw youth in. Many young people, especially in rural and peri-urban areas, do not know what services are available and where to find them. They emphasized the importance of privacy and confidentiality and said they wanted clinics to offer a full-range of services, including family planning and diagnosis and treatment of STIs. A number of youth also said they would like to have younger health workers serve them who could better understand and identify with the needs of youth. If this is not possible, then older health workers and counsellors need to be trained to work effectively with young people. Many youth also mentioned that there should be greater youth involvement in designing and delivering services and more emphasis must be placed on reaching girls with voluntary counselling and testing (VCT) services and boys with sexual and reproductive health services. Because of the stigma faced by young people when seeking services, a number of youth thought that sensitizing/educating parents about this would help break down barriers for youth. While most service providers recognized the need to improve access to clinical facilities and make services more youth friendly, very little was mentioned about the need to create demand for services and improve health-seeking behaviours among youth. Nearly all of the young people with whom the researcher spoke also mentioned their preference for outreach services.

From the above literature, youth friendly services are defined as services that are accessible, acceptable and appropriate for youth. They are in the right place, offered at the right price or free where necessary and delivered in a manner that is acceptable to young people. They meet the individual needs of young people who return when they need to and they recommend these services to friends (WHO, 2002). Sexual and reproductive health services might not be acceptable to young people, even if available and accessible because they lack knowledge of what services are offered, fear about lack of confidentiality, stigma attached to being recognised in a waiting room or health workers who are not trained in communication with youth (Tylee *et al*, 2007; WHO, 2008a; Braeken *et al*, 2007 and Kenya, Republic of, Ministry of Health, 2005). The fear of parents or guardians finding out about a visit to a health service can be profound especially in cultures in which social norms forbid premarital sex. Other reasons for low acceptability of services relate to the attitude of the provider. Young people fear that health workers will scold, ask difficult questions, or carry out unpleasant procedures. Health providers might also lack training in communicating with young people [Olowu, 1998; Erulkar *et al*, 2005].

To ensure prevention and early intervention efforts, clinicians and public-health workers are increasingly recognising the pressing need to overcome the many barriers that hinder the provision and use of SRH services by youth and to transform the negative image of health facilities to one of welcoming youth-friendly settings. Research from both developed and developing countries has revealed how health services can be made more youth-friendly. Recommendations encouraging the removal of the barriers (Tylee *et al*, 2007) have been complemented by the WHO-led call for the development of youth-friendly services worldwide (WHO, 2002).

2.1.4 Uptake of Services from facilities providing reproductive health services

In Zimbabwe a study that examined young people's access to reproductive health care services via an urban youth advisory centre sought to explain why they did not always use existing health services (Mashamba and Robson, 2002). Data from exit questionnaires with 30 users of services and 3 focus group discussions with non-users, all aged 10-24 years were analyzed to evaluate service accessibility. From the study, majority of clients (83%) accessing services were females of reproductive age. The findings revealed that spatial accessibility is not the only factor necessary to ensure equal access to health services and barriers such as lack of knowledge about existing services, stigmatization and "adultist bias", where services are designed by adults with little consultation with young people. The study also identified neglect of young people's SRH needs by service providers and policy makers as a barrier to accessing services. Other access barriers identified include peer pressure, unwelcoming atmosphere, waiting times, poor attitudes of staffs, negative associations with STDs, prostitution and loose sexual morals, and cultural taboos in discussing matters of sexuality. Participants recommended a multi-pronged approach to overcome all the barriers preventing utilization and satisfaction in accessing existing reproductive health services.

A study conducted in China found that youth face a variety of barriers when they seek sexual and reproductive health services because the current services were designed for married people. Therefore, youth think they are not welcome in the clinics and facilities, and they choose not to seek reproductive health services regardless of their needs (China Family Planning Association & Program for Appropriate Technologies in Health, 2005)

In 2000, Kuoye et al collected both retrospective and prospective data from adolescent clients of 10 family planning centers in Abidjan to assess adolescents' clinic use and reproductive health needs. A combination of focus group discussions and in-depth interviews were used to collect prospective data from adolescent clinic users and service providers. Of all clinic users, only 8% were adolescents aged 10-19 years. This was explained by the fact that family planning services are mostly tailored to the needs of older, married women. Both providers and focus group participants spoke of service delivery concerns indicating a need for changes to clinic infrastructure and reproductive health policy, for example: adding more facility personnel and equipment; introducing extended hours of operation to meet young clients' needs, and setting up separate waiting rooms for youth. In addition, they recommended that service providers be trained to improve their interpersonal skills for working with young people in such areas as sexually transmitted diseases and contraception. In effect, they felt that making existing services more youth-friendly would respond to young people's sexual and reproductive health needs and encourage their use by current non-users.

Mbonye (2003) in a study on disease and health seeking patterns among youth in Uganda sought to evaluate the impact of youth-friendly health services piloted in Jinja district, Uganda. Results showed that implementation of adolescent friendly services improved access and use of services. However, services need to be scaled to the lower health units up to the community level. Training of health workers, ensuring a constant supply of contraceptives, STD drugs and availing VCT services are key program issues to consider.

In Kenya, a national survey carried out by the National Council for Population and Development revealed that youth-friendly services are not widely available, with only 12 percent of facilities nationwide offering such services. 5 percent of all facilities (1 in 10 of

facilities offering HIV testing) had youth-friendly services associated with Voluntary Counselling and Testing (VCT) or Prevention of Mother to Child Transmission (PMTCT). Among facilities with an HIV testing system, maternities and stand-alone VCT facilities were found most likely to offer youth friendly services, with 1 in 5 facilities each reporting they have youth-friendly services. Youth-friendly services are most available in Rift Valley, Coast and Nyanza provinces (24, 18 and 14 percent of facilities, respectively). No facilities in Central province reported providing youth friendly services (National Council for Population and Development, Central Bureau of Statistics, and Macro International, 2005).

In Kenya, discussions on providing SRH services to youth have always been sensitive. This is borne out of cultural and traditional orientation on matters related to sexuality. Some sections of the community are concerned that providing such services may encourage sexual activity among young people. Though research has shown that this is not true, program planners need to be aware of this as they seek to mobilize the widest community support for youth services. The socio-cultural context in which youth in Kenya find themselves has changed considerably within the past few generations. Youth are experiencing social turmoil resulting from conflicting values due to industrialization and urbanization (Kenya, Republic of, Ministry of Health, 2005).The lack of decentralized health care delivery system in Kenya leading to disparities in service provision and youth reproductive health services are offered alongside those of the adults and this makes them unappealing to youth. Thus the global concept of youth-friendly services is yet to be localised in developing countries, and particularly in sub-Saharan Africa.

2.2 Literature Gap

As evidenced by this review, programme planners and managers are increasingly aware of the need to serve youth with reproductive health services but limited evaluation findings are available to assist program planners in designing youth friendly centres or in making existing programmes friendlier. A limited number of efforts have been made to make services attractive, relevant, and friendly enough that youth will seek care.

The literature review reveals that while a few youth friendly services evaluation studies in Kenya have been done in other provinces (Schueller *et al*, 2006) or in Nyanza province (Njue *et al*, 2001), no study has focused its activities on Kisumu Municipality after the implementation of the **Adolescent Reproductive Health and Development Policy in 2005 (Kenya,** Republic of, Ministry of Health, **2005).** Most evaluation activities to assess reproductive health services have mainly assessed the overall effects of programme design and not focused on reproductive health services for youth (Family Health International, 2000). This study aimed to assess how specific youth friendly components contribute to overall friendliness and uptake of services. Information about how each of the components are important to and contribute to overall youth friendliness in health facilities in Kisumu Municipality will be an important step in an effort to improve service delivery in this region where HIV and other STI prevalence rates remain high among young people despite a national decline in prevalence (National AIDS & STIs Control Programme, 2008).

2.3 Conceptual Framework

The conceptual framework for the study borrows from the Theory of Reasoned Action. The Theory of Reasoned Action is a behaviour change theory that has wide application in the sexual and reproductive health field. This theory has been used in the development of several

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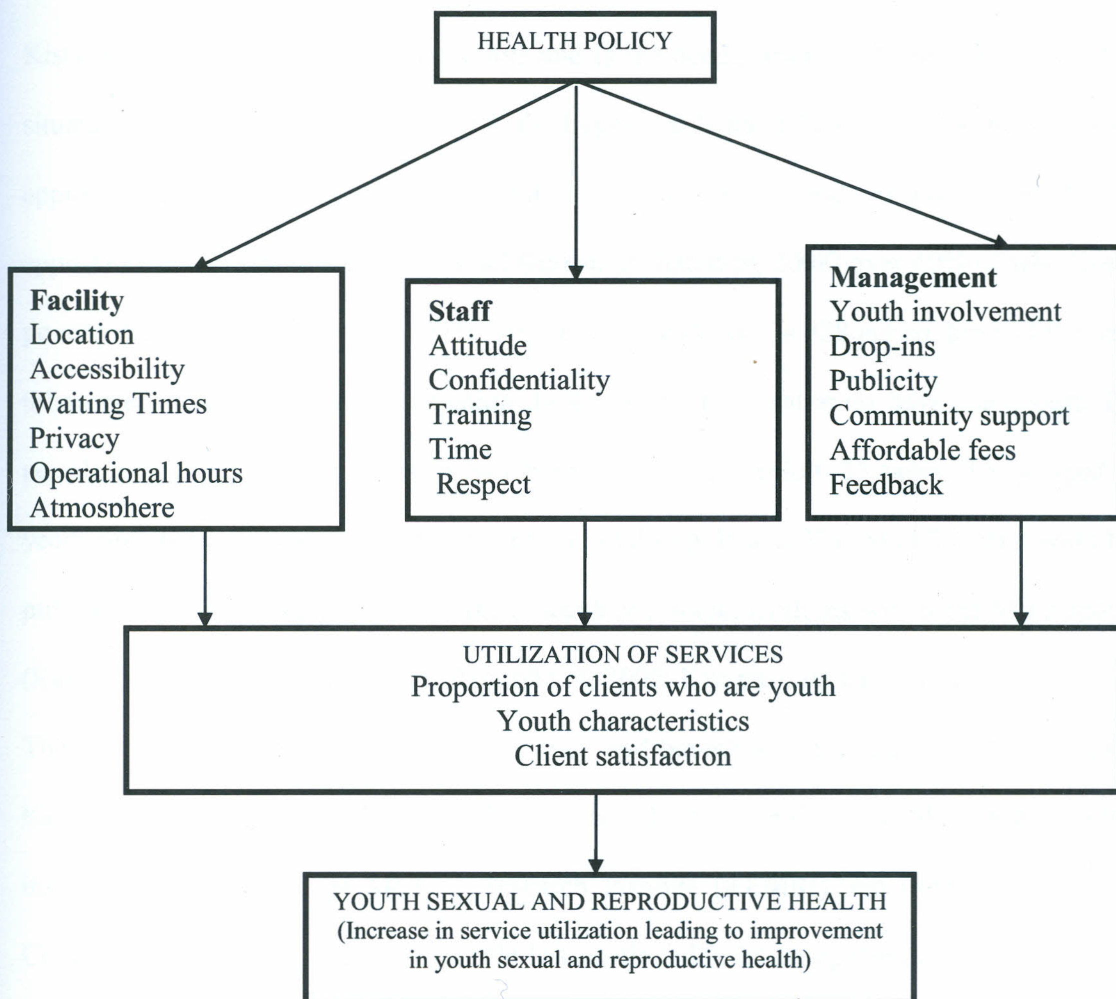
evidence based youth HIV prevention interventions including Parents Matter, Making A Difference and Making Proud Choices (Forehand *et al*, 2004; Guilamo-Ramos *et al*, 2004). All the above interventions have been culturally adapted for sub-Saharan Africa and are currently being scaled up in Kenya and other countries (Poulsen *et al*, 2010). The Theory of Reasoned Action focuses on the relationship between attitudes and behaviour (Ajzen and Fishbein, 1980). According to the theory, intentions are the most important determinant of health behaviour. Therefore the decision to seek reproductive health services will be influenced by youths' behavioural intentions which are in turn influenced by their attitudes and personal beliefs. Youths' behaviour towards youth friendly services will relate to their attitudes towards that particular behaviour and the belief that they will be certain outcome (perceived risks or benefits) associated with that particular behaviour (seeking services). This theory also proposes that the beliefs about whether others will approve or disapprove the behaviour is important and in the case of youth, what their peers, parents and the general community think of them will determine whether they seek services or not. This theory therefore provided justification for studying youths' perceptions towards youth friendly services and the determinants of their health seeking behaviour.

The conceptual framework that guided this study is depicted in Figure 2.1. This framework was based on the provision and utilization of services. Services were assessed in three areas: facilities (location, hours, and atmosphere), staff (training, attitudes, confidentiality, time and respect) and management (fees, involvement of youth, whether both boys and girls were welcome, services available, referrals, waiting time, policies, and publicity). Service utilization was assessed in terms of level of service uptake and characteristics of adolescent clients. The framework assumes that health policy directly affects youth friendly services in

terms of the facility, staff and management and also indirectly influences the characteristics of youth who utilize services.

The conceptual framework assumes that when a minimum package of essential services are available, accessible and accepted, young people are more likely to utilize services and express satisfaction with the services provided. Therefore, when youth clients are satisfied with the services provided this will contribute to improvements in their sexual and reproductive health.



[Adapted from Nelson et al, 2000]

Figure 2-1: Schematic diagram of the conceptual framework

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CHAPTER THREE: METHODOLOGY

3.1 Overview

This chapter provides information on how the study was carried out. It describes the study area, study design, study population and the sampling procedures. The instruments of data collection, procedures of data collection and methods of data analysis are also explained.

3.2 Study area

Kisumu is the third largest city in Kenya and is the headquarters of Nyanza Province. It is situated on the shores of Lake Victoria, the largest fresh water lake in Africa, which covers approximately 297 Km^2 while approximately 120 Km^2 is dry land. It has a population of approximately 453,592 (Kenya National Bureau of Statistics, 2008) over 60% of who live in poverty (Kisumu City Council, 2003). The population density is 828 per sq. km and the peri-urban areas have the highest population density while the rural areas have the lowest. The population is mainly youthful with two thirds (67%) aged below 25 years. Those aged 65 years and above account for only 3.4% of the total population. The youthful population has put pressure on the available educational, health and social facilities within the Municipality (Kenya, Republic of, 2002; Kenya, Republic of, 2005; Kisumu City Council, 2005).

The town hosts the provincial general hospital and branches of leading private hospitals in Kenya e.g. The Aga Khan Hospital. The town also hosts several renowned medical research institutions like the Kenya Medical Research Institute (KEMRI) and Centres for Disease Control (CDC) among others whose role has continued to be recognized across the country. Key health challenges facing Kisumu include high HIV prevalence rate, malaria and water borne diseases contributing to high child morbidity rate, respiratory tract infections and

malnutrition (Kisumu District Health Office, OP Morbidity Summary Tables 2006-2009). Pneumonia, tuberculosis, anaemia, skin diseases, ulcers, urinary tract infections and intestinal worms are also common.

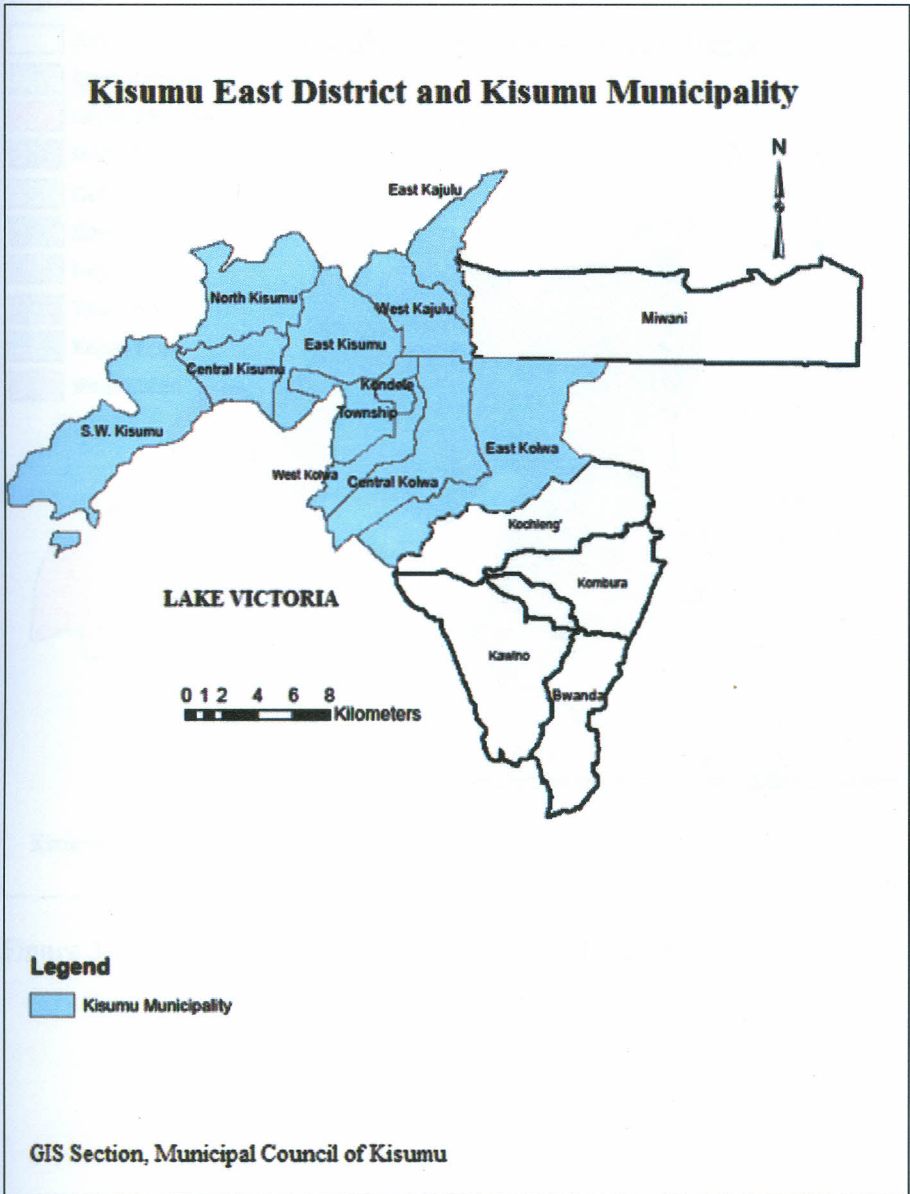

Figure 3-1: Map showing Kisumu Municipality

As of June 2009, there were 61 health facilities in Kisumu Municipality 29 of which are public sector facilities and 22 are managed by faith-based organizations (FBOs), non-governmental

organizations (NGOs) and private entities. Figure 3-2 and Table 3-1 shows the distribution of health facilities within Kisumu Municipality.

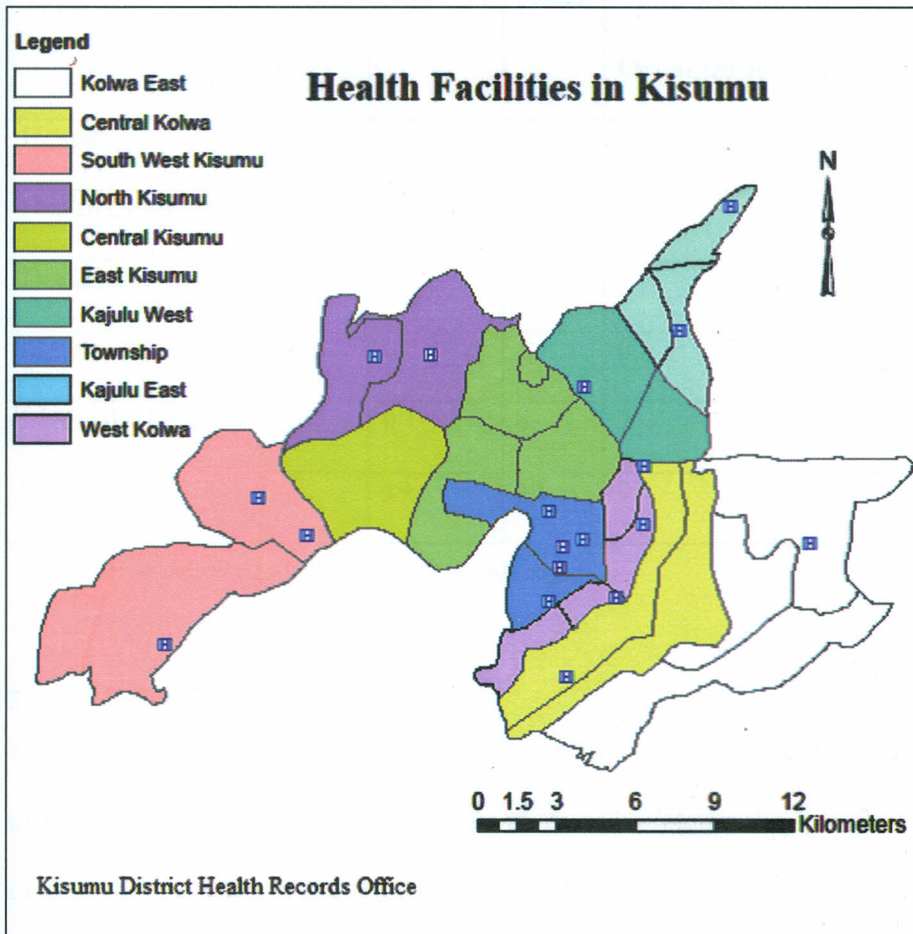

Figure 3-2: Map Showing Health Facilities in Kisumu

Table 3-1: Health Facilities in Kisumu Municipality

Facility Type	Public	Private			
		NGO	Faith Based Organizations	Other private	Total facilities
Hospital	2	1	0	6	9
Health Centre	6	3	0	4	7
Dispensary	21	3	2	2	28
Maternity/Nursing Home	0	1	0	3	4
Medical Clinic	0	4	7	2	13
Total	**29**	**12**	**9**	**17**	**61**

Source: www.ehealth.go.ke/facilites/downlaods/aspx

3.3 Study Design

This was a cross sectional study design. Cross sectional studies yield data that can be used to examine relationships between variables to describe relationship patterns. This study sought to describe the current status of youth friendly services in health facilities within Kisumu Municipality. The study collected both quantitative and qualitative data from youth and health service providers in the sampled health facilities. Quantitative methods were used to review facility records while the interview guide and youth questionnaire collected both quantitative and qualitative data.

3.3.1 Study Population

The total number of 10 -24 year olds within Kisumu Municipality is about 172, 898 (Kenya National Bureau of Statistics/National Council for Population and Development, 2008). Data

obtained from the health facilities showed that between July 2008 and June 2009, a total of 13,845 clients aged 10 to 24 years accessed sexual and reproductive health services within Kisumu Municipality.

To obtain research data, this study targeted health facilities within the central business district and high density residential areas.

3.3.2 Sampling and Sample Size Procedures

3.3.2.1 Number of Facilities

Quota sampling was used to identify health facilities to be included in the sampling frame. Kenya has a hierarchical public health care system with six levels as shown in Figure 3-3.

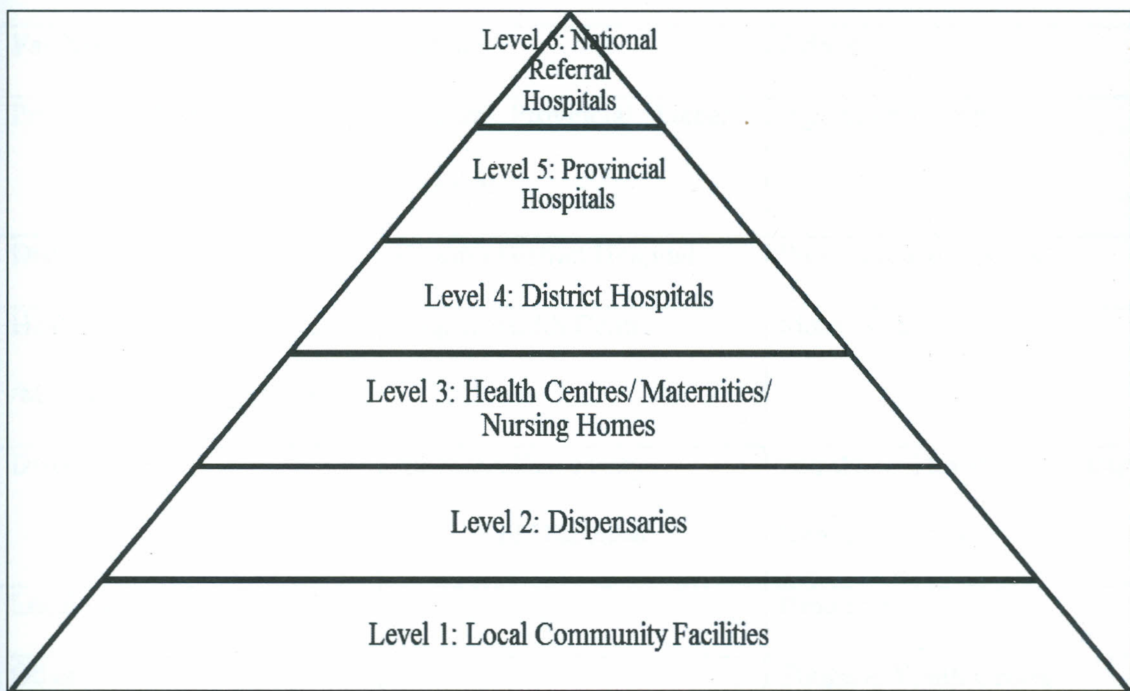

Figure 3-3: Health Service Delivery Levels

A list of all health facilities was first compiled and stratified into public and private health facilities which were then further stratified into the different levels (Private health facilities were also categorised by corresponding levels as those of the public health facilities). From each health facility level, one public facility and one private health facility were purposively selected based on client volume obtained from the records of the previous year. Kisumu Municipality only has five levels of health service delivery so from both public and private sectors a total of 10 facilities were sampled. There are no local community facilities in the public sector therefore two dispensaries were sampled. An additional health facility, Tuungane Youth Centre was purposively selected because it was the only stand-alone youth centre and had high client volumes. Interviews were then conducted in a total of 11 facilities.

Table 3-2: List of Sampled Health Facilities

Facility Level	**Public**	**Private**
Provincial Hospital	Nyanza Provincial General Hospital	Aga Khan Hospital
District Hospital	Kisumu District Hospital	Port Florence Hospital
Health Centre /Maternity/Nursing Home	Migosi Health Centre	Marie Stopes
Dispensaries	Railways Dispensary Town Hall Dispensary	Family Health Options Kenya (FHOK)
Local Community Facilities		Pandipieri
Other		Tungane Youth Centre

Table 3-3: Proportionate allocation of participants across the different facility levels

Facility Levels	**Client Volume 10-24 year olds**	**Percentage of total client volume**	**Number of sampled clients**
Provincial Hospitals	1802	14	34
District Hospitals	1999	14	34
Health Centres	3468	25	62
Dispensary/Clinics	1811	13	32
Maternity/ Nursing Home	1153	8	20
Others-Youth Centre	3612	26	64
Total	**13845**		**246**

At each level, the number of sampled clients was evenly distributed between the public and private health facility. In addition, a manager and a staff in charge of reproductive health or youth friendly services or reproductive health clinic were engaged in in-depth interviews.

3.3.3.2 Number of Participants

According to Mugenda and Mugenda (2003), the minimum sample size where the population is more than 10, 000 can be evaluated as follows:

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n= the minimum sample size if the target population is greater than 10,000

Z= the standard normal deviate at the required confidence level.

p = the proportion in the target population estimated to have characteristics being measured. Use 0.5 if unknown.

q =1-p

d= the level of significance set.

In this case the target population is 13845 which is greater than 10000.

Hence the formula used was:

Once the required sample size was determined, proportion allocation was used to obtain the required number to be sampled from the different levels of health facilities.

In this case Z=1.96, p=0.8, q=0.2 and d = 0.05.

Therefore,

$$n = \frac{(1.96)^2(0.8)(0.2)}{(0.05)(0.05)}$$

$$n = 246$$

The table below shows how the sample size was proportionately distributed across the different facility levels.

3. 4 Data collection

Qualitative data was used to provide an in-depth analysis of youths' perceptions towards youth friendly services and the characteristics of youth friendly services from the youth, managers and staff. An observation checklist also yielded both qualitative and quantitative data. Quantitative data gave socio-demographic characteristics of the youth and statistics of services sought.

3.4.1 Primary data

This was collected through interviews and observation. The main study population was youth residing within Kisumu Municipality. Data was collected over a period of one month from 246 youth who had sought services from the targeted health facilities using questionnaires which were administered face to face. 22 staff and facility managers of the same facilities were also interviewed.

Before each interview the researcher explained in detail the purpose of the study to the respondent and obtained verbal consent.

3.4.1.1 Key Informant Interviews

Semi-structured interviews were conducted with one staff member directly in charge of youth friendly services and/or reproductive health services and the facility managers of the same facilities were also interviewed.

3.4.1.2 Youth Interviews

A semi-structured questionnaire was administered by the researcher to youth clients who had utilised health services and provided socio-demographic information, their perception of the youth friendliness of the services they had received and a description of what they thought were characteristics of youth friendly services.

3.4.1.3 Observation

A data observation checklist was used to examine facility environment, existence of IEC materials and client/provider interactions as well as to verify existence of protocols and guidelines. A camera was used to capture salient features of the health facilities.

3.4.2 Secondary data

Secondary data was used to obtain relevant statistics, more information on other studies on youth friendly services and to identify the knowledge gaps. Secondary data was obtained from libraries, Kisumu District Medical Office, Municipal Council of Kisumu and the internet. Documents reviewed included books, journals, theses and dissertations, newspapers and health facility registers.

3.5 Data analysis and presentation

A description of the study population is provided first.

Qualitative data was categorized into emerging thematic issues and patterns.

The main analyses conducted were:

- **Assessment of how sexual and reproductive health services are being provided in Kisumu Municipality:**
    - A description of the characteristics of youth friendly services [key informant interviews, youth interviews and observation checklist]
    - Comparison of services in the public and private health facilities
        - Uptake of services: Proportion of clients who were aged 10-24 years and their characteristics
        - Comparison of youth friendliness of public and private health facilities
        - Satisfaction with services
- **Perceptions of youth about available health services**
    - An analysis of the interviews on perception of the youth friendliness of health facilities and an exploration of what youth consider as youth friendly, what kind of services they seek and why they may or may not use existing health services.

Results were organized around the three objectives. Descriptive statistics were used to show distributions and proportions in terms of text, percentages, and charts and show relationships between the different variables under investigation. Pictures were used to show salient features.

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3.6 Procedure for Data Collection and Ethical Considerations

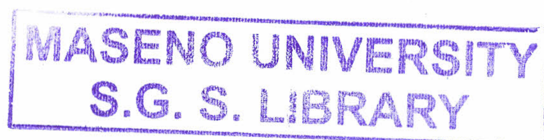
The researcher obtained an introduction letter from the Head of Department of Urban and Regional Planning, Maseno University. Written approval was also provided by the Provincial Medical Officer to conduct interviews within the health facilities. In addition, permission to conduct interviews was sought from the management of all participating health facilities.

To ensure respondents' rights are respected at all times throughout the study, the respondents' verbal consent was obtained before the interviews began and they were assured that they had the right to refuse to answer specific questions during the interview. Respondents were also assured of confidentiality throughout the study and their identities were protected by not disclosing any reference to individuals or institution names.

3.7 Limitations

The main limitation experienced during data collection of the study was that keeping of routine records and management among the different health facilities varied thus the researcher had to make multiple visits in order to get the data required. Most of the facilities did not segregate their data by age and the researcher had to ensure that the data sets fell into the selected categories by doing actual counts in the registers.

Given the number of youth in Kisumu Municipality, findings from 246 youth clients may not be generalizable. Data utilization was based on facility records and was limited to one year from July 2008 to June 2009. The study was limited to perceptions about health facilities within Kisumu Municipality.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CHAPTER FOUR: FINDINGS AND DISCUSSION

4.1 Overview

This chapter presents the findings of the study. The socio-demographic characteristics of the study population are presented to provide the basis for appreciating the discussion of the findings. The findings and discussion are presented as per the objectives.

4.2 General Characteristics of Respondents

Detailed socio-demographic characteristic of the youth participants is provided in Table 4-1.

Of all youth aged 10-24 years who participated in the study, 182 (74%) were female. Those aged 15 to 24 years accounted for the majority, 140 (57%), the mean age of the clients was 19. 5 years while the modal class was 20 – 24 years. Youths who were out of school formed the majority, 164 (66%) of clients possibly because data was collected during the school term. The majority, 150 (61%) of the clients who sought services were single while 34% were married or cohabiting. Half of the youth interviewed reported that their parents were the main household income earners, followed by siblings at 37%. Only a few, 27 (11%) of the youth interviewed were the main income earners.

Table 4-1: Socio-Demographic Data of Youth Clients

Socio-Demographic Data of Youth Participants, N=246			
		N	%
Gender			
	Male	64	26
	Female	182	74
Age			
	10-14	15	6
	15-19	91	37
	20-24	140	57
Currently in school			
	Yes	82	33
	No	164	67
Marital Status			
	Single	150	61
	Married	45	18
	Cohabiting	39	16
	Divorced	12	5
Main Household Income Earner			
	Parents	123	50
	Siblings	91	37
	Self	27	11
	Missing	5	2

Table 4-2 below provides a summary of the socio-demographic characteristics of service providers interviewed in the study. Among health service providers interviewed, 85% were female. The median age was 36 years while the majority (84%) of service providers were involved in providing clinical services while the rest were non-clinical staff.

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Table 4-2: Socio-Demographic Data of Staff

Socio-Demographic Data of Staff, N=107			
		N	**%**
Gender			
	Male	16	15
	Female	91	85
Age			
	20-29	22	21
	30-39	49	46
	40-49	27	25
	>50	9	8
Training Type			
	Nurse	24	22
	Counsellor	30	28
	Clinical Officer	24	22
	Gynaecologist	4	4
	General practitioner	5	5
	Pharmacist	2	2
	Nutritionist	1	< 1
	Community health worker	3	3
	Manager/ coordinator	3	3
	Receptionist	4	4
	Clerk	2	2
	Support staff	5	5

4.3 Youth-Friendliness of the Reproductive Health Services Provided at Various Health Facilities

In order to assess for youth friendliness of the health facilities data was collected from the staff and management of all the sampled health facilities, youth who had already received services at the facilities and using an observer checklist which the researcher used to take note of facility conditions and service provision. Direct quotations from participants are provided in italics.

4.3.1. Facility Characteristics

Braeken *et al*, 2007 and Olowu, 1998 indicate several facility characteristics determine youth friendliness of health facilities. These include whether the operating hours and facility locations and hours were convenient, adequate staff and sufficient privacy and confidentiality and surroundings were comfortable.

Interviews with youth and facility managers as well as observation revealed that all the facilities were easily accessible by public transport and located less than one kilometre from the nearest schools, markets, shopping malls or recreation facilities. This is consistent with the guidelines provided and with findings from studies of youth friendly reproductive health services conducted in Botswana, Ghana, Tanzania Uganda and Zimbabwe (Senderowitz *et al*, 2003; Mashamba & Robson, 2002) which found that geographic location was frequently not a barrier to access and most facilities were located within easy reach.

Facility managers were asked about operational times and both of the hospitals reported that they operated for 24 hours though the specific clinics where these services (family planning

clinic, maternal and child health clinic or VCT centres) were offered mainly operated between 8 and 5 pm on weekdays except for the private nursing home which reported that they operated for 24 hours every day. Only the youth centre opened everyday though half day on Sunday. None of the government facilities operated over the weekends or after 5pm and only 13% of the facilities (all private) had special hours for serving youth clients every Saturday. It was observed that whereas sometimes the clinics would be open by 8:00 am, staff would be unavailable leading to longer waiting times. This was also observed at different points in the day when clients would be queuing yet staff were engaged in meetings or other duties again leading to longer waiting times. Ironically, when the youth were asked about operational times, 86% of them reported that they felt the hours of operation were convenient but this could have been because most of them were out of school or unemployed and therefore had more flexible hours.

These findings are similar to those of a study conducted in Tanzania to assess youth friendliness of sexual and reproductive health services in health facilities (African Youth Alliance/Pathfinder International, 2003) which revealed that facilities generally do not allocate specific times to provide services to youth. This is considered a barrier as most of the service hours coincide with school hours and work times. Youth are generally impatient and want immediate assistance, they do not like waiting for services for long hours and may also they fear that someone they know might see them there and mistake them for being sexually active. This may make them leave if they are not attended to within the shortest time possible.

In terms of client privacy, both facility managers and youth clients from all the facilities reported that consultation services were provided in partitioned areas or separate rooms but although this was confirmed though observation, it was noted that the doors were

occasionally left partially open. Discussions were generally carried out in low tones and 80% of the clients felt confident that their conversations could not be overheard. However, while only 13% of the staff interviewed reported that their colleagues did not interrupt during consultation, it was observed that this was not always upheld especially in the public facilities even when there were signs on the door indicating that consultation was in progress. Staff blamed the interruptions on facility arrangements such as having supplies within the consultation rooms so other staff would interrupt in order to collect such supplies or where there was understaffing, staff would even be called out of the consultation room to attend to other issues, this was observed in all the public health facilities. Youth on the other hand (all from the youth centre) reported that interruptions occurred because the service providers felt the need to consult their colleagues on how best to deal with particular health concerns raised by the clients. Findings from this study are consistent with data from other studies (African Youth Alliance/Pathfinder International, 2005) which found that lack of privacy was a major issue due to doors that were left open and multiple interruptions during client consultation.

Interviews with facility managers, staff and youth as well as observation revealed that in all the facilities, the waiting rooms were comfortable with shelter from rain and sun. Posters with a wide variety of SRH messages were available in 75% of the facilities with all the private facilities having posters and reading materials that youth could carry away as well as audio-visual equipment. Only 13% of the facilities had posters on client rights in the waiting area while 25% (all private) had walls that were painted in attractive colours with some bearing health messages. None of the facilities had separate waiting rooms or space for youth clients and they had to wait in the same area with adult clients except for the youth centre which did

not serve adults. However, in 13% of the facilities, managers reported that the younger clients were isolated and counselled separately. One of the nurses in a public hospital remarked, *"Counselling and testing services can improve so that we have a youth friendly corner where youth can have their services provided as a targeted group".*

Of the staff interviewed 13% felt that the facility environment where they provided reproductive health services to clients was not comfortable as they were too small.

Picture 4-1: Brightly painted wall and posters with health messages in a waiting room at the youth centre

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When youth were asked about the labels on clinics or doors, only 25% of them reported that they were comfortable with some of the labels such as STI clinic, Family Planning or MCH in the clinics or doors:. This corroborates findings from Tanzania (African Youth Alliance/Pathfinder International, 2005) which revealed that such labels were a barrier to service use as youth feared that someone from their community might see them. In the same study, men also reported that they would rather self-treat an STI than be seen at a Maternal and Child Health clinic seeking treatment. Many youth, especially girls, do not want to be associated with family planning organizations because it suggests sexual activity or because young people brand them as places for those with sexually transmitted diseases (Family Health International, 2000). Of the facilities visited, 13% reported that following suggestions from youth clients they had changed the names of their organisations or room labels to remove association with family planning in order to encourage uptake of services.

4.3.2 Providers/Staff Characteristics

In addition to medical training, staff who work competently and sensitively with young people are often considered the single most important condition for establishing youth-friendly services. Acquired skills must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity. In addition, all non-medical staff (e.g. receptionist, guard, etc.) should be oriented to the needs of youth as they are the first point of contact. Adequate time is allocated for client and provider interaction: Providers should assume that it will take more time for youth to disclose their problems than it would for an adult and therefore allocate time appropriately. Youth friendly approach should include repeated training sessions to refresh the skills of current

staff as well as developing new skills for new staff. Staff should also be people who demonstrate interest and willingness to work with youth (Senderowitz, 2002).

Data was collected on the type of basic training received by the staff in the reproductive health clinics, any orientation on youth friendly services and attitudes towards provision of youth friendly services.

Figure 4-1 gives an overview of any general training received, training specific to reproductive health or provision of youth friendly services that all the health workers in the facilities interviewed had received.

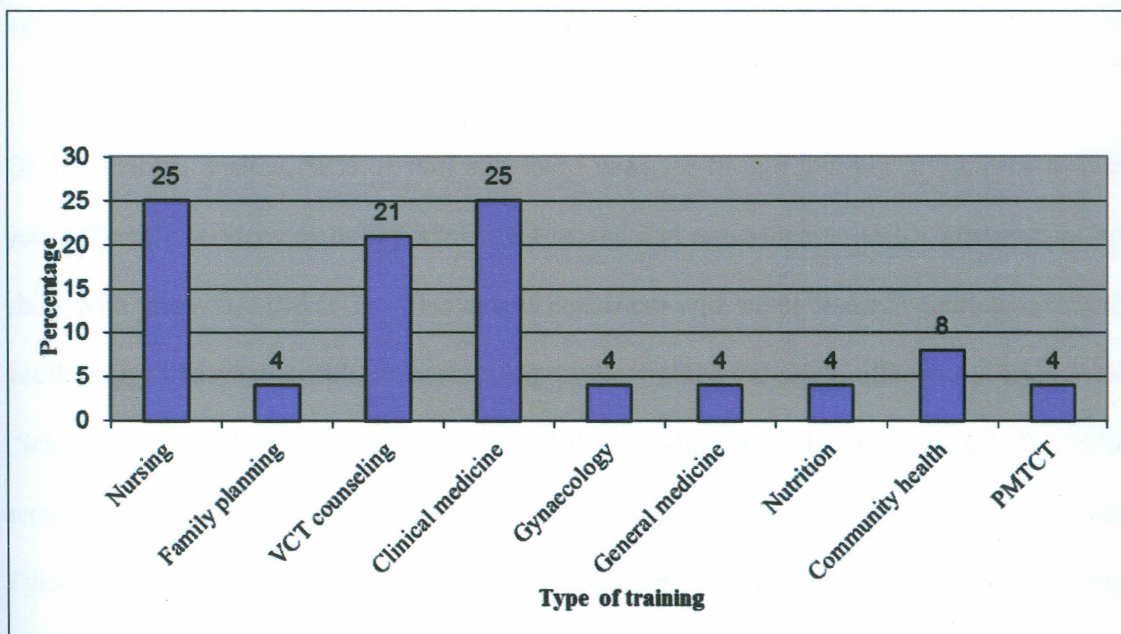

Figure 4-1: Percentage of health workers with basic training in reproductive health

All the staff members interviewed had some basic health training. However, less than half reported that that their training covered reproductive health or youth friendly services. Only 13% of the facility managers reported that all staff (including the receptionist and support

staff) had been given orientation on youth friendliness. All the managers interviewed also had basic health training with only 13% having both a medical and administrative background. Half of the health workers were trained in clinical medicine or nursing. Less than 15 percent of the workers had any training in family planning, gynaecology or prevention of mother to child transmission of HIV (PMTCT).

Health workers in private health facilities were more likely than those in public health facilities to have training or orientation on youth friendly services and/or reproductive health. Half of the staff interviewed had recently (2 or 3 weeks prior to the assessment) attended refresher courses on various topics such as child counselling, couple counselling, home based counselling and testing, ante-natal care and community strategies for dealing with HIV with 38% of them coming from private health facilities.

Of the facilities visited, 88% of staff expressed need for further training in the provision of youth friendly services including adolescent sexual and reproductive health, communication skills with youth and PMTCT. This data is consistent with other research findings in which youth suggested that health workers need to be trained to work effectively with them (Schueller *et al*, 2006) and also recommended expanding provider training in both public sector and NGOs to include counselling techniques, contraceptive technology and referrals. Tylee *et al* (2007) also observed that although youth report that they welcome the opportunity to discuss health issues such as contraception and sexually transmitted infection with health-care providers and are generally prepared to trust their advice, they tend not to disclose their health-risk behaviours to health-care providers unless prompted and good communication skills are required for this. Other studies (Tylee *et al*, 2007 and China Family Planning Association & Program for Appropriate Technologies in Health, 2005) also found that staff

providing youth friendly services needed not only knowledge of sexual medicine, psychology, physiology and sociology but also skills for communicating with youth. Therefore communication skills of service providers are also critical as youth want an open, respectful and friendly attitude so that they can talk about themselves in a comfortable environment. All of the service providers reported that they spend more time with youth as they take longer to open up and share their problems. 91% of the clients felt that the service providers spent enough time with them.

When facility managers and staff were asked about written guidelines regarding client confidentiality, 75% the facilities reported that they had written guidelines or protocols on the same although physical evidence of this was only seen in 38% of the facilities. These protocols were not easily accessible because the staffs who kept them were unavailable while some facilities reported that they knew the documents existed at the district medical office or with the facility managers but had never actually seen them. 89% of the clients felt that the information they shared with providers would be kept confidential because they were assured of that at the beginning and that medical ethics and existing policies also required that staff not divulge any information. Less than 5% of the clients felt that confidentiality was not maintained and reported that facility staff liked to discuss client information amongst each other as soon as the client left.

Staff on the other hand reported that confidentiality is maintained in various ways in the different facilities: in all the public health facilities, clients carry their own cards or files; in the youth centre, clients' files are assigned numbers or codes rather than names, in another 13% of the facilities, only clinicians handle client files and in yet another 13% of the facilities, staff are required to sign a confidentiality agreement.

In terms of staff attitudes, only 13% of the staff members interviewed reported that they find it difficult to discuss sexual and reproductive health issues with youth citing embarrassment in discussing sexuality issues.

4.3.3 Management Characteristics

In terms of management characteristics, data was collected to assess youth involvement in program design and continuous feedback, whether drop-in clients are welcomed and/or appointments arranged rapidly, short waiting times, adequate waiting space, affordability of fees, publicity of services offered, whether young men are welcomed and served, availability of wide range of services, arrangement of referrals where necessary and availability of educational materials.

In regard to cost of services, 63% of the facilities reported that they charged standard fees based on the services sought and not the clients' ages while 26% reported that they assessed economic status to determine charges and all the services were free in the rest of the facilities. Over half (56%) of the clients reported the services offered were affordable 25% of the facilities were found to be very expensive as reported by both youth and staff. Of all the youth interviewed, 5% left without accessing services because they could not afford to pay the required fees (all of these were private health facilities). In 13% of the facilities (all private), staff reported that youth clients hardly sought reproductive health services due to the fees charged and only those with able parents or medical insurance would utilize their services This could be explained by the fact that only 11% of the clients interviewed in this study reported that they were the main income earners in their households. **Studies in Kenya have also indicated that the cost of health services hinders a significant number of young**

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people from seeking healthcare. The majority of the youth are in school, unemployed and poor. They depend on their parents, guardians or relatives to meet health care and other costs, a situation which contributes to their reluctance to seek services (Kenya, Republic of, Ministry of Health, 2005).

When facility managers were asked about youth involvement, only the private health facilities had involved youth in various capacities as peer educators, counsellors and to conduct community sensitization and mobilize other youth for health services and various activities such as recreation. The youth were mainly involved in a volunteering capacity. Those who had not involved them said the youth are not keen and are therefore unreliable. This is consistent with findings from a needs assessment conducted in Nyanza province (Njue *et al*, 2001) which revealed that although many organizations involved young people as peer educators in the implementation of programmes only a few of them allowed young people to participate from the initial stage of a project up to the evaluation stage, though this trend is slowly changing. However, the same study found that very few programs had adopted a policy to include a certain proportion of youth in their management teams and steering committees, recognising the value of youth participation at all levels. Schueller *et al*, (2006) also reported that many youth felt that there should be greater youth involvement in designing and delivering services.

The staff who were interviewed described some of the challenges they faced in working with young people as volunteers because they are highly mobile mainly because of the desire to be economically independent yet most facilities could not financially support the peer educators they work with. In a study conducted in Nyanza province, Njue *et al* (2001) also found that these same elements contributed to the high attrition rate of youth volunteers. Most

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organisations did not find an effective answer to this problem, but the need to include income generating activities in youth-focused programmes was acknowledged by many as essential to increase sustainability

Since males are often ignored in the provision of reproductive health services, questions were included to assess how boys/young men might be treated at the health facilities. All the facilities that were assessed served both boys and girls. However, 88% of the staff reported that boys rarely visited the facilities especially in the hospitals as reproductive health services were offered either in the family planning or MCH clinic and they felt out of place as these were perceived as females-only clinics. This confirms findings from an assessment of youth friendliness of SRH in Tanzania (African Youth Alliance/Pathfinder International, 2006) in which some young men reported that they would rather self-medicate than be seen at a Maternal and Child Health clinic seeking treatment. Ironically this study found that all the youth who reported that they ignore their health concerns or self-medicate were female. When youth were asked if they preferred a service provider of the same sex, 48% responded affirmatively while the rest said they were more concerned about competence than sex of the service provider; the majority (70%) of these were female.

One 24 year old female youth explained her sex preference of providers:

> *"I don't mind any provider, so long as they understand my problem, but the ladies quarrel a lot so sometimes men are better".*

Some specific strategies that some of the facilities reported using to encourage male attendance was referrals from other clinics, couple counselling, referrals from girls, removing the word family planning from the facility name, increasing the number of male staff, promotion of male circumcision services and sensitization in community meetings.

All of the service providers reported that they spend more time with youth as they take longer to open up and share their problems. One female nurse reported,

> *"Girls require a lot of counselling, they don't open up easily. The boys however open up fast and understand quickly so they are easier to deal with though they fear coming in for services".*

This confirms findings from other studies that showed that service providers need good communication skills in order to provide youth friendly services (Tylee, 2006). A high number (91%) of the clients felt that enough time was spent with the provider.

This study relied on the minimum package of essential sexual and reproductive health services [See appendix B for a copy of the Minimum Essential sexual and reproductive health Services for youth] as provided by the Ministry of Health. All facilities were assessed for availability of the following services:

1. Counselling services: the guidelines provide a list of specific counselling services that health facilities should make available to its youth clients. These include counselling on specific sexual and reproductive health topics such as sexuality, relationships, growing up, abstinence, nutrition, rape, sexual abuse and violence, abortion, STI, contraceptives, and male involvement in sexual and reproductive health.

2. Voluntary Counselling and Testing (VCT): in addition to counselling on the topics listed above, the guidelines also require that facilities offer VCT for HIV

3. Treatment services: provided for under the guidelines are treatment of HIV related conditions and STIs. Treatment for general ailments is also included based on the

knowledge that availability of general treatment services will promote acceptance of the facility by youth indirectly contributing to uptake of sexual and reproductive health services. Other care and treatment services included are post-rape care and ante- and post natal care services

4. Screening services: screening for both STIs and pregnancy is also included in the guidelines

5. Other sexual and reproductive health related services: the guidelines also make provision for life skills training as a key component of building sexual and reproductive health. Linkage to other facilities providing opportunity for referrals is also a requirement under the guidelines.

The categories listed above make up a total of 13 services upon which each facility was assessed [See appendix A for a copy of the Minimum Essential SRH Services]. Service records and interviews with facility managers revealed that 50% of the facilities offered all the services according to the minimum package of services as shown in Figure 4-2.

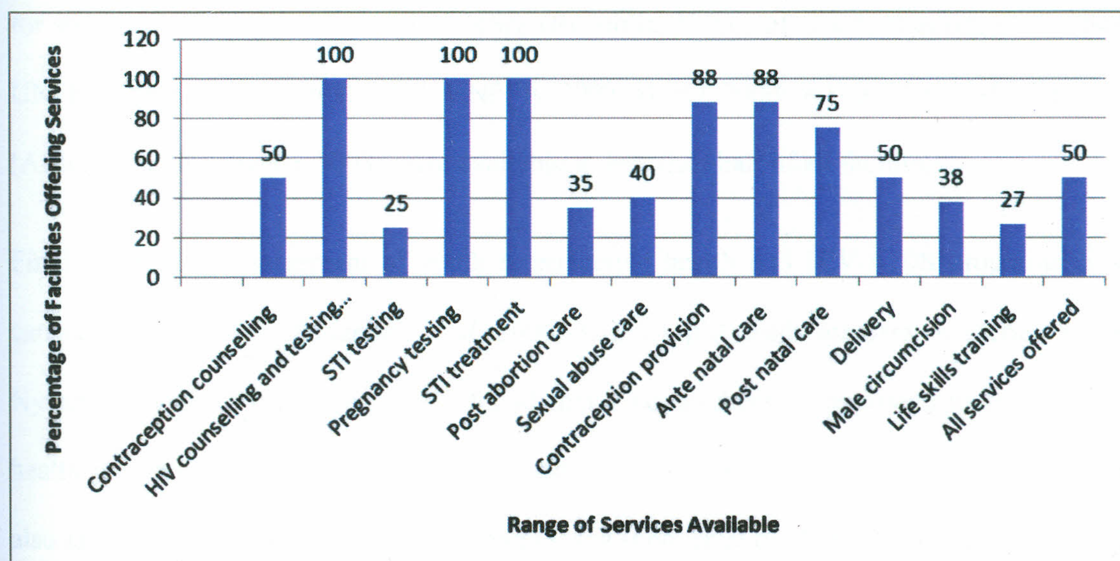

Figure 4-2: Range of services available

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All the facilities provided counselling, VCT and pregnancy testing. Although STI treatment was available in all the facilities, only the hospitals had diagnostic tests for STIs. Contraceptives and post abortion care were not provided in the faith-based organization as this was against their religious beliefs while male circumcision was only available in the hospitals and in the private facilities. Ante-natal care was provided in all the facilities although only the hospitals offered delivery services; post natal care was available in all the hospitals and in half of the private facilities. Some of the least available services include STI screening (25%), life skills training (27%), post-abortion care (35%), male circumcision (38%) and sexual abuse care (40%) Only the hospitals provided post-abortion care while only the youth centre had off-site access to information and counselling through a telephone hotline. Only 27% of the facilities provided life skills training to youth The findings confirm the Kenya Service Provision Assessment conducted in 2004 (Muga *et al*, 2005) which showed that hospitals and nursing homes were more likely to provide a full range of reproductive health services than dispensaries or clinics. Despite availability of a wide range of sexual and reproductive health services, several essential services for youth such as care for survivors of sexual abuse and violence (Republic, Kenya of, 2005; Braeken et al, 2007; UNFPA, 2008, Dickson et al, 2007; UNFPA, 2008; WHO, 2000; WHO, 2002), STI diagnosis (African Youth Alliance, 2003) were available in less than half of all facilities.

Findings from an assessment of youth reproductive health and HIV/AIDS programmes in carried out in Kenya (Schueller *et al*, 2006) and a rapid needs assessment carried out in Nyanza province (Njue *et al*, 2001) found that a comprehensive approach to reproductive health including life skills education, recreation, as well as reproductive health issues was also lacking. In a study done in Kenya and Ghana (Glover *et al*, 2008; Muganda-Onyando *et al*, 2003) involving young people as researchers to collect data on how to improve youth

friendly services, findings showed that providing more services at one clinic or the "One Stop Shop" idea is particularly ideal given the nature of young people's health seeking behaviour. It is important to reduce referral points and offer as wide a range of services as the facility can competently cope with. It was observed that the wider the range of services available including outreach services, the higher the uptake of services from the particular facilities. Mmari and Magnani (2008) also found that access to youth friendly health services is enhanced if facilities are able to offer a wider range of services as well as outreach efforts that take services to the community.

Facility managers were interviewed about provision of outreach services and 63% of the facilities reported that they offered outreach services to the community including peer education, mobile clinics, VCT, behaviour change campaigns and home based VCT. All of these facilities were private.

Picture 4-2: Outreach services for VCT at a school neighbouring one of the health facilities

Referrals were available in all the facilities except one. Only 13% of the facilities had a formal tracking system to track and follow up referred clients and they reported that youth who were referred to other facilities frequently failed to honour the appointments; this further underscored the need for all services to be offered within the same facility where possible. The main services referred were provision of contraceptives from the faith based organization which did not provide them, abortion (including post abortion care) from all the facilities and male circumcision from the dispensaries to the hospitals or youth centre.

In terms of waiting time, facility managers reported that the average waiting time was between 10 – 30 minutes in 75% of the facilities visited, in 13% of the facilities, youth clients were immediately ushered in so there was no waiting time and in another 13% of the facilities waiting time was over 30 minutes due to client volumes. 82% of clients felt waiting time was reasonable. Only 25% of clients reported that they had to wait more than 30 minutes to be attended to while the majority (57%) were served in less than 15 minutes. Observation revealed that waiting times were generally shorter in the private health facilities except in one of the private hospitals.

In order to assess for the friendliness of administrative procedures, facility managers were asked about different policies and guidelines. All the health facilities visited reported that they had written guidelines and standard operating procedures for different services such as ante-natal care, male circumcision and syndromic management of STIs. However, evidence of these protocols was only available in a quarter of the facilities; in some of the facilities, it was reported that the custodians of the documents were busy or unavailable. It was also reported that access to such documentation was generally restricted.

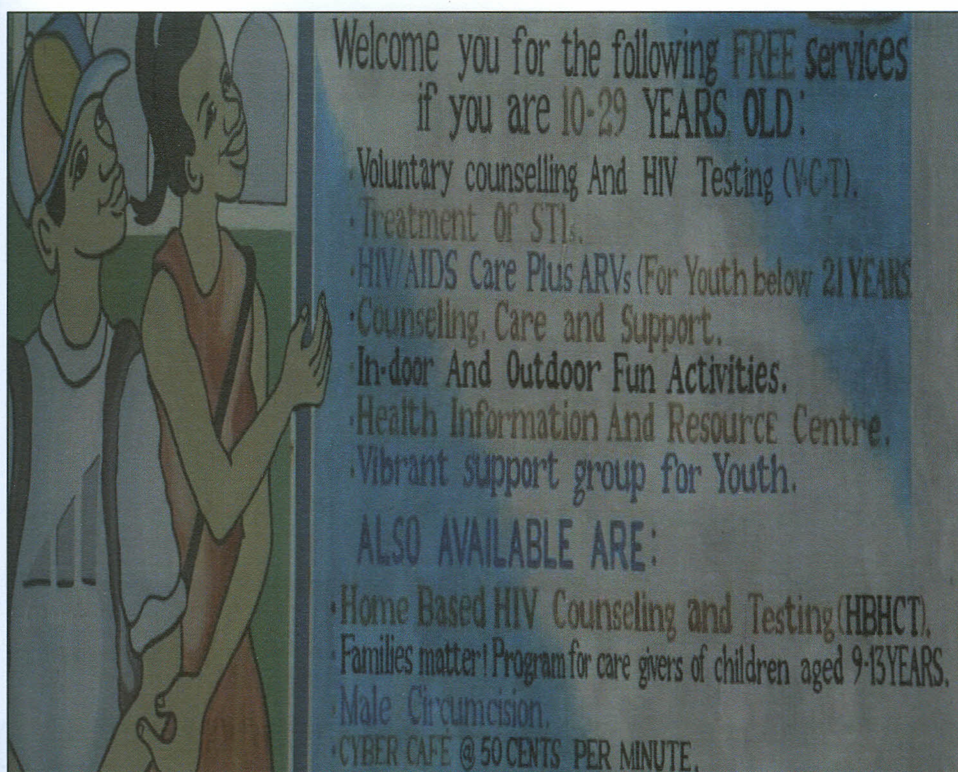
None of the youth reported being turned away on the basis of their age or marital status. However, managers who were interviewed reported that surgical services (male circumcision and surgical contraceptive methods) required parental consent for those less than 18 years. VCT was also restricted to those aged 18 years and above except for those who reported that they were sexually active, those who were pregnant or those who were already mothers.

Although all the facility managers reported that client registration was privately done, it was observed that in 25% of the facilities privacy was compromised during client registration as the waiting rooms were crowded so those who were closest to the registration desk could hear what was discussed. All the facilities reported that client records were stored securely in locked cabinets or locked rooms and again entry was restricted to the personnel working in those departments and this was confirmed by observation.

In terms of publicity of youth friendly services, majority (63%) of the facility managers reported that the facilities did not have any signs to direct potential clients to the facilities or indicating the range of services offered. It was observed that by the roadside or entrances to the facilities were the preferred locations for those facilities which had signs listing the services they provided. 60% of the youth learned about services offered through referrals from friends and relatives and they recommended that signs would attract more youth if they knew services existed. These findings were consistent with data from other assessment findings (African Youth Alliance/Pathfinder International, 2003) which found that the majority of facilities did not have any signs directing potential clients or indicating the type of available services.

All the private health facilities had some type of advertising including radio, internet, newspapers, word of mouth referrals and brochures. Radio, newspapers and referrals were found to be the most effective type of media. Public health facilities scored poorly in terms of publicity about their services; only 13% of them had sign posts and they did not use any form of media to advertise their services. The main messages communicated were public health campaigns and information on where and when to access services such as Pictures 4-3 and 4-4.

Picture 4-3: Sign showing that male circumcision is offered at the facility



Picture 4-4: Sign post showing the range of services offered at a health facility

In terms of how clients are served, all the facility mangers interviewed reported that service is on a first come-first served basis except for emergency situations (applicable to all clients and was not specific to youth). In 13% of the private health facilities, the managers reported that there are no waiting queues and clients are immediately ushered in although it was observed that this was not always the case.

When staff were asked about availability of job aids (flip charts, posters that remind them of key messages, clients' rights, penile models, condoms, etc), it was found that all the facilities had job aids although the public facilities reported that they sometimes run out of stock. Less than half of the youth reported that providers did not use job aids during while providing services.

All the facilities with the exception of the faith based organizations (13%) reported that they had condom dispensers or a system of providing condoms. It was observed that the condom dispensers in the majority (87%) of public facilities were empty and the service providers instead kept the condoms on their desks. 30% of the clients reported that condoms were frequently kept on the providers' desks and they were only available on request so they opted to get them from other sources like chemists or shops.

In one of the facilities, the condom dispenser was in full view of the waiting area and the consultation room and youth reported that they were embarrassed to pick the condoms with everyone watching as shown in Picture 4-5 below.

Picture 4-5: Youth clients queuing for services at a health facility-the condom dispenser is in full view of other clients and the clinician's office

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None of the facilities required youth clients to make appointments before receiving services. Appointments were only given for those who needed to go for treatment review.

While 63% facilities reported that they had suggestion boxes, the researcher was only able to see these in 25% of the facilities. The other facilities reported that they used both written and verbal exit interviews to solicit for youths' opinions. Only 38% of the health facilities reported that they had made changes based on clients' feedback and this included making rooms more colourful, giving staff further training on how to work with youth and moving clients under 5 years to the Maternal and Child Health clinic.

4.4 Assessment of Youths' Perceptions towards youth friendly services

To assess youths' knowledge of youth friendly services they were asked to define what they perceived to be youth friendly services. The results are shown in Table 4-3.

Table 4-3: Definition of youth friendly services

Definition of Youth Friendly Services	Distribution of clients by age group (%)			Distribution of clients by sex (%)		Number of responses	%
	10-14 years	15-19 years	20-24 years	Male	Female		
Services for youth/ Youths' welfare	-	81.8	18.2	16.7	83.3	71	27
Free or affordable services	8.3	33.3	58.3	25.0	75.0	71	27
Don't know	9.1	36.4	54.5	45.5	54.5	66	25
Counselling and testing/ Services that help youth know about their status	-	-	100.0	-	100.0	18	7
Place for advice on health related matters/counselling	-	50.0	50.0	-	100.0	13	5
Services offered at youth centres targeting youth e.g. educating and treating them	-	50.0	50.0	50.0	50.0	13	5
Youth coming together for a common cause like getting treatment and advice	-	100.0	-	100.	-	5	2
Services that enable youth live positively	-	-	100.0	-	100.0	5	2
Missing						4	< 1
Total						266	

Over half (54%) of the responses rightly identified youth friendly services as those that are provided for youth at hospitals, other organizations and youth centres to educate and treat them or services that are free or affordable. They reported that they utilized these services to help them solve their problems, protect their lives and for their general wellbeing/welfare.

> *"...we like ... [name of facility withheld] because they provide free services so you can go even when you don't have money", [23 year old female].*

Socio-demographic data in Table 4-1 showed that only 11% of the youth interviewed reported that they were the main household income earners and this could explain why cost of services was frequently cited among the older youth who could have been unemployed while it was least reported among the 10-14 year olds who were most likely still under the care of their parents. These findings are similar with those from studies conducted in Ghana by the Planned Parenthood Association of Ghana and in Kenya by the Family Planning Association of Kenya in which youth described youth friendly services as an 'ideal' service as one with services that are subsidized or free (Glover *et al*, 1998). These definitions included counselling and testing services that enable youth to know their status, centres for counselling on health issues and services offered at youth centres, services targeting youth for example treating and educating them, services that enable youth to live positively or youth coming together for a common cause like getting treatment and advice.

A quarter of the responses cited revealed that youth did not know what constitutes youth friendly services. This is similar to an assessment of youth reproductive health and HIV/AIDS programmes carried out in Kenya (Schueller *et al*, 2006) which found that many youth especially those in urban and peri-urban areas do not know what youth friendly services are or even where to find them. However, the same study (Schueller *et al*, 2006)

found that youth defined youth friendly services as clinics that do not look like actual clinics but disguised facilities with other activities going on in order to attract youth. Erulkar *et al*, (2005) in a study to assess youths' preferences for reproductive health services in Kenya and Zimbabwe found that cost, short waiting times and staff attitudes were the most important characteristics for Kenyan youth while Zimbabwean youth having confidential services, a nurse that takes her time, short waiting time, one-stop approach and friendly staff were the most important. These findings show that many youth (71%) are able to define youth friendly services or describe some of its characteristics as per the internationally and nationally accepted definitions and guidelines.

Factors Influencing Youths' Uptake of Services

When youth were asked which factors influence them to use or not use the existing health services the reasons in Table 4-4 were cited:

Table 4-4: Factors Influencing Uptake of Services

	Number of responses	**%**
Fear of knowing status	89	23
Lack of money and services are expensive	84	21
Those who care/are responsible about their health go in order to protect their lives	45	12
Ignorance	45	12
Don't know services exist	22	6
Lack of parents to pay bills or accompany	22	6
Far distances	22	6
Most youth prefer private health facilities	22	6
They don't go because they want privacy	17	4
Don't believe in going to hospital to get treatment	11	3
They buy medicine from the shops so don't see the need to visit the health facilities	6	1
They don't go care so don't visit hospitals	6	1
Total	**391**	

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The majority of the responses cited (23%) reported that some youth did not visit health facilities because they had fear of the unknown or feared knowing their HIV status especially for those with multiple partners.

Cost was also cited as a major (21%) reason for not utilizing health services, this could be explained by the fact that very few (11%) of the youth reported that they were the main income earners in their households.

Ignorance (12%) is another negative factor for youth not accessing services self—awareness is low as they do not think they are at risk of HIV or sexually transmitted infections, they cannot assess this adequately.

Mmari and Magnani (2003) found that some of the reasons youth did not seek services were policies that restrict their access to services and information, negative community attitudes/perceptions toward providing reproductive services for unmarried youth, service provider bias, youth embarrassment at being seen at facilities, and fear that their privacy and confidentiality will not be honoured.

Health Seeking Behaviour of Youth

To assess youth's practices towards youth friendly services, they were asked what they do when they have any health concerns. The results are shown in Table 4-5 below.

Table 4-5: Health Seeking Behaviour of Youth

	Number of responses	%
Visit the hospital	105	62
Go for testing e.g. HIV, pregnancy or malaria	33	9
Inform parents	88	7
Tell friends	50	5
Go for check up	50	5
Buy drugs from a chemist	6	5
Keep themselves healthy/keep fit	6	3
Most of them don't care and prefer to keep quiet	8	2
Eat balanced diet	6	2
Total	**352**	

The majority (62%) of youth reported that they go to hospital to seek medical attention when they are sick.

Table 4-5 further shows that 12% informed their parents or sought advice from friends; *"...if you are pregnant you may go to a friend and discuss with her on what to do or how to do it maybe because they will not be harsh on you and they will encourage you...", [18 year old female]*

Other reasons (12%) cited by the youth as to what some of them do when they have any health concerns included some youth not doing anything and just preferred to keep quiet,

exercise/eating a balanced diet or buying drugs from a chemist shop when they had any health related issues.

These findings are similar to Tylee's study (Tylee *et al*, 2007), in which he observed that in developing countries, young people are less willing to seek professional help for more sensitive matters and turn more readily to friends, or family members they can trust for sexual advice. Often, the adults around the adolescent decide whether or not health care needs to be sought, and if so when and where it should be sought. Youth might not be accessing services because they have low risk perception of the consequences of not seeking information and services when they have health concerns; lack of resources to pay for the services or not knowing that youth friendly services exist to address their health needs. Youth need to be made aware of the existence of youth friendly services and on the need to seek professional help instead of self-medicating or just ignoring their health concerns. Youth friendly services should also be publicised. Schueller *et al* (2006) also found that while most service providers recognized the need to improve access to clinical facilities and make services more youth-friendly, very little was mentioned about the need to create demand for services and improve health-seeking behaviours among youth.

4.5 Comparison of Uptake of Services between Private and Public Facilities

In order to compare uptake of services between the private and public facilities, data was collected on health service utilization for the period April to June 2009 was collected from all health facilities in the study area.

Differences in service use among public and private health facilities

Results of the comparison of utilization of health services by service and facility type are shown in Table 4-6; During that period (January to March 2009), a total of 21192 visits (by both children and adults) were made to the 62 health facilities. Of these visits, 3903 were made by youth aged 10-24 years (18% of total visits). It was observed that the public health facilities had the highest number of clients for contraceptives, ante-natal care and delivery possibly because the costs of these services were subsidised. Private health facilities had more clients for pregnancy testing, STI treatment and male circumcision. Life skills were only offered in the private health facilities.

Among those who sought VCT, the proportion of those who were aged 15-19 years was highest (55%) as shown in Table 4-7. Majority of the clients seeking pregnancy tests were single (83%) There were more females (75%) who sought STI treatment. VCT services had the highest uptake probably due to public health campaigns urging the public to know their HIV status and also because it was the only service that was offered free of charge across all the health facilities.

Table 4-6: Differences in Uptake of Services by Service and Facility Type

	Total Clients	10-24 year olds	% 10-24 year olds	Public	Private
STI testing	198	120	61	0	120
VCT	7575	2399	32	1949	450
Pregnancy testing	501	173	34	51	122
STI treatment	463	129	28	20	109
Post abortion care	33	18	54	5	13
Sexual abuse/rape care	95	5	5	5	0
Contraceptives	2333	131	5	80	51
Ante-natal care	3160	288	9	217	71
Post-natal care	2117	45	2	6	39
Delivery	2570	76	3	68	8
Male Circumcision	519	31	6	12	19
Life Skills	478	478	100	0	478
	21192	3893			

Table 4-7 further reveals that service use by sex indicates that there are differences between females and males in seeking reproductive health services. Males scored highest only in circumcision, knowing how to live positively and information on condom use. Most of the health providers in the health facilities were female (85%), which may have made boys uncomfortable using the services.

Table 4-7: Difference in service use by youth characteristics

Service use by youth	Age group (%)						Gender (%)				N
	10-14		15-19		10-24		Male		Female		
	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	
Counselling	-	-	100.0	-	-	-	-	-	100	-	32
VCT (counselling and testing)	-	-	25.0	20.4	25.0	29.7	-	29.7	25.0	20.4	79
Contraception	-	-	-	-	100	100	-	-	100	100	32
STI treatment	-	-	-	-	-	100	-	-	-	100	47
Pregnancy testing	-	-	71.4	-	28.6	-	-	-	100	-	28
Other	14.3	-	28.6	14.3	-	42.9	14.3	15.2	35.7	34.8	28

The findings indicated that the majority (57%) of those receiving services were aged 20 years and above. This could have been due to the fact that most of the younger youth were in school at the time of the assessment and could only be served after school, over the weekends and during the school holidays. Ironically, only the hospitals operate 24 hours but the specific clinics where reproductive health services are offered close by 5:00 pm and some remain closed at the weekend yet many schools have extra studies until much later in the evening and over the weekends. Muganda-Onyando *et al* (2003) also observed that age was also a key factor in access to both information and services. Results of a baseline survey conducted

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indicated that most of those youth receiving services were over 20 years. This was due to the fact that most 14-19 years olds were in school and were therefore only served after normal working hours or during school holidays. It could also be explained by the fact that most providers were above 20 years and therefore served mainly their peers.

Overall comparison of youth friendliness in terms of the characteristics of youth friendly services was also done in terms of facility, staff and management and the results presented in Tables 4-8 to 4-10.

Table 4-8 shows that most of the facilities scored average in terms of comfortable surroundings and convenience of facility hours was generally poor. The private health facilities had higher scores in terms of convenient location, maintaining privacy and comfortable surroundings while the public facilities scored just a little higher in terms of convenient hours. A paired t-test performed on the data below indicated that the mean score of public health facilities is significantly less than that of private health facilities (p=0.048).

Table 4-8: Comparison of youth friendliness in terms of facility characteristics

Facility characteristics	**Public Health Facilities (% Score)**	**Private Health Facilities (% Score)**
Convenient location	58	69
Convenient hours	39	37
Sufficient privacy	40	55
Comfortable surroundings	43	60
Mean Score	**45.0**	**55.3**

Private facilities scored highly in terms of training and competence of staff, confidentiality was above average and staff attitudes were average in both public and private health facilities as depicted in Table 4-9. A paired t-test performed on the data below indicated that the mean score of public health facilities is not significantly different from that of private health facilities (p=0.3065).

Table 4-9: Comparison of youth friendliness in terms of staff

Staff	**Public Health Facilities (% Score)**	**Private Health Facilities (% Score)**
Training	44	62
Competency	72	74
Confidentiality	55	56
Attitudes	50	50
Mean Score	**55.3**	**60.5**

Table 4-10 shows the comparison of friendliness of management indicators in the public and private health facilities. Public health facilities were found to be friendlier in terms of affordability of fees and shorter waiting times but scored poorly in promoting their services through any forms of publicity, involving youth and policy support. Both public and private health facilities scored highly in providing a wide range of services and supportive administrative procedures and averagely in welcoming both boys and girls and in providing referrals for services not offered. A paired t-test performed on the below data indicated that the mean score of public health facilities is significantly less than that of private health facilities (p=0.045).

Table 4-10: Comparison of youth friendliness in terms of management indicators

Management indicators	Public Health Facilities (% Score)	Private Health Facilities (% Score)
Affordable fees	85	68
Youth involvement	20	54
Both boys and girls welcomed and served	54	59
Wide range of services available	73	78
Referrals available	22	30
Waiting time	63	52
Policy support	33	71
Publicity	07	58
Administrative procedures	67	86
Mean Score	**47.1**	**61.8**

All the clients reported that they were satisfied with the services while 85% said they would recommend the services to others. Private health facilities had higher scores in terms of satisfaction (67%) as compared to public health facilities which scored 47%.

These findings are consistent with those from a study by Mmari and Magnani (2003) which found that clinics that scored the highest in terms of youth-friendliness were those that had implemented youth friendly services projects (as opposed to non-youth friendly services clinics, which offered "standard" public sector services). In youth friendly services project clinics, most young clients reported being satisfied with the services they received, and most of the nurses and staff reported being supportive of providing reproductive health services to youth.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of findings, conclusion and recommendations.

5.2 Summary of Findings

This study sought to identify the characteristics of youth friendliness of reproductive health services in health facilities within Kisumu Municipality. Findings from interviews with youth, staff and management revealed all the facilities were easily accessible by public transport (less than 1 km from the nearest school, market or recreation facilities) and facilities visited operated from 8:00 to 5:00 and although the hospitals operated for 24 hours the specific clinics where reproductive health services were provided did not operate after 5:00 pm. 13% of the facilities had special operating hours for youth on Saturdays although 86% of the youth reported that the hours were convenient for them. Discussions were generally carried out in low tones and 80% of the clients felt confident that their conversations could not be overheard. Interruptions during consultation were reported by 13% of staff reported interruptions and similarly 13% felt that the facility environment where they provided reproductive health services was too small. Majority of youth (75%) reported being uncomfortable with some of the labels such as STI clinic, Family Planning or MCH in the clinics or doors. Despite having basic health training less than 50% of the staff reported that that their training covered reproductive health or youth friendly services. Orientation on youth friendliness to all staff including the receptionist and support staff was largely lacking (78%). All the managers interviewed also had basic health training while 13% had both a medical and administrative background. Half of the staff interviewed had recently (2 or 3 weeks prior to the assessment) attended refresher courses on reproductive health. Of the facilities visited, 88% of staff expressed need for further training in the provision of youth

friendly services including adolescent sexual and reproductive health, communication skills with youth and PMTCT. All of the service providers reported that they spend more time with youth as they take longer to open up and share their problems. The clients mainly (91%) felt that the service providers spent enough time with them. Majority (75%) the facilities reported that they had written guidelines or protocols on the same although physical evidence of this was only seen in 38% of the facilities. 89% of the clients felt that the information they shared with providers would be kept confidential because they were assured of that at the beginning and that medical ethics and existing policies also required that staff not divulge any information.. Staff on the other hand reported that confidentiality is maintained in various ways in the different facilities: in all the public health facilities, clients carry their own cards or files; in the youth centre, clients' files are assigned numbers or codes rather than names, in another 13% of the facilities, only clinicians handle client files and in yet another 13% of the facilities, staff are required to sign a confidentiality agreement. In terms of staff attitudes, only 13% of the staff members interviewed reported that they find it difficult to discuss sexual and reproductive health issues with youth citing embarrassment in discussing sexuality issues. The study examined availability of essential sexual and reproductive health services for young people as a critical measure of youth friendliness of health facilities. Only half of the 11 health facilities visited provided all 13 essential sexual and reproductive health services. HIV counselling and testing, pregnancy testing and STI treatment were the only services available in all the facilities. Only a quarter of the health facilities had screening for sexually transmitted infection services while sexual abuse care services were only available in 40% of the facilities and similarly a low number of facilities (27%) provided life skills training which is key for youth. 63% of the facilities reported that they offered outreach services to the community including peer education, mobile clinics, VCT, behaviour change campaigns and home based VCT. Referrals were available in all the facilities except one

although only 13% of the facilities had a formal tracking system to track and follow up referred clients and they reported that youth who were referred to other facilities frequently failed to honour the appointments. Only 25% of clients reported that they had to wait more than 30 minutes to be attended to 57% were served in less than 15 minutes. Observation revealed that waiting times were generally shorter in the private health facilities except in one of the private hospitals. All the health facilities visited reported that they had written guidelines and standard operating procedures for different services such as ante-natal care, male circumcision and syndromic management of STIs. However, evidence of these protocols was only available in 25% of the facilities; in some of the facilities, it was reported that the custodians of the documents were busy or unavailable. It was also reported that access to such documentation was generally restricted. None of the youth reported being turned away on the basis of their age or marital status. In terms of publicity of youth friendly services, only 37% of the facilities had any signs to direct potential clients to the facilities or indicating the range of services offered. 60% of the youth learned about services offered through referrals from friends and relatives. Only the private health facilities had some type of advertising including radio, internet, newspapers, word of mouth referrals and brochures. Service provision was reported to be on a first come-first served basis except for emergency situations (applicable to all clients and was not specific to youth). It was found that all the facilities had job aids although the public facilities reported that they sometimes run out of stock. All the facilities with the exception of the faith based organizations (13%) reported that they had condom dispensers or a system of providing condoms although it was observed that the condom dispensers in the majority (87%) of public facilities were empty and the service providers instead kept the condoms on their desks making the clients opt to buy them rather than request for them. Facilities reported using suggestion boxes (63%) while others used both written and verbal exit interviews to solicit for youths' opinions. Only 38% of the health

facilities reported that they had made changes based on clients' feedback and this included making rooms more colourful, giving staff further training on how to work with youth and moving clients under 5 years to the Maternal and Child Health clinic.

In terms of youths' perceptions of youth friendly services, (54%) of the responses defined youth friendly services as those that are provided for youth at hospitals, other organizations and youth centres to educate and treat them or services that are free or affordable. They reported that they utilized these services to help them solve their problems, protect their lives and for their general wellbeing/welfare. A quarter of the responses cited revealed that youth did not know what constitutes youth friendly services. When asked about health seeking behaviour, 23% of the responses cited reported that some youth did not visit health facilities because they had fear of the unknown or feared knowing their HIV status especially for those with multiple partners, inability to pay for services (21%) and ignorance or low risk perception (12%). The majority (62%) of youth reported that they go to hospital to seek medical attention when they are sick, 12% would tell their parents or friends, 14% would go for a check-up/test, 5% would self-medicate and 2% would just keep quiet.

The data from facility inventory also shows low service utilization levels, particularly among youth clients aged 20-24 years. Of the 21192 visits made between April to June 2009, 18% (3903) were made by youth aged 20-24 years. Public health facilities recorded a higher frequency of youth clients (2401) compared to the privately-run facilities (1502). VCT services were offered in all the facilities and had the highest uptake. Majority (57%) of those receiving services were aged 20 years and above while the clients seeking pregnancy tests were mainly single (83%) There were more females (75%) who sought STI treatment. In terms of facility characteristics, the mean score of public health facilities is not significantly

different from that of private health facilities (p=0.3065). For staff characteristics a paired t-test indicated that the mean score of public health facilities is significantly less than that of private health facilities (p=0.048) and similarly for management characteristics the mean score of public health facilities is significantly less than that of private health facilities (p=0.045). All the clients reported that they were satisfied with the services while 85% said they would recommend the services to others. Private health facilities had higher scores (67%) in terms of satisfaction as compared to public health facilities which scored 47%.

5.3 Conclusions

This study assessed the youth friendliness of reproductive health services within Kisumu Municipality. From the findings, it is clear that only half of the health facilities provide the minimum and essential sexual and reproductive health services youth require. Despite availability of a wide range of sexual and reproductive health services, several essential services for youth such as care for survivors of sexual abuse and violence (Kenya, Republic of, 2005; Braeken et al, 2007; UNFPA, 2008, Dickson et al, 2007; UNFPA, 2008; WHO, 2000; WHO, 2002), STI diagnosis (African Youth Alliance, 2005) were available in less than half of all facilities. Equally, the proportion of youth clients was rather low (18%). It is therefore tempting to conclude that majority of services being provided in these facilities are geared towards adults.

In terms of youth perceptions towards youth friendly services the study shows that youth have an idea of what youth friendly services are and can even describe some of the characteristics. However, this did not necessarily match their health seeking behaviour as they cited several reasons that hinder them from seeking services such as cost, fear, ignorance, perceived lack of privacy and preference for self-medication.

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In seeking to compare service uptake it was clear that service uptake does not necessarily match satisfaction as service uptake was higher in the public health facilities yet satisfaction was higher in the private health facilities.

5.4 Recommendations

1. In order to make health services more youth friendly as per the guidelines provided, some work is needed to change the structural operations of some of the facilities such as policies and structural aspects like improving facility hours to include lunch hour, evenings and weekends; facility managers should also take steps to ensure that staff observe working hours and do not engage in other activities when they should be providing services. In order to minimize interruptions, supplies should not be kept within consultation rooms or there should be a system through which these are collected before the clients arrive. Service providers need continuous training on all aspects of youth friendly services. In addition **health facilities should work out systems whereby costs for** youth friendly services **are waived or subsidized for youth who are unable to pay** and incentives such as cost reduction could also be provided to females who seek health services with their partners in order to encourage males to visit health facilities and more male staff can also be employed. Youth should have separate waiting areas or separate service hours and labels associated with STIs, family planning or Maternal and Child Health clinic should be removed and possibly even provide recreation within the facility. Facilities should strive to create separate space, timings or days for youth clients so that they do not have to mix with adult clients. Meaningful youth participation makes programmes more relevant and sustainable as it will give service providers a better

understanding of youth needs, and they will be able to adjust service content accordingly. A wider range of service provision is more assuring that youth will receive the care they need as they may not honour referrals or even later appointments.

2. More awareness creation would help the youth to have a positive attitude towards youth friendly services available at different health facilities and in turn promote uptake. Utilization of services can be improved by creating more publicity about what youth friendly services are in order to make them the choice source of sexual and reproductive health information and services. This could be done through signs listing the services offered, using youth as peer educators to reach out to other youth and even using media to promote health seeking behaviour among youth.
3. Increasing service use is key to development of youth friendly services and improving health outcomes within Kisumu Municipality. Counselling through telephone hotlines and social sites can also promote service uptake to youth who form an increasing number of mobile phone users.

5.4.1 Areas for Further Research

1. Further research needs to be carried in order to find out the views of those youth who did not seek any youth friendly services.
2. It is also recommended that further research is needed to assess the effectiveness of youth friendly services in changing reproductive health indicators for youth within Kisumu Municipality.

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