

Evaluation of the Provision of Sexual and Reproductive Health Services to Young People in Wagai and Karemo Divisions, Siaya County, Kenya

Obong'o, C. O.¹, Dr. Zani, A. P.²

¹Post Graduate Researcher, Department of Sociology and Social Work University of Nairobi, P.O. Box 30197, 00100, Nairobi, Kenya

²Lecturer, Department of Sociology and Social Work, University of Nairobi, P.O. Box 30197, 00100, Nairobi, Kenya

Abstract: Barriers related to the availability, acceptability and accessibility of sexual and reproductive health services (SRH) make it difficult for young people to access and utilize (SRH) hence exposing them to unintended pregnancy, HIV/AIDS and other sexually transmitted infections. The study evaluates the provision of SRH services to young people in Karemo and Wagai divisions, Siaya County. It uses a cross-sectional design and focus group discussions to collect qualitative and quantitative data from 168 adolescents aged 15-19 years, 41 service providers and 23 health facilities. Findings showed that none of the 23 selected health facilities provided all 21 essential SRH services and only 30% provided more than 80% of the essential SRH services. FGD participants reported that lack of services, personnel, facility environment, and marketing and provider attitude are barriers to SRH services. Eighty percent respondents said the facilities' environment, waiting area and location were welcoming, comfortable and convenient. Some 90% boys' and 98.3% girls' respondents said they would visit the facilities once more for similar or related services. The study recommended training of service providers focusing on their biases towards adolescent SRH services and, improvement of facility environment and marketing of available services.

Keywords: Health acceptability, Health acceptability, Health availability, Kenya, Sexual and Reproductive Health Services

I. Introduction

Many young people living in developing countries continue to face hurdles in accessing sexual and reproductive health services [Braeken et al, 2007]. And in a few countries where these services are relatively available, young people are unable to access them due to a combination of legal, social and economic barriers [Ross and Ferguson, 2006]. A 2001 rapid youth assessment study by the Belgian Institute of Tropical Medicine (ITM) in Nyanza Province, Kenya, to identify the gaps between the most pressing sexual and reproductive health needs of youth and the existing services, found that some of the barriers inhibiting youth uptake of sexual and reproductive health services include lack of confidentiality, harsh treatment and denial of services by service providers, mixed messages about services, high cost of services, long distance to services especially in rural areas, and long waiting queues at service facilities [Vandenhoudt et al, 2001]. Participants in this study argued that these barriers could easily be eliminated if SRH services could be provided in a youth friendly manner, including manning health services with youthful counselors who are responsive to the needs of young people.

Having youth friendly facilities is necessary because on a global scale sexual and reproductive health problem remains a preserve of the young people. About 40% of all newly acquired HIV infections in the world occur among those between 15 and 24 years [UNAIDS 2007]. Sub-Saharan Africa is by far the worst HIV-affected region in the world, home to almost two-thirds of all people living with HIV or AIDS [WHO, 2002; 2006]. In Kenya, the 2004 Demographic and Health Survey [CBS, 2004] found a HIV prevalence of 4% among women aged 15-19 years and 1% among men in the same age group. According to the survey, 23% of all pregnant women are adolescents, and half of those from poor households deliver at home. The situation is the same in Nyanza, which has a HIV/AIDS prevalence of 15.3% among adults aged 15-49 in Nyanza compared to the national estimate of 7.1% [KAIS, 2007]. A cross-sectional study by the Kenya Medical Research Institute (KEMRI) and the US Centers for Disease Control and Prevention (CDC) in Gem (Wagai and Yala divisions where current study is based) in 2005, recorded 10% HIV prevalence among female adolescents aged 15-19 compared to 1% among males of the same age group. Some 24% males and 17% females between 13 and 14 years reported having had sex and 23% of the female adolescents aged 13-19 were already married[Vandenhoudt et al, 2006].

The high numbers of unwanted teenage pregnancies, unsafe abortions and rising HIV/STI infections in Nyanza province indicate that young people are initiating sexual activity earlier than before [CBS, 2004]. In response to the situation various health stakeholders in Siaya County have adopted various strategies to increase young people's utilization of sexual and reproductive health services including setting up of a dedicated youth friendly health facility in Wagai division, but little is known about the success of these efforts. In particular, the District Health Management Team of Siaya County in its 2009-10 annual operation plan highlighted the challenges faced by young people in increasing utilization of sexual and reproductive health services adding that the young lack the means to navigate the increasing range of sexual and reproductive health problems facing them.

According to the Siaya District Health Management Team (DHMT) 3 young people cannot utilize SRH services due to poor delivery. Data from the youth intervention program indicate that fewer adolescents utilize SRH services at the Wagai Youth Center compared to those who receive services during daily outreach activities. A survey between July and September 2008 showed that 142 adolescents aged 15-19 years received clinic services and 57 were voluntary counseled and tested for HIV at the youth center compared to 355 adolescents and 336 others of the same age who were reached with clinic and VCT services respectively during outreach activities.

Given these circumstances this study was designed to:

- Identify available and preferred sources of sexual and reproductive health services for young people,
- Estimate the proportion of sexual and reproductive health services clients who are aged 15-19 years,
- Assess attitudes of health service providers towards the sexual and reproductive health needs of young people,
- Assess young people's levels of satisfaction with sexual and reproductive health services provided in health facilities in Karemo and Wagai divisions,
- Identify opportunities for improvement in the provision of youth friendly sexual and reproductive health services in the selected facilities.

1.2 Barriers to Sexual and Reproductive Health Services

Although there is a growing international consensus on adolescents' sexual and reproductive health needs, the preferences of the types of services among adolescents vary across countries, regions, cultures and social settings. Some case studies conducted in Kenya, Argentina, Peru, and the Philippines to explore young peoples' impressions of sex education in schools revealed that most young people prefer to get information on these topics from health providers rather than from teachers [UNFPA, 2008; Sovd et al, 2006; WHO, 2000]. Yet in other studies conducted in Africa the school has been found to be the most influential agent for sexual and reproductive health services needs for young people suggesting that sexual and reproductive health needs and behavior of in-school adolescents might differ from those of out of school adolescents [Hallman, 2009; Fylkesnes et al, 2001].

However sexual and reproductive health services ought to appeal to young people, meet their varying sexual and reproductive health needs and succeed in retaining them for continuing care [Senderowitz, 1999; AYA, 2003; Ross and Ferguson, 2006]. Unfortunately the services are not **available, accessible, acceptable and satisfactory** in most developing countries and more so in sub-Saharan Africa where sexual and reproductive health services are not available [Tylee et al, 2007]. Provision of sexual and reproductive health services to young people in sub-Saharan Africa is still hampered by restrictive laws and policies [Braeken et al, 2007; Senderowitz, 1997; Hughes and McCauley, 1998]. And owing to the fact that many African cultures and social norms do not condone pre-marital sex, many unmarried young people with a sexual problem prefer either to try and solve the problem themselves, or turn to trusted friends and service delivery points such as pharmacies rather than seek help from health facilities for fear of social consequences [Tylee et al, 2007].

Young people are also unable to utilize the available SRH services in Africa because high costs, lack of convenience and public awareness and benefits about the existing services [Braeken et al, 2007; Olowu, 1998]. The youth also shun visiting the available health facilities because of they are treated in non friendly manner. According to Kenya HIV/AIDS Service Provision Assessment (KSPA) of 2004 which sought to understand whether the provision of voluntary HIV counseling and testing (VCT) on the prevention of mother to child transmission services (PMTCT) was done in a youth friendly manner found that only 12% of health facilities were able to provide youth friendly services [Muga et al, 2004].

Lack of confidentiality is another major reason that makes young people reluctant to seek sexual and reproductive health services [Braeken et al, 2007]. Pregnant adolescents fear that health workers cannot maintain confidentiality to parents. Young people also fear to be asked difficult questions and to be scolded by health providers. They also think that health providers are poor at communicating with young people and more often carry out unnecessary procedures [Olowu, 1998; Erulkar et al, 2005].

1.3 Sexual and Reproductive Health Services for Young People

Studies on sexual and reproductive health services targeting young people are few and sparse. A 2002 study conducted in Bulawayo, Zimbabwe through exit interviews among 30 service users and 3 focus group discussions with non-users aged 10-24 years found that young people shun the existing health services because of lack of knowledge about existing services, stigmatization and “adults bias” and neglect of young people’s sexual and reproductive health needs by service providers and policy makers. The study also found out that 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 prevent the young from utilizing the existing health services [Mashambe et al, 2002].

A study in 2009 which used simulated clients to assess whether voluntary HIV counseling and testing (VCT) services in Cape Town were accessible, acceptable, and appropriate for adolescents, and whether services provided by clinics involved in the National Adolescent-Friendly Clinic Initiative (NAFCI) were superior than others showed improvement in the accessibility of HIV testing for adolescents. However, the initiative did not have an impact on service acceptability measured by provider– client attitudes and respect for confidentiality. The study recommended that youth-friendly initiatives need to change clinic environment and provider attitude in order to make an impact on service acceptability [Mathews et al, 2009].

Similarly Warenius et al used 820 nurse-midwives in Kenya and Zambia to investigate their attitudes towards adolescent sexual and reproductive health problems and found that the nurse-midwives disapproved of adolescent sexual activity, including masturbation, contraceptive use and abortion. Another study by the African Youth Alliance [AYA, 2002] assessed youth friendly services in Dar es Salaam through interviews with facility managers, service providers and young clients and an examination of facility environment, material and provider/client interactions, and clinic service statistics revealed that about 80% adolescents did not spend adequate time with health providers, 90% felt that the providers did not pay attention to them, while another 80% were not happy with services at the reception. Nearly all reported that health providers did not explain and they also did not routinely discuss prevention of pregnancy and STI/HIV.

In 2005, the Kenya Medical Research Institute (KEMRI) carried out a cross-sectional survey of HIV/STI and pregnancy in Gem to provide baseline information for the development of sexual and reproductive health interventions for youth. A sub-study in the survey targeted adolescents aged 13-19 years to find out sexual behavior and existing and preferred sources of sexual and reproductive health information. There were 608 adolescents aged 15-19 years in this study and 7% reported that they get information from health service providers compared to 29% who said they get information from teachers and 18% who said that friends are their important sources of information. Only 14% reported having received sexuality information from a health service provider 6 months prior to the study [Vandenhoudt, et al, 2006].

1.4 How Young People Make Choices in Seeking Sexual and Reproductive Health Care

This research is informed by two theories namely: the Theory of Reasoned Action and the Rational Choice Theory. The Theory of Reasoned Action is a behavior change theory that has wide application in the sexual and reproductive health field. This theory has been used in the development of several evidence based youth HIV prevention interventions including **Parents Matter, Making A Difference and Making Proud Choices**, which have been culturally adapted for sub-Saharan Africa and are currently being scaled up in Kenya and other countries [Guilamo-Ramos et al, 2004, Poulsen et al, 2010].

The theory focuses on the relationship between attitudes and behavior and their role in shaping sexual and reproductive health behavior [Fishbein and Ajzen, 1975]. The theory proposes that behavioral intention is the most important determinant of behavior. In this study the decision to seek sexual and reproductive health services by young people is influenced by their behavioral intentions. The theory defines behavioral intentions as the perceived likelihood of performing a behavior, in this case, seeking sexual and reproductive health services. Behavioral intentions are in turn influenced by attitudes towards the behavior and the subjective norms. While attitudes towards the behavior relates to the individual’s evaluations of the perceived costs and benefits of performing the behavior and the belief that behavioral performance is associated with certain attributes or outcomes, subjective norms relates to belief about whether referents approve or disapprove the behavior.

The Rational Choice theory on the other hand proposes that patterns of behavior in society emerge from the choices individuals make as they try to maximize their benefits and minimize their costs. The theory makes the assumption that people make decisions about how they should act by comparing the costs and benefits of different courses of action. As a result, patterns of behavior within the society develop according to the choices they make.

Normally people make rational decisions based on their preferences; and the actions they take are influenced by the expectations about the outcomes of those actions. Actions are often expressed as a set. For example, if a young person has a sexual and reproductive health problem and has to choose between visiting a

traditional healer, a chemist to buy medicines, a private health facility, or a public health facility, their set of possible choice of actions could be: A = [Traditional healer, Chemist, Private facility, Public facility]

This theory forms the basis for studying the available sources of sexual and reproductive health services in order to understand the options available to young people and the different characteristics of available health services they consider when prioritizing sources of sexual and reproductive health services.

II. Methodology

2.1 Study Site

The study was carried out in Wagai and Karemo divisions of Siaya County. The county has an area of 1,520sq km and an estimated population of 493,326 people (2008). Sixty eight percent of the urban population in Siaya County resides in Karemo Division an area approximately 235 Km² with a population of 76,986 served by 9 government, 2 church, 2 private and 1 community health facilities. Wagai division covers an area of 193 Km² and has a mainly rural population of 54,438 served by 8 government and one church health facilities. It is the only division in the county with a standalone health facility targeting young people.

2.2 Study Design

The study collected both qualitative and quantitative data from young people and health service providers in Karemo and Wagai divisions in two phases. The research conducted focus group discussions (FGD) with 68 adolescents aged 15-19 years divided into several groups to assess general knowledge about sexual and reproductive health problems, available and preferred sources of sexual and reproductive health services, and perceptions about seeking sexual and reproductive health services in health facilities. The research collected information about the range of available services, their utilization, characteristics of the facilities, and attitudes of health providers. Fourty one providers in the study area were interviewed to assess their attitudes towards provision of sexual and reproductive health services to adolescents. Exit interviews with 100 adolescents were also conducted to assess their satisfaction with all health services provided at the clinics.

2.3 Sampling Procedures

Four day secondary schools – two in each division - with the highest student population were identified, and a complete list of all students aged 15-19 years compiled. A random sample of five male and five female students was then generated. All registered youth groups from the same village where a day secondary school was selected were also asked to identify 15-19 years out of school adolescents within their community and a random sample of ten adolescents (5 male and 5 female) were selected to participate in the FGD. The research also selected health service providers from 22 health facilities. The nurse-in-charge in each of the 22 health services and the District AIDS and STI Coordinator (DASCO) at Siaya District Hospital participated in the service provider interviews. One non-clinical staff from each of the 22 health facilities was randomly selected to participate in the service provider interviews. Finally, a random sample of 10 facilities, 5 from each division was selected for client exit interviews which were conducted for 4 consecutive days in a week. Two to three exit clients were interviewed per day per facility. Quantitative data was analysed through SAS while NVivo8 was used to analyze qualitative data.

III. Results

3.1 Socio-demographic characteristics

Some 43% (72) respondents aged 15-19 years in the study were male. The median age for both boys and girls was 17 years. Close to half 49% (82) respondents had lost either one or both parents and 39% (66) were out of school at the time of the study (table 1).

Table 1: Socio-Demographic Data for Adolescent Participants (N=168)

| Socio-Demographic Characteristics | N (%) |
|--|--------------|
| Gender | 72 (43%) |
| Male | 96 (57%) |
| Female | |
| Age | 24 (14%) |
| 15 | 30 (18%) |
| 16 | 43 (25%) |
| 17 | 38 (23%) |
| 18 | 33 (20%) |
| 19 | |

| | |
|---------------------|-----------|
| Parents Alive | 86 (51%) |
| Yes | 13 (8%) |
| No Mother died | 41 (24%) |
| No Father died | 28 (17%) |
| No Both died | |
| Currently a student | 102 (61%) |
| Yes | 66 (39%) |
| No | |
| Occupation | 6 (3.5%) |
| Farmer | 4 (2%) |
| Casual Worker | 6 (3.5%) |
| Self-employed | 5 (3%) |
| Homemaker | 102 (61%) |
| Student | 45 (27%) |
| Other | |

Source: Research Survey 2011

3.2 Socio-demographic characteristics of health service providers

Some 71% (29) health providers were female and the median age was 43 years for males and 35 for females. Also 78% (32) health providers were married and only 7% (3) were enrolled as a student at the time of the study. More than half, 54% (22), of service providers were involved in providing clinical services while the rest, 46% (19), were sub-ordinate staff. The summary of the socio-demographic characteristics of service providers interviewed in the study is provided below in table 2.

Table 2: Socio-Demographic Data for Health Service Providers (N=41)

| Variable | N (%) |
|------------------------------------|----------|
| Gender | |
| Male | 12 (29%) |
| Female | 29 (71%) |
| Age | |
| 20 - 29 | 4 (10%) |
| 30 - 39 | 19 (46%) |
| 40 - 49 | 10 (24%) |
| 50 - 59 | 8 (20%) |
| Marital Status | |
| Single | 5 (12%) |
| Married | 32 (78%) |
| Widowed | 4 (10%) |
| Currently a student | |
| Yes | 3 (7%) |
| No | 38 (93%) |
| Position in health facility | |
| Cleaner | 7 (17%) |
| Security Officer | 1 (2%) |
| Clerk/Secretary | 8 (20%) |
| Registered Nurse | 8 (20%) |
| Nurse Aid | 13 (32%) |
| Clinical Officer | 1 (2%) |
| Other | 3 (7%) |

Source: Research Survey 2011

3.3 Description of health facilities

The study conducted an inventory of all 23 health facilities within Karemo and Wagai divisions. Nine facilities are located in Wagai division while the rest are in Karemo division. Fifty six percent (13) are dispensaries and 22% (5) are health centers. About three quarters of facilities (17) are government run, 13% (3) are affiliated to the church, and 9% (2) are privately owned while 4% (1) is affiliated to a community based organization (table 3).

Table 3: Description of Health Facilities (n=23)

| Variable | N (%) |
|-----------------------|------------|
| Facility Level | |
| District | 1 (4.4%) |
| Health Center | 5 (21.7%) |
| Dispensary | 13 (56.4%) |
| Clinic | 1 (4.4%) |

| | |
|-------------------------------|------------|
| Missionary | 1 (4.4%) |
| Other | 2 (8.7%) |
| Facility Type | |
| Government/Ministry of Health | 17 (73.9%) |
| Faith Based | 3 (13%) |
| Community Based | 1 (4.4%) |
| Private | 2 (8.7%) |

Source: Research Survey 2011

3.4 Available and Preferred Sources of Sexual and Reproductive Health Services

The research assessed the facilities for availability of counseling services in sexual and reproductive health topics like sexuality, relationships, growing up, abstinence, nutrition, rape, sexual abuse and violence, abortion, STI, contraceptives, and male involvement; Voluntary Counseling and Testing (VCT); treatment services; screening for both STIs and pregnancy; life skills training as a key component of building sexual and reproductive health.

The research found that 2 facilities provided 95% of these services, 9 facilities provided between 71% and 86% of these services, 7 provided less than half of the services, while the remaining two provided 38% of these services. There was no significant difference in scores between government run facilities (64%) and non-government run facilities (68%). Facilities in Wagai division recorded a mean score of 67% while facilities in Karemo division recorded a mean score of 62%.

All 23 facilities provided general counseling, treatment for general ailments and ante- and post-natal care services. Similarly 22 health facilities provided other highly available services including STI counseling, referral services and contraceptives. Contraceptive counseling and HIV treatment were available in 87% (20) and 70% (16) of facilities respectively. Life skills training services were only available in 17% (4), STI screening in 26% (2), sexual abuse and violence counseling in 35% (8) and growing up counseling in 39% (9) of these facilities. Despite availability of a wide range of sexual and reproductive health services, several essential services for adolescents like care for survivors of sexual abuse and violence [MOH, 2005] and STI diagnosis [AYA, 2003] were available in less than half of all facilities.

3.5 Availability of health service providers

The presence of health service providers has a direct impact on availability and quality of health services. The 23 health facilities were served by 706 service providers. Some 29% (207) providers were clinical service providers including 6 medical officers, 23 clinical officers, 149 nurses, 3 registered midwives, 9 pharmacists and 17 laboratory technologists. Some 338 (48%) providers were non-clinical providers. They included 10 HIV counselors, 321 community health workers, 4 social workers and 3 public health officers. The remaining 161 (23%) were sub-ordinate staff providing support services.

Table 4: Health Service Providers by Provider Category, Facility and Location

| Category | Wagai | | Karemo | | Total (%) |
|---------------------|----------|---------|----------|---------|------------|
| | GoK | Non-GoK | GoK | Non-GoK | |
| Clinical | 23(69%) | 10(31%) | 131(76%) | 43(33%) | 207(29%) |
| Non-Clinical | 187(99%) | 2(1%) | 141(95%) | 8(5%) | 338(48%) |
| Subordinate | 31 (72%) | 12(28%) | 70(59%) | 48(41%) | 161(23%) |
| Total (%) | 241(91%) | 24(9%) | 342(76%) | 99(24%) | 706 (100%) |

Source: Research Survey 2011

3.6 Other youth friendly characteristics of health facilities

In addition to availability of health services and health service providers, the study also assessed other variables related to youth friendliness in regard to sexual and reproductive health services. Braeken et al, 2007 and Olowu, 1998 have listed several other indicators that the youth find friendly about health facilities including cost of services, facility location and environment, preparedness of service providers through training, policies, and availability of IEC material (table 5). Our results found that the cost of accessing all categories of the health services was not a big issue amongst the adolescents.

Most of the facilities were located about three quarters of a kilometer from a public utility. Non-government run facilities were located nearer to public utility at an average of 154 meters from a road, shopping center or a school compared to 927 meters for government run facilities. In Wagai, clients travelled an average of 1 kilometer from a public utility to access a health facility.

The research also gave each facility a score on various aspects of service provision. All facilities scored an average of 42% for appropriateness of the facility environment, 28% for provider preparedness, and 31% for policies that favor provision of sexual and reproductive health services to adolescents. Government facilities were found to invest more in staff training (25.9%) compared to non-government facilities (4.3%). However

non-government facilities utilized more youth friendly policies in their procedures (50%) compared to government facilities (24.5%) as shown in Table 5 below.

Table 5: Other Youth

| | Cost | Location | Environment | Training | Policies | IEC Material |
|----------------|--------|----------|-------------|----------|----------|--------------|
| Wagai | 31.11 | 1040.6 | 38.9% | 28.9% | 37.0% | 16.1% |
| Karemo | 227.14 | 622.7 | 45.2% | 28.6% | 27.4% | 18.1% |
| GoK | 30 | 907.6 | 40.2% | 25.9% | 24.5% | 17.2% |
| Non GoK | 491.67 | 154.6 | 50.0% | 50.0% | 50.0% | 2.9% |

Friendly Characteristics of Selected Health Facilities

Source: Research Survey 2011

3.6 Availability and Preference of Sexual and Reproductive Health Services

Results of FGDs indicated that adolescents were aware of the availability of general treatment services but said they would be happier if they received information about sexual and reproductive health from parents, guidance and counseling, and health service providers. They said that information on abstinence and safe sex was scanty. They were also found to be aware that circumcision, contraceptives, ante- and post-natal care, delivery, testing services (for HIV and pregnancy) and treatment services (for HIV and STI) are available in local health facilities. They complained that health service providers offered medicines without providing counseling services on the benefits of the medicine.

The research also found that adolescents got information about the existing facilities and services through their parents and teachers, door-to-door campaigns, media, friends, and posters. The adolescent preferred counsel from parents because the latter were able to take action and help adolescents' access medical care. The adolescents also preferred to get information from health service providers because they offered advice on technical health issues such as HIV treatment. Adolescents also preferred to seek information from friends and peers because they thought that peers were also going through similar challenges.

The adolescents preferred to take HIV tests in VCT centers because they maintained privacy and confidentiality. They also preferred facilities with integrated adolescent programs because on top of getting the services they were also entertained. They also opted to visit private health facilities whenever they sought abortion and other teenage pregnancy related issues. The reason why they visited public health facilities was because they were guaranteed of cheap and affordable services.

3.7 Health Service Utilization by Adolescents

The second objective of the study was to estimate the proportion of health service users who are adolescents aged 15-19 years. This data for this research was collected during the period October to December 2009 from all health facilities in the study area. During that period both children and adults made a total of 35,683 visits to the 23 health facilities. The adolescents between 15-19 years made 4,932 (17.2%) visits. Female adolescents made 2,965 (60%) of the visits compared to 1967 (40%) visits male adolescents. Of all the visits made 7,758 were for HIV care and treatment services and 1,129 for VCT services. Adolescent visits for HIV care and treatment and VCT services was 116 (1.49%) and 201 (17.8%) respectively. More adolescents visited facilities in Wagai for curative (21.9%) and VCT (32.6%) services. The adolescents also made more visits for curative (23.8%) and HIV (2.1%) services in the non government run facilities.

About three quarters 77% (27,331) of the total visits and 64% (3,245) of visits by adolescents aged 15-19 were in Karemo. Some 91% (32,482) visits were in government run facilities and they accounted for 86% (4,244) of visits made by adolescent clients aged 15-19. Again Karemo division recorded 1952 total client visits per facility compared to 928 in Wagai, and 225 adolescent visits per facility compared to 199 in Wagai. Government run facilities on the other hand recorded 1,911 total visits per facility compared to 534 in non government facilities, and 250 adolescent visits per facility compared to 115 in non government facilities (Tables 6, 7 and 8 below).

Table 6: Utilization of Health Service by Facility, Location and Type

| Utilization of Health Services | | | | | | |
|--------------------------------|----------------|---------------|-----------|---------------|------------------------|---------------|
| | | Total Clients | | | 15-19 Year Adolescents | |
| | Category | Facility | Frequency | Freq/Facility | Frequency | Freq/Facility |
| Location | Karemo | 14 | 27331 | 1952.21 | 3145 | 224.64 |
| | Wagai | 9 | 8352 | 928 | 1789 | 198.78 |
| Facility Type | GoK | 17 | 32482 | 1970.71 | 4244 | 249.65 |
| | Non GoK | 6 | 3201 | 533.5 | 688 | 114.67 |

Source: Research Survey 2011

Table 7: Utilization of Health Service by Service Type and Facility Location

| | Curative Services | | HIV | | VCT | |
|----------------------|-------------------|--------|-------|--------|--------|--------|
| | Wagai | Karemo | Wagai | Karemo | Wagai | Karemo |
| Total Clients | 7609 | 19187 | 381 | 7377 | 362 | 767 |
| 15-19 Years | 1666 | 2949 | 5 | 111 | 118 | 83 |
| %15-19 Years | 21.90% | 15.37% | 1.31% | 1.50% | 32.60% | 10.82% |

Source: Research Survey 2011

Table 8: Utilization of Health Service by Service Type and Facility Type

| | Curative Services | | HIV | | VCT | |
|----------------------|-------------------|---------|-------|---------|--------|---------|
| | GoK | Non GoK | GoK | Non GoK | GoK i | Non GoK |
| Total Clients | 24265 | 2531 | 7570 | 188 | 647 | 4182 |
| 15-19 Years | 412 | 603 | 112 | 4 | 120 | 81 |
| %15-19 Years | 16.53% | 23.82% | 1.48% | 2.13% | 18.55% | 16.80% |

Source: Research Survey 2011

3.8 Attitude of Health Service Providers towards Adolescents

The third objective of the study was to assess the attitude of health service providers towards the sexual and reproductive health needs of adolescents and the provision of these services to adolescents. The research interviewed a total of 41 service providers and 85% (35) felt that adolescents should be provided with condoms and allowed to use them; 80% (33) said adolescents should be taught how to use contraceptives; 78% (32) said adolescents should be free to have sex when they decide to; and 53% (22) said adolescents should be provided with contraceptives and allowed to use them. More clinical providers (98%) felt that adolescents should be provided with condoms and taught how to use them compared to 71% among non-clinical providers. Similarly 80% clinical providers felt that adolescents should be provided with contraceptives and taught how to use them compared to 58% among non-clinical providers.

Those with opposite views said that teaching adolescents how to use condoms would promote sexual activity. About half, 53% (22) service providers felt that parental consent should be sought before providing sexual and reproductive health services to adolescents. Whereas 59% of clinical service providers felt that teaching adolescents about condom and contraceptives use does not promote sexual activity, only 16% of non-clinical providers felt the same way. Similarly 45% of clinical service providers felt that providing adolescents with condoms and contraceptives does not promote sexual activity compared to 21% of non-clinical service providers who felt the same way. There was no significant difference in provider attitudes between service providers in government facilities and those from non-government facilities.

3.9 Adolescent Clients' Satisfaction with Health Services Provided in Public Facilities

The research interviewed 100 (60 female and 40 male) adolescents at the point of exiting services in 10 public health facilities in the two divisions to assess whether they were satisfied with the services offered. Some 61% adolescents 21 males and 40 females were sexually active. Thirty one (50%) females were pregnant, and 24% (14) were married, while all the males were single.

In order to understand the reasons why the adolescents sought health services from the facilities they visited the research requested them to mark all health services they sought at the time of the interview. A total of 111 marks were made with 68% (76) indicating that they sought general curative services, 16% (18) sought ante- and post-natal care, while 2% (3) sought HIV care and treatment. Only 1% adolescent in exit interviews sought HIV counseling, STI testing, HIV testing, pregnancy testing, and contraceptives.

Some 83% respondents said they visited the facility because it was close to home, 14% (14) respondents said it was affordable, 8%(8) said it was recommended by their friends, while 6% (6) said they visited the facility because it offered sexual and reproductive health services. Others said they admired the attitude of service provider 5% (5), short waiting time 2% (2), and 1% respondents said facility operated for 15 hours. Additionally 72% (72) respondents said the fees were affordable, all clients said it took them an average of 42 minutes to travel to the health facility and it took about 37 minutes before receiving services.

We also asked respondents to state how well they were received at the clinics, whether the waiting areas were comfortable or not, and how convenient was the location of the facility to their health needs. Some 32% and 60% respondents found the environment of the health facility very welcoming and welcoming respectively; 16% and 66% found the waiting area very comfortable and comfortable respectively; and 23% and 61% found the facility location very convenient and convenient respectively. There was no significant difference in the way the respondents perceived the different health facilities.

Seventy four percent respondents said they were welcomed at the facility by a sub-ordinate staff, 22% by a nurse while 1% by a clinical officer and 3% by an administration staff. Seventy three percent who were welcomed by either a sub-ordinate staff or an administration staff said the staff was either very welcoming (22%) or welcoming (51%). Some 66% of these respondents were directed on where to wait for the next service;

5% were informed on how long they would wait; 28% were told who would attend them and 17% were told what would be required of them. All 23% respondents welcomed by medical staff reported the staff was very welcoming (11%) or welcoming (12%).

Majority respondents said the provider was either very friendly (39%) or friendly (58%). Similarly 50% respondents said the provider was very prepared and 48% said prepared. All respondents said the provider either listened very well (57%) or listened (43%). Some 40% respondents were given an opportunity to ask questions and had their questions well answered. Seventeen percent respondents felt that someone could overhear their conversation with the service provider while 11% had their session with the service provider interrupted. Some 89% and 78% respondents felt they could trust the service provider and other members of staff at the facility respectively to maintain confidentiality, while 6% respondents asked for parental consent in order to visit the health facilities.

Majority respondents (95%) indicated that they were either “very satisfied” or “satisfied” with the services they received on the day of the interview. Some 90% (36) male and 98.3% (59) female respondents said they would visit the facilities once more for similar or related services. The respondents wished to get a warm welcome 37% to be listened to 28%, to be given time to ask questions (39%), to have more privacy (24%), to spend less time waiting (44%); and to have clear directions on what to expect (23%) during the next visit. More females than males would want to be given time to ask questions (43% for females and 36% for males); to have more privacy (31% for females and 16.7% for males); and to spend less time waiting (51.7% for females and 36.1% for males).

Table 9: Rank of Facility Features by Adolescent FGD Participants

| Rank | IN | OUT | COMBINED |
|------|--------------------------|--------------------------|--------------------------|
| 1 | availability of services | availability of services | availability of services |
| 2 | attitude of provider | Privacy | Privacy |
| 3 | Privacy | Cost | Cost |
| 4 | Cost | attitude of provider | attitude of provider |
| 5 | operating hours | waiting time | waiting time |
| 6 | waiting time | facility environment | operating hours |
| 7 | Location | location | facility environment |
| 8 | facility environment | operating hours | Location |
| 9 | IEC material | provider competence | IEC material |
| 10 | provider competence | age of provider | provider competence |
| 11 | age of provider | IEC material | age of provider |
| 12 | gender of provider | gender of provider | gender of provider |

Source: Research Survey 2011

We also asked the FGD participants to state what they thought should be done to improve the provision of sexual and reproductive health services to adolescents and their answers included: make sexual and reproductive health services available to adolescents; ensure confidentiality; facilities should recruit providers with an open mind, friendly and who have specialized training on handling adolescents; that facilities hold regular sensitization meetings with adolescents to inform them of available services, and use peer counselors and the media to conduct community mobilization; provide moonlight services to target adolescents who have no time during the day; and that facilities take time to understand the needs of the targeted adolescents (table 9 above).

IV. Summary

The study examined availability of essential sexual and reproductive health services for young people as a critical measure of youth friendliness of health facilities. Several studies have underscored the important role played by service providers in promoting acceptability of health care services [Mathews et al, 2009; Warenius et al, 2006]. The findings of this study confirm those of Warenius et al. that nurse-midwives disapproved of adolescent sexual activity, including contraceptive use and abortion. Whereas 80% of sexual and reproductive health service providers interviewed had positive attitudes towards providing adolescents with sexual and reproductive health services such as condoms and contraceptives and teaching them how to use these services when they decide to, only about 36.5% felt that providing these services and teaching adolescents how to use them would not necessarily promote sexual activity. More clinical service providers had positive attitudes towards providing adolescents with sexual and reproductive health services and teaching them how to use those services compared to non-clinical and sub-ordinate service providers.

The study found that 82% respondents chose a health facility due to its location from their homes. On the other hand FGD participants chose a facility due to availability of services, privacy, provider attitude, cost and waiting time. The gender of provider, age of provider, IEC material and provider competence were the least considered aspects in choosing a facility. Ninety two percent respondents said the facility environment was

welcoming, the waiting area was comfortable (82%) and the facility location was convenient (84%). The respondents were also generally happy about their interactions with the service provider. Ninety seven percent said the provider was friendly; 98% said the provider was well prepared and all (100%) said the provider listened well. Ninety five percent respondents indicated that they were either “very satisfied” or “satisfied” with the services they received and 90% of the boys and 98.3% of the girls said they would come back to the facility for similar or related services.

V. Conclusion and Recommendations

This study assessed the provision of sexual and reproductive health services to adolescents in two divisions of Siaya district. From the findings, it is clear that the four aspects of youth friendliness of sexual and reproductive health services are not fully addressed.

The study shows that majority of the health facilities do not provide the minimum and essential sexual and reproductive health services to the adolescents. Despite availability of a wide range of sexual and reproductive health services, several essential services for adolescents such as care for survivors of sexual abuse and violence [MOH, 2005; Braeken et al, 2007; UNFPA, 2008, Dickson et al, 2007; UNFPA, 2008; WHO, 2000; WHO, 2002], STI diagnosis [AYA, 2003] were available in less than half of all facilities. Equally, many of the health facilities did not have direct strategies for reaching out to young clients. It is therefore tempting to conclude that most services provided in these facilities were geared towards adults.

With regard to accessibility of services, the average cost of services was generally affordable to adolescents. However, many of the facilities examined in this study lacked adequate personnel and had providers whose attitude towards provision of sexual and reproductive health services to adolescents was not positive. Findings of this study raise a question about what has the greatest effect on the service provider when he/she is providing services; is it their knowledge of policy requirements that adolescents do have a right to sexual and reproductive health services, or is it their (providers’) own judgment about the outcome of providing sexual and reproductive health services to adolescents?

The study shows that providers are well informed about the need to provide sexual and reproductive health services to adolescents. They however have negative perceptions about the potential outcome of providing such services to adolescents. To address this problem, service providers need to be put in intensive training focused on attitude change. In addition, a lot of work is needed to change the structural operations of many of the facilities including policies, facility environment, training of personnel and use of IEC material.

Knowledge of the fact that adolescents do rate service providers as the preferred source of sexual and reproductive health services particularly those relating to complicated and sexual and reproductive health needs such as treatment services is encouraging. However more effort is required to ensure availability, access and utilization of sexual and reproductive health services. A good start is to encourage service provider to increase the amount and quality of time they spend educating adolescent clients on sexual and reproductive health.

References

- [1]. Braeken D, Otoo-Oyortey N, and Serour G. 2007. Access to sexual and reproductive health care: adolescents and young people. *International Journal of Gynecology and Obstetrics* 98 (2007), 172-174.
- [2]. Rose, Dick, and Ferguson (eds.) 2006. “Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries (Steady, Ready, Go!).” Geneva: WHO.
- [3]. Vandenhoudt H, Njue C, Remes P, Buve A. (2001) (Unpublished report). Reproductive health problems of youth in Nyanza
- [4]. UNAIDS. AIDS epidemic update : December 2007
- [5]. Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro.
- [6]. WHO (2002). Adolescent friendly health services: an agenda for change. WHO Geneva, October 2002
- [7]. WHO (2006). Building a better future for youth: Learning from experience and evidence,” Africa Regional Forum on Youth Reproductive Health and HIV, 6-9 June 2006, Dar-es-Salaam, Tanzania.
- [8]. Vandenhoudt H, T Thomas and P Nasokho (2006) (unpublished work) Gem HIV, STDs and Pregnancy Baseline Cross Sectional Survey
- [9]. UNFPA: Reproductive Health Services: <http://www.unfpa.org/rh/services.htm>; accessed 20th May 2008.
- [10]. Sovd T, Mmari K, Lipovsek V, and Manaseki H S. 2006. Acceptability as a key determinant of client satisfaction: lessons from an evaluation of adolescent friendly health services in Mongolia. *Journal of Adolescent Health* 38,(2006), 519–526
- [11]. WHO (2000). Progress in Reproductive Health Research. Geneva, 2000, 53:1. African Youth Alliance (2002). Needs assessment report for youth friendly services in Tanzania.
- [12]. Hallman K.K. (2009) Researching the Determinants of Vulnerability to HIV among Adolescents. *IDS bulletin* 39(5), 2009, :36-44
- [13]. Fylkesnes K., Musonda R.M., Sichone M., Ndhlovu Z., Tembo F., and Monze M. (2001). Declining HIV prevalence and risk behaviours in Zambia: evidence from surveillance and population-based surveys. *AIDS*. 15(7), 2001, 907-916
- [14]. Senderowitz, J. 1999. Making Reproductive Health Services Youth Friendly. Washington DC: FOCUS on Young Adults
- [15]. African Youth Alliance/Pathfinder (2003). Youth-friendly sexual and reproductive health services: an assessment of facilities.
- [16]. Tylee A., Haller DM., Graham T., Churchul R., and Sancu LA. 2007. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet* 369, 2007, 1565-73
- [17]. Hughes J and McCauley A. Improving the fit: adolescents’ needs and future programs for sexual and reproductive health in developing countries. *Studies in Family Planning* ; 29(2), 1998, 233–245.

- [18]. Folarin. Quality and costs of family planning as elicited by an adolescent mystery client trial in Nigeria. *African Journal of Reproductive Health* 2(1), 1998, 49-61
- [19]. Muga Richard, Patrick Ndavi, Paul Kizito, Robert Buluma, Vane Lumumba, Paul Ametepi, Nancy Fronczak, and Alfredo Fort. 2005. Kenya HIV/AIDS Service Provision Assessment Survey 2004.
- [20]. Erulkar AS, Onoka CJ, and Phiri A (2005). What is youth-friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe. *African Journal of Reproductive Health*, 9(2), 2005, 1-58.
- [21]. Mathews C, Guttmacher SJ, Flisher, FC, Mtshizana YY, Nelson T, McCarthy J and Daries V (2009) The Quality of HIV Testing Services for Adolescents in Cape Town, South Africa: Do Adolescent-Friendly Services Make a Difference? *Journal of Adolescent Health* 44, 2009, 188–190.
- [22]. Guilamo-Ramos V, Jaccard J, Casillas E. (2004). The Parents Matter! Program: Practical, theoretical and methodological perspectives. *Journal of Child and Family Studies*, 13, 113-123
- [23]. Poulsen MN, Vandenhoudt HA, Wyckoff SC, Obong'o C, Ochura J, Njika G, Otwoma NJ, Miller, KS. (2010). Cultural adaptation of a US evidence-based parenting intervention for rural Western Kenya: From Parents Matter! to Families Matter! *AIDS Education and Prevention*, 22(4).
- [24]. Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley
- [25]. Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall
- [26]. Ministry of Finance, Siaya District Development Plan 2002 – 2008, Nairobi, 2002
- [27]. Ministry of Gender, Sports, Culture & Social Services, Kenya National Youth Policy, 2005
- [28]. UNICEF, UNAIDS, WHO. *Young people and HIV/AIDS – opportunity in crisis*. New York, UNICEF, 2002.