

**FACTORS INFLUENCING ACCESS AND UTILISATION OF  
PREVENTIVE REPRODUCTIVE HEALTH SERVICES BY  
ADOLESCENTS IN KENYA. A CASE STUDY OF MURANG'A  
DISTRICT**

DISSERTATION

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By

Anne Wairimu Kamau, M.A



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Dissertation advisors:

Prof. Dr. med. Ulrich Laaser, D.T.M. & H., M.P.H

Priv.-Doz. Dr. med. DrPH Reinhard Bornemann

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“...human sexuality is just a vital. In some ways, in fact, the  
consequences of skipping math are less consequential than  
ignorance about sexuality -- the misuse of algebra is not likely to  
cause an unintended pregnancy...”

Don Ardell, 2002

## **ABSTRACT**

Sexual and reproductive health is part of physical and emotional well-being of all human beings. Adolescents globally have unique sexual and reproductive health needs and accompanying vulnerabilities. Many adolescents face sexual health risks of early sexual debut, sexually transmitted infections including HIV/AIDS, unplanned pregnancies and illegal abortions. These challenges threaten their health and survival. The 1994 International Conference on Population and Development stressed that adolescent sexual and reproductive health needs are basic human rights. It emphasised the need to offer sexual health services and information to adolescents and to address reproductive health challenges across the lifespan. For adolescents to effectively transit into adulthood, they need to be provided with factual, affordable, accessible, confidential, non-judgemental and friendly sexual health information and services. Despite this recognition, adolescent preventive reproductive health services (PRHS) and programmes remain largely inadequate in sub-Saharan Africa. In Kenya, efforts to provide reproductive health care services to adolescents have faced numerous challenges. These challenges include lack of mandatory health insurance, inadequate health facilities, and shortage of health care providers. The lack of decentralized health care delivery system in Kenya causes disparities in service provision, favouring urban as opposed to rural areas.

The purpose of this study was to establish the factors that influence access and utilisation of preventive reproductive health services by the in-school adolescents in Kenya. This goal was achieved by carrying out a four months research in Murang'a District of Kenya. The study focused on five priority themes: (i) Understanding of sexual health concerns of adolescents, (ii) The availability of preventive reproductive health services for adolescents, (iii) The level of access and utilisation of preventive reproductive health services by adolescents, (iv) Existing reproductive health policies for adolescents and how they affected adolescents access and provision of services, and

(v) Understanding of the challenges faced by adolescents in accessing and utilising the services. Data were collected by carrying out structured face-to-face interviews with 114 in-school adolescents, 25 health providers and 18 key informants. The study also used documents analysis and observation methods. Qualitative data were analysed using content analysis, whereas quantifiable data were coded and analysed using SPSS.

This study has established that adolescents had unmet behavioural, psychosocial, emotional, maturation, developmental and gender-specific sexual and reproductive health needs and concerns. It has further established that Murang'a District did not have specific adolescent friendly preventive reproductive health services. The level of access and utilisation of preventive reproductive health services by adolescents was low. This was due to the following factors: - lack of adolescent-friendly services, inadequate school health services, and lack of adequate awareness among adolescents on available preventive reproductive health services. Other factors included lack of clear and effective policies to guide provision of preventive reproductive health services to adolescents, lack of adequate awareness among health providers and caregivers about existing adolescent reproductive health policies, restrictive eligibility criteria and rigid legal requirements for parental consent, judgmental attitude and professional bias among health providers.

This study has further established that there existed communication challenges that affected the level of access and utilisation of PRHS by adolescents. Adolescents were embarrassed and shy to share sexual health concerns with their parents, with familiar health providers, and with health providers of the opposite sex. The findings further show that the health providers faced considerable challenges that hampered their ability to adequately offer PRHS to adolescents. The challenges arose from staff shortages and heavy workload, lack of adequate reliable transport means, weak outreach health programmes targeting adolescents, poor set-up of health facilities and lack of friendly environment, inappropriate labelling of services, inadequate consulting rooms and space and inappropriate and non-confidential condom outlets.

Drawing from the lifespan theoretical concepts, this study has concluded that there existed a service gap in provision of adolescent preventive reproductive health services. Adolescents continued to be socially excluded from accessing and utilising preventive reproductive health services. Existing reproductive health policies and services emphasise post-exposure reproductive health services, as opposed to pre-exposure reproductive health services. Consequently, adolescents mainly seek post-exposure services.

The following were identified as areas for improving adolescents access and use of services. Expanding and intensifying provision of standard adolescent-friendly services; use of information packs and brochures to increase awareness and sensitisation of adolescents, health providers, caregivers, teacher, parents, communities and key stakeholders about reproductive health services for adolescents; engendering adolescent health services to meet the needs of boys and girls; development and regular review of adolescent reproductive health policies and guidelines, and development of clear working definition of adolescent. Other recommendations include: strengthening of school health and outreach services; regular training and in-servicing of health providers, teachers, school caregivers and counsellors to effectively serve adolescents; initiation and provision of parents' guidance and counselling to educate them about adolescents sexual and reproductive health and about adolescents rights to confidential and comprehensive services.

This study further recommends the need to strengthen public-private sector partnership and stakeholder participation in adolescent health, active involvement of adolescents in their reproductive health matters, continuous data gathering on reproductive health indicators of adolescents, monitoring and evaluation of adolescents services. All these have implications for immediate and future reproductive health of adolescents, and for bridging the reproductive health service gap across the lifespan.

## **DEDICATION**

**To my late grandmother (Veronica Wairimu)**

*Cucu*, your prayers, inspiration and wisdom are deeply missed and cherished. They say - *the greatest soul is the heart* - RIP.

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## DECLARATION

I, the undersigned, confirm that this dissertation is all my own work. Reference to, quotation from and discussion of the work of any other person has been correctly acknowledged within this dissertation. Any errors and omissions are however the responsibility of the author.

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Ich erkläre hiermit, dass Ich die vorliegende Dissertation selbst angefertigt habe und keine anderen als angegebenen Quellen und Hilfsmittel verwendet habe. Alle Textstellen, die dem Wortlaut nach anderen quellen entnommen sind, habe Ich unter Angabe der Quellen als Zitat gekennzeichnet.

Anne W. Kamau

Bielefeld, July 2006.



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## ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ASRH	Adolescent sexual and reproductive health
CBO	Community based organisation
CBS	Central Bureau of Statistics (Kenya)
DASCO	District AIDS/STDs Coordinator
DEO	District Education Office(r)
DMOH	District Medical Officer of Health
DPHN	District Public Health Nurse
DSDO	District Social Development Officer
FBO	Faith (religious) based organisation
FGM	Female genital mutilation
FP	Family planning
FPFS	Family Planning Private Sector
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IWHC	International Women's Health Coalition
JSI	John Snow International
KDHS	Kenya Demographic and Health Survey
KECHN	Kenya enrolled community health nurse
MCH	Maternal and Child Health
MoE	Ministry of Education (Kenya)
MoH	Ministry of Health (Kenya)
NACADA	National Agency for the Campaign against Drug Abuse (Kenya)

NACC	National AIDS Control Council (Kenya)
NCPD	National Council for Population and Development (Kenya)
NGO	Non-governmental organisation
PHO (T)	Public Health Officer (Technician)
PLWAs	People Living With AIDS
PRH	Preventive Reproductive Health
PRHS	Preventive reproductive health services
RHS	Reproductive health services
RoK	Republic of Kenya
SRH	Sexual and reproductive health
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organisation

# CHAPTER 1

## INTRODUCTION

### 1.1 Background

Adolescent sexual and reproductive health has gained increased attention among researchers, public health experts and policy makers over the past decade. Adolescence is a time of rapid growth and development. Major physical, cognitive, emotional, sexual and social changes that affect adolescent behaviour occur during this period. Contrary to the early development theorists notion that adolescents are a relatively healthy group with no major physical illness (Dehne and Riedner, 2005), there is now substantial literature indicating that adolescents face unique reproductive health challenges. The 1994 International Conference on Population and Development (ICPD) marked a paradigm shift by recognising that adolescents have unique needs and vulnerabilities. Many adolescents increasingly become sexually active before the age of 20 (WHO, 2003a) and many face difficulties in obtaining reproductive health care. Also adolescents are typically poorly informed about how to protect themselves from pregnancies and sexually transmitted diseases.

Researchers have explored the need to provide adolescent-friendly sexual and reproductive health services to curtail adolescents exposure to sexual health risks of unintended pregnancies, sexually transmitted infections (STIs) including HIV/AIDS, and early sexual debut (McIntyre, 2002; Dehne and Riedner, 2005). The ICPD highlighted the vulnerabilities of adolescence and called for greater recognition of adolescents as a special category with special needs. It emphasised the need to provide adolescents with sexual and reproductive health information and services and for adoption of integrated and comprehensive approaches to reproductive health. Additionally, the ICPD underscored the need to remove social barriers that hinder

adolescents access to reproductive health services, and to modify policies and programs to meet the demographic realities of the 21st century (Germain, 2000). Thirty-eight of the participating countries from sub-Saharan Africa, Kenya included, committed themselves to a Program of Action aimed at providing adolescents with sexual and reproductive health education, information and services. This, it was hoped, would help adolescents to understand their sexuality and protect themselves from sexual health risks (United Nations, 1995).

Despite the call by ICPD and Kenya's commitment to the Program of Action, adolescents in Kenya lack access to sexual and reproductive health services. Also, despite evidence that adolescents face sexual health risks, the perception of 'healthy adolescents' persists. Adolescents globally access health services less frequently than expected and are more likely to seek services after sexual exposure (Hocklong et al. 2003). Although adolescents both in the developed and developing countries face challenges in accessing reproductive health services, there exist regional differences with adolescents in developing countries facing greater challenges.

Although there is substantial literature about adolescent-friendly services, few studies have looked at the factors determining the extent to which adolescents access and utilise existing services. Still, whereas 'adolescent-friendly services' and 'youth-friendly clinics' are seemingly global concepts, and the norm in developed countries and certain urban areas of developing countries, adolescent-friendly services are largely lacking in developing countries. The marginalisation of rural areas creates further challenges for adolescents wishing to access and utilise preventive reproductive health services (PRHS). Attempts to provide adolescents with reproductive health services have focused mainly in the urban areas leaving out the rural areas. However, even in the urban areas, the services are offered alongside those of the adults and this makes them

unappealing to adolescents. Thus the global concept of adolescent-friendly services is yet to be glocalised<sup>1</sup> in developing countries, and particularly in sub-Saharan Africa.

Several factors have been associated with poor access and low use of reproductive health services among adolescents in developing countries. These include general lack of access to family planning services (including contraceptives), lack of access to prevention and treatment services for sexually transmitted diseases, and to pregnancy care. For many adolescents, the opening times, location and cost of services make the services inaccessible. It is also not unusual for health providers to request for parental or spousal consent before providing services to adolescents below 18 years. There are also situations in which provision of adolescent sexual and reproductive health (ASRH) services is prohibited and regulated by law. This presents additional challenges for adolescents since they may not wish to involve their parents in matters relating to their sexual health.

In addition, the lack of clear adolescent health policies, lack of guidelines for provision of adolescent services, and lack of information about existing services hamper adolescents access and use of reproductive health services. In Kenya, reproductive health services provided by the government are offered within the Maternal and Child Health and Family Planning (MCH/FP) programmes. The services fail not only to target adolescents, but also to enhance their confidentiality. This makes adolescents to shy away from using the services, preferring instead to seek care from private service providers. The private sector services are expensive for adolescents who have no

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<sup>1</sup> The meaning of glocalisation (Global + Local = Glocal). Global denotes anything that can be done, or that is available in the same form, anywhere in the world. In science one describes it as universal knowledge, which is applicable everywhere (Global), in contrast to particular knowledge, which refers to a specific place with specific conditions (Local). Both (Global and Local) are important and need to be considered together. In context to this study, adolescent health and sexuality is a global phenomenon. However, the response efforts and interventions aimed at addressed the reproductive health challenges of adolescence have not been applied similarly in all regions and countries. What are evident are regional, gender and socio-cultural differences and imbalances. Thus, the goals of ICPD are yet to be realized.

Source, Management of Medicine in International Health Course Notes. Acknowledgements to InWent-Bonn, Health Division. <[www.InWent.de](http://www.InWent.de)>

income of their own and have to depend on their parents or guardians for support. The lack of adequate skills among health care providers contributes to their having judgemental attitude towards adolescents, and failure to enhance adolescents confidentiality and privacy during service provision.

Adolescents are also embedded within policy, cultural and social contexts that are likely to influence their access and use of preventive reproductive health services (PRHS). In Kenya, like in most African communities, sexuality matters are seen as taboo for adolescents. Sex is seen as sacred and often a topic for the married. The prohibitive silence that says no to sex before marriage (Ahlberg, 2000) and the prevailing socio-cultural and policy environment affect provision of reproductive health information and services to adolescents. Religious bodies oppose reproductive health care in favour of abstinence only among the unmarried. Attempts by the government to introduce sex education in schools in the early 1990s were resisted by religious organisations, particularly the Catholic Church and the Muslims (Brockman, 1997). The Catholic Church, for example, publicly opposed and denounced the use of condoms and other contraceptives, publicly burnt them and other AIDS awareness materials, and demolished condom dispensers (IPS, 1996). Also, the family life education programs in schools were banned (Erulkar et al. 2004). This culture of silence leads to lack of sexuality information among adolescents, and necessary services to help protect themselves from reproductive health challenges facing them. Failure to provide adolescents with reproductive health information, has also led to their lack of life skills needed to enable them to effectively negotiate transition challenges of adolescence.

In Kenya, the shift from cultural traditions to modernity deprived adolescents informal education systems through which adults taught them about sexuality matters. The introduction of formal education system shifted the roles of educating and informing adolescents from the communities to the teachers. Further, the lack of curriculum to guide the teachers and lack of training skills on sexuality issues makes teachers to shy away from teaching sexuality education. This has left adolescents with

nobody to inform them about sexuality matters and they rely on their peers for information. As a result, adolescents have wrong information and myths (Ahlberg, Jylkäs, and Krantz, 2001). For example, they assume that conception can be prevented if one takes a bath immediately after a sexual encounter, by having sex standing up, or by jumping up and down after sex (Kiragu and Zabin, 1995).

Clearly, adolescents need sexual and reproductive health services. This study examines the factors that influence adolescents access and use of preventive reproductive health services. Specifically, the study investigates whether adolescents have unique sexual health needs that require them to seek preventive reproductive health services. Additionally, the study seeks to understand whether there exist PRHS that adolescents can use to meet their sexual and reproductive health needs, whether they access and use the services, and the challenges they encounter in so doing. Finally, suggestions for addressing identified challenges are explored to come up with policy recommendations aimed at enhancing access and utilisation of preventive reproductive health services by adolescents.

## **1.2 Problem Statement and Research Questions**

Although adolescents share many characteristics with adults, their health related problems and needs are different. Adolescent sexuality remains a global challenge particularly in developing countries. Although most adolescents become sexually active before the age of 20, the sexual contacts are generally unprotected (WHO, 1998). Every day, more than a quarter of a million young people become infected with an STD, and more than half of all new HIV infections occur in young people. Globally, 60 out of every 1,000 adolescent girls give birth each year, and many of the pregnancies are unwanted. Further, up to 4.4 million girls aged 15 to 19 undergo unsafe abortions (WHO, 1998). Adding to the challenge is the sheer magnitude of the numbers. About half of the world's population is under the age of 25, and one in every five people in the

world is an adolescent (UNFPA, 2005a; WHO, 1998). About 85% of adolescents live in developing countries and the remainder in the industrialised countries (WHO, 1998; Dehne and Riedner, 2005). Sixteen percent of adolescents living in developing countries live in Africa (WHO, 2000a). Sexual activity among young people is not always consented and this exposes them to greater risks. Thus, adolescents are more vulnerable to rape, harassment and sexual exploitation, and physical and verbal abuse because they are less able to prevent or stop such manifestations of power (UNFPA, 2000a).

Evidence shows that providing information and services to adolescents result in their improved health. Despite this recognition, socio-cultural and policy barriers, as well as lack of adolescent-specific services make it difficult for adolescents to access and utilise reproductive health services. Sexuality is considered a sacred topic that is not talked about freely. Many parents do not give their children sexuality information. In Kenya, provision of reproductive health services for adolescents is controversial. There is still no consensus between the government and religious bodies about sex education in schools and about the content of the sex education pack. The lack of consensus has slowed down the publishing of an information pack that would equip adolescents with information about sexuality and where to get services. Also, NGOs are governed by organisation policies and mandate and may not provide adolescents with reproductive health services. The effect has been lack of focused guidance for adolescents about their sexuality and reproductive health. As a result, adolescents have little knowledge about reproductive health matters relating to their bodies. Consequently, they depend on their peers for information. The peers just like them are ill informed and have myths about sexuality. The myths are untrue and have contributed to increase in unintended pregnancies, consequent abortions and school dropouts as well as rise in STIs among adolescents.

The lack of clear policies on adolescent sexuality and reproductive health means that adolescents are not guaranteed their right to access reproductive health services. In Kenya, like in other developing countries, adolescents are often denied services for



reasons that they are not married or are below 18 years, in which case they have to seek parental consent before being provided with services. Lack of clear policies has also led to professional dilemma among health care providers on whether to provide adolescents with services and the kind of services to provide. This has resulted in lack of information among adolescents about where they can access reproductive health services such as condoms and other contraceptives. Adolescents thus rely mainly on themselves and other uninformed sources for guidance and information on where to seek care and services. Even when condoms are available, only adolescents who can afford to pay for them can access them. Although the government STI and family planning programmes offer reproductive health services in public health facilities, ethical, institutional and structural problems create access barriers to the services. For example, lack of private consulting rooms denies adolescents confidentiality and privacy. Whereas health facilities are located in open areas and public places where they can be easily accessed, this does not translate into effective use by adolescents who need the services. Adolescents may fail to use services if the services do not enhance confidentiality and privacy. For example, if condoms dispensers are placed near consulting or waiting area, many adolescents and service seekers may feel embarrassed to pick condoms while being seen. The highlighted challenges, inadequacies and gaps point towards the need to develop clear policies for addressing adolescent reproductive health problems.

The principal purpose of this study was to fill this research gap and add to existing literature by investigating factors that influence adolescents access and use of PRHS in Murang'a District, Kenya. To achieve this, the study sought to answer the following research questions.

1. What are the existing preventive reproductive health services for adolescents in Murang'a District?
2. What barriers and challenges do adolescents in Murang'a District face while accessing and utilising preventive reproductive health services?
3. In what ways can the identified barriers and challenges be addressed to improve access and utilisation of preventive reproductive health services by adolescents in Murang'a District?

### **1.3 Rationale and Objectives of the Study**

This study is warranted for several reasons. First, the study has the potential to generate empirical data about available PRHS for adolescents in Murang'a District. To the best of my knowledge, there is no existing data about adolescent health services in Murang'a District and the level of utilisation of PRHS by adolescents. This study is expected to fill this research gap and contribute to current adolescent health and sexuality literature. The study focuses on adolescents who are still in the formative stage of the lifespan, and are vulnerable to risky behaviour that can affect their present and future reproductive health. Although adolescent sexual and reproductive health is a relatively new and sensitive area, research has shown that provision of sexual and reproductive health (SRH) services to adolescents can have positive reproductive health outcomes (Hocklong et al. 2003; Stone and Ingham, 2003). Focusing on the factors that affect adolescents access and utilisation of PRHS thus promises to enhance measures to reduce the sexual health risks and consequences facing adolescents.

Second, the present study provides a forum for adolescents, health providers and stakeholders to share their views regarding provision of PRHS for adolescents in Murang'a District. The first step towards addressing the challenges faced by adolescents in accessing and utilising PRHS in Kenya would be to identify the barriers first, and the

best ways to solve them. Information generated in this study is thus vital in improving PRHS for adolescents, as well as removing barriers that hamper adolescents' access to the services. In addition, the study promises to generate knowledge that is useful for informing policy, and to identify potential areas of intervention in order to ensure better access, utilisation, and provision of PRHS for adolescents in Kenya.

Third, this study is expected to contribute towards assessment of existing reproductive health policies for adolescents, and the extent to which the policies affect access and use of PRHS by adolescents in Kenya. Considering these aspects will broaden the understanding of adolescent sexual and reproductive health within a policy context. Moreover, discrepancies in policy and practice persist between the government, NGOs and religious organisations. As a result, adolescents lack information about available services and where to seek them. This research can go a long way towards resolving these discrepancies and addressing gaps in policy and practice.

Fourth, this study attempts to provide a better understanding of the challenges that adolescent in rural areas face in accessing and utilising PRHS. In Kenya, adolescents lack adequate information and knowledge about available reproductive health services. In an ideal situation, information brochures describing available services should be provided. An alternative would be existence of a functional referral system where service users are informed about available services. However, delivery of reproductive health services in Kenya is achieved through a centralised system that does not effectively reach the grassroots level thus cutting off rural areas from services. Moreover, the rural areas have few (if at all) ASRH services and hardly any information brochures. The lack of electricity in rural areas, the low living standards, and the fact that expenditures are kept at minimum, limit adolescents access to mass media reproductive health programmes and information.

Finally, this study intends to provide a theoretical understanding of the factors affecting adolescents access and use PRHS by locating adolescent health issues within the lifespan developmental approach. The study is expected to demonstrate how the

notions of ‘healthy adolescence’, ‘problem-based adolescence’ and legal aspects contribute to inclusion or exclusion of adolescents from accessing and utilising PRHS. The study outlined several objectives that helped to achieve its aim.

### **Objectives of the Study**

The main objective of this study is to investigate the factors influencing access and utilisation of preventive reproductive health services (PRHS) by adolescents in Murang’a District, Kenya. The specific objectives are to:

1. Find out about the main sexual health concerns of adolescents.
2. Investigate the existing PRHS for adolescents in Murang’a District.
3. Find out the barriers and challenges adolescents in Murang’a District face in accessing and utilising PRHS.
4. Develop better ways of addressing the challenges and barriers faced by adolescents to foster increased access and use of PRHS among adolescents in Murang’a District and in Kenya.

## **1.4 Structure of the Dissertation**

Chapter 2 provides a critical review of relevant literature. Theoretical and conceptual issues that explain ASRH are discussed. Also, existing definitions of adolescence are explored and critically reviewed. In addition, the chapter presents the theoretical guidelines for the study. These include a description of the lifespan developmental approach and theories that explain the origin of adolescence. They include the historical, biological, medical, sociological and contemporary notions of adolescence. It also presents the social exclusion theoretical perspective to illustrate how discrepancies in health care delivery system could lead to failure by adolescents to access and use PRHS.

Chapter 3 contains the description of the study methodology. It describes the study site, the study design, data sources, and data collection methods and analysis. Chapter 4 presents the study results of adolescent interviews about their sexual health concerns, their awareness about available services for adolescents, their access and use of services and the encountered barriers. In addition, adolescents suggestions for addressing identified barriers are presented. Chapters 5, 6 and 7 provide the analytical review and discussions of the study findings. Chapter 5 is a discussion on adolescent reproductive health concerns, response efforts and available PRHS. Chapter 6 discusses existing reproductive health policies and their effect on access, use and provision of adolescent PRHS. Chapter 7 discusses barriers that affect access, use and provision of PRHS for adolescents. It also provides suggestions for addressing these barriers. Chapter 8 draws together the main lessons learnt from the study, suggests proposals and way forward for improving access, use and provision of PRHS for adolescents. It also highlights the implications of the study findings for theory and future research. Table 1.1 below outlines the structure of the dissertation.

Table 1.1 Structure of the dissertation

<b>Structure</b>	<b>Chapters</b>	<b>Contents</b>
Background	Chapter 1	Introduction, research questions and objectives
Theory & literature	Chapter 2	Theoretical perspectives and review of relevant literature
Materials & Methods	Chapter 3	Study design, sampling procedures, data collection and data management
Results	Chapter 4	Results of adolescent interviews
Discussions & review of study findings	Chapter 5	Adolescent reproductive health concerns, response efforts and available PRHS
	Chapter 6	Reproductive health policies and their effect on access, use and provision of PRHS for adolescents
	Chapter 7	Barriers to access, use and provision of PRHS for adolescents, and suggestion for addressing the barriers.
Conclusions and Recommendations	Chapter 8	Lessons learnt, implications and way forward for improving adolescents access and utilisation of PRHS

## **CHAPTER 2**

### **REVIEW OF RELATED LITERATURE AND THEORICAL APPROACHES ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH)**

This section presents the various definitions and perspectives of adolescence. Terms and conceptual issues on adolescent sexual and reproductive health (ASRH) are also presented.

#### **2.1 Global Public Health Perspective of ASRH**

##### **2.1.1 A global concern**

Adolescent sexual and reproductive health is a global public health concern. This is because adolescent sexual activity has increased in many countries around the world in the last two decades (Naré, Katz and Tolley, 1997), and at increasingly younger ages. Adolescence is described as a period of increased risk-taking because adolescents are susceptible to behavioural problems during puberty (UNFPA, 1997). Adolescents at this period try to form their own identity, to be autonomous and are conscious of making their own choices and actions (Häggström-Nordin, 2005). Merluzzi and Nairn (1999) noted that adolescents perceive themselves as being healthy. Since they have few peers facing major illness, adolescents tend to think that they are invulnerable to illness. This perception creates the tendency among adolescents to engage in risk-taking behaviours that expose them to health risks which adversely affect their present and future health. Adolescents simultaneously engage in multiple health-risk behaviours that threaten their health and well-being (Elster and Kuznets, 1994). Most adolescents engage in early and unplanned sexual activity (Wilbon, 2005) which

incurs the risk of unintended pregnancies and of transmission of sexual infections. The consequences have social, economic and physical health ramifications like illegal abortions, dropping out of school, out-of-wedlock births, as well as contracting sexually transmitted diseases (STDs) and HIV.

Global estimates indicate that every year about 3 million adolescents (one in every eight sexually active adolescents) are infected with an STD; and that the highest rates of Chlamydia are among the 15 - 19 year olds, mainly adolescent women (AGI, 1999; Bassett, 2000; RCAP, 1994). In many developing countries, more than half all-new HIV infections are among young people 15 - 24 (UNFPA, 2000a). Early sexual debut and the prevalence of STIs in Africa are seen as some of the factors driving the spread of HIV infection. The WHO estimates indicate that STI rates are highest in sub-Saharan Africa with 69 million new cases per year in a population of 269 million adults aged 15 – 49 years (Corbett et al. 2002).

There are also gender variations. Girls face greater reproductive health challenges than boys following puberty. Foremost among these are early pregnancies and childbearing. In Kenya, available data show significant period of sexual activity before marriage. The 1998 demographic and health survey (KDHS) showed the medium age at first sexual intercourse as 16 for men (RoK-MoH, 2001a). The 2003 KDHS data also showed increase in the mean age at first sexual intercourse from 16.7 in 1998 to 17.8 years in 2003. It also showed that girls living in rural areas have their first sex almost a year earlier than those living in urban areas (CBS, MOH and ORC, 2004). The WHO 1993 estimates Kenya's proportion of births from unmarried adolescent as the third highest in sub-Saharan Africa (WHO, 2004a). It is estimated that 10,000 unmarried girls in Kenya drop out of school every year due to pregnancy (UNFPA, 1999). Also, about 5 million girls aged 15 to 19 have abortions every year, 40% of which are performed under unsafe conditions that lead to high rates of mortality. In Kenya, Nigeria and Tanzania, adolescent girls make up more than half the women admitted to hospital for complications following illicit abortions (WHO, 1998). Despite



the above evidence, the lack of sexual and contraceptive knowledge, along with difficulty in obtaining contraceptives results in continued early childbearing among adolescents.

Adolescent girls also face greater risks of contracting HIV/AIDS and STDs compared to boys due to social and physiological factors (NACC 2002; Leslie et al. 2002). Studies have found HIV infection levels to be highest among young girls and young women aged 20-24 years, and that 18% of women are infected within two years of becoming sexually active (RoK-MoH, 2001a). According to the 2003 KDHS, HIV prevalence rates among girls aged 15 to 19 was 3%. This was six times higher compared to 0.5% HIV prevalence among boys of the same age (RoK-MoH, 2005). Several factors have been associated with the changing trends in adolescent sexuality. These include changes in traditional control of sexual activity, greater tolerance for premarital sex, development of communication networks, schooling and urbanisation. Naré, Katz and Tolley (1997) observed that Africa has a socio-cultural tradition of early childbearing in which teenage sexuality is not so much a factor of age, but of social and marital status.

### 2.1.2 Global challenges in accessing ASRH services

Adolescents globally continue to face challenges in accessing reproductive health services. They access health services less frequently than expected and are also more likely to seek services after sexual exposure. Kipke (1999) identified problems that adolescents undergo particularly the lack of access to health care services. He noted that many adolescents lack a consistent source of basic care and are less likely to visit a doctor or have any regular source of medical care than young children or adults. Kipke further noted that many of the health issues of adolescents, such as sexuality issues, are socially stigmatised or difficult to discuss. Stone and Ingham (2003) observed that many young people think about, and take steps to obtain adequate protection only after having

sexual intercourse. Hocklong et al. (2003) in an article on access to adolescent reproductive health services supported this view. They noted that three-quarters of female participants in the United Kingdom aged 21 or younger, who had not sought reproductive health care before first sex, did so within six months of sexual initiation. Hocklong et al. (2003) further observed that adolescents who face greater sexual health risks have greater access challenges to services than their less exposed peers. They noted, for instance, that youths in the United States were at greater risk of pregnancy and STDs than their British and other western Europeans peers. However, the US youths were more likely to encounter access challenges than those in United Kingdom and other western European countries.

Research has shown that adolescents also seek health care services less frequently than any other age group and are less likely to have health insurance than any other age group. The challenges of accessing PRHS are greater for adolescents living in developing countries where adolescent health care services are few or lacking, and there are no mandatory health insurance systems (Cohen, 2002). Goodburn and Ross (2000) observed that in developing countries, the health of adolescents has largely been ignored in comparison to that of children under 5 years and adults. In Bangladesh, for example, the Associates for Community and Population Research (ACPR, 2003) while conducting a baseline survey, noted the lack of adolescent-friendly health care facilities in the country. In sub-Saharan African, although adolescents face greater sexual health risks, they also face greater challenges in access to reproductive health services, including preventive care. In Kenya, like in other developing countries, existing societal, cultural and external prohibitions affect provision of adolescent PRHS. The need to provide adolescents with PRHS largely came about because of the HIV/AIDS pandemic. However, even with these efforts, HIV rates among adolescents particularly among young women aged 15 – 24 years remain unacceptably high.

### 2.1.3 Global response: Efforts to offer adolescent-friendly services

The 1994 and 2004 ICPD conferences in Cairo and Dakar respectively made several recommendations for improving adolescents access to reproductive health services and education. Participating countries affirmed their commitment to intensify efforts to enhance the rights of adolescents to access sexuality information, counselling and youth-friendly services; to safeguard adolescents right to privacy, confidentiality and informed consent; and to involve them in the design, implementation, monitoring and evaluation of youth programmes (UNFPA, 2005b). ICPD 2004 reiterated the need for provision of sexual and reproductive health information, education and services throughout the life cycle.

Since the 1994 ICPD, attempts have been made globally to address reproductive health challenges of adolescence. An example is the establishment of adolescent-friendly clinics, particularly in developed countries. However, there are no standard or uniform models of adolescent health services. Different countries adopt different approaches. Some countries use varying models. In the United States, for example, some programmes maintain the traditional medical model by offering drop-in and after-school hours. Others set aside time in clinics for sessions open only to teenagers. In addition, some communities support reproductive health care as a component of school-based health services (Hocklong et al. 2003). Critics have however argued that a mix-up of models creates confusion about available services, how and where the services can be accessed.

Evidence from research shows remarkable achievement in adolescent sexuality in countries where adolescent services are available and offered. For instance, the United States, the United Kingdom and other western European countries have recorded significant drop in adolescent pregnancy rates since 1970s. The drop has partly been attributed to the availability of more effective methods of contraceptives and increase in condom use (Hocklong et al. 2003). In the United Kingdom, the positive changes were

attributed to the 1990 Health of the Nation initiative, which spurred the creation of more effective adolescent pregnancy and STD prevalence strategies at the national level. However, rates in the United Kingdom recently seem to go up again (Bornemann, 2006).

Youth or adolescent centres are acknowledged as essential part of preventive health work among adolescents. In Sweden, youth clinics or centres were established in the 1970s. These are centres where adolescents can receive advice, counselling, information, medical examination, treatment and therapy about sex and relationships (Häggström-Nordin, 2005). Adolescent or youth centres have multi-professional structure where medical, psychosocial, and educational expertise is available. Staff attitude and skills, confidentiality, anonymity, ease of geographic access, appropriate opening times, suitable location, and premises are important factors to successful healthcare for the adolescents (Häggström-Nordin, 2005).

Awareness of the importance of youth-friendly services is on the rise worldwide. Several developed countries like Germany, Netherlands, Sweden, the United Kingdom, Canada and the United States of America, have ‘youth information centres’ or ‘youth-friendly’ clinics. In Africa, South Africa is among the leading countries to implement adolescent health services through its *National Adolescent Friendly Clinic Initiative* (NAFCI) dubbed as ‘love-life’ (FHI, 2000). Efforts have also been made in sub-Saharan Africa to provide adolescents friendly services for example in Kenya, Uganda, and Ghana through the USAID *Prime Project* (IntraHealth International, ca. 2004), as well as in Angola (UNFPA, 2000b). However, provision and implementation of ASRH services vary from country to country, and is influenced by multiple factors. Some countries like the United Kingdom have been more successful in launching comprehensive prevention efforts (Hocklong et al. 2003). This is because of increase in the availability of youth-oriented sexual health services, and provider knowledge and sensitivity regarding the needs of adolescents.

Effective health services should reach adolescents who are growing up in difficult circumstances as well as those who are well protected by their communities.

The WHO (2002a) underscored the need to link health services with adolescents services. This would ensure that the services are part of a supportive structure that protects adolescents against sexual health risks, and help them to build knowledge, skills and confidence. Heaven (1996) underscored the role of the health care system in addressing health risks of adolescence. He noted that health authorities have at their disposal a variety of methods for promoting adolescents health. Arguably, a country's approaches to prevention are rooted in the interplay of socio-economic, political and cultural forces (Hocklong et al. 2003).

Researchers have suggested that adolescent health service models should be ideal, clear, acceptable and understood. Hocklong et al. (2003) suggested a "tiered service delivery system for youth that expands and links non-clinical services with clinical services". This *linked model* is thought to have the potential to remove challenges to reproductive health care. An important aspect of the tiered-service-delivery system is that it should reflect a community's culture and values, and offer confidential counselling and education along with over-the-counter methods, including condoms in non-clinical settings. The non-clinical models according to Hocklong et al. (2003) can be located in schools and community settings close to where teenagers meet for recreational or other activities. Heaven (1996) likewise emphasised that effective delivery of health care services for adolescents should occur in places most likely to be frequented by adolescents. He emphasised the importance of making adolescents to feel at ease in health care settings and to make them feel accepted and respected.

The *linked model* is considered effective in meeting the needs of both sexually experienced and inexperienced adolescents because it combines counselling and behaviour interventions. For example, abstinence-based messages and strategies may be offered for young people who want to delay sexual initiation, and who want to know how to handle pressure in relationships that might lead to greater intimacy. Adolescents who chose to be sexually involved can receive free condoms or tests for STDs and pregnancy. In this model, adolescents are informed about the benefits of medical care

and are assured of confidentiality and affordability of that care. They also become familiar with service providers. This is important because adolescents desire to be attended to by one person or provider other than by different persons (Naré, Katz and Tolley, 1997). An example of what might fit in the link model description is the United Kingdom where youth oriented sexual health services are delivered from different venues other than health care settings that are accessible and acceptable to young people. These include such venues as youth centres, general advice centres, town halls, schools and fitness clubs (Stone and Ingham, 2003). The services vary in their approach but they offer contraceptive information, advice and products, and many provide specialized counselling services. Hocklong et al. (2003) noted that the success and sustenance of tiered approaches present own challenges. The challenges include issues related to payment for non-medical services, and systematic documentation of education and counselling activities. Heaven (1996) also observed that the methods of alerting youth to health risk factors vary from culture to culture.

#### 2.1.4 ASRH policy situation in Kenya since ICPD

In Kenya, reproductive health and rights of adolescents have since ICPD gradually gained recognition. Efforts have been made to provide awareness creation and education programs targeting the young people. Examples include condom promotion programmes aimed at reducing the rate of new HIV and STIs infections among young people. Youth clinics and voluntary counselling and testing centres (VCTs) have been set up mainly in urban areas. The UNFPA, for example, supported projects in Nairobi which turned 11 health clinics into ‘youth-friendly’ facilities by expanding working hours and providing separate rooms for youth counselling (UNFPA, 2000b). The government has also made attempts to develop reproductive health policies mainly for curbing the spread of HIV/AIDS. Following the ICPD, and after the government

declared HIV/AIDS a national disaster in 2000, the government facilitated the development of several policies. These included the following:

- (i) *The 1997 Sessional Paper No. 4 on AIDS* (RoK-MoH, 1997). The paper stipulated the need to target young people with HIV/AIDS programmes. It recognised the need for strong political commitment in the implementation of a multisectoral prevention and control strategy (RoK-MOH, 2001a). It also highlighted the government's role in co-ordinating HIV/AIDS prevention activities and programmes, especially programmes that would delay the onset of sexual activity among young people. Further, the paper emphasised the need to harmonise the age of consent, marriage and maturity to 18 years and to encourage voluntary testing (RoK-MOH, 2001a). In response to the Sessional paper, the government embarked on programmes aimed at awareness creation, education, condom distribution and STD management.
- (ii) *The "Condom Policy and Strategy"* (RoK-MoH, 2001b). The strategy aimed at enhancing access to condoms by all sexually active Kenyans at affordable prices. It identified youth-friendly condom distribution systems as key in increasing demand for and use of condoms. The government hoped to increase access to information especially to the youth on HIV/AIDS, cultural and social development during adolescence, biological changes, and how to respond appropriately to these transitions without endangering their lives or their reproductive health. The strategy emphasised development and adoption of appropriate behaviour, and avoidance of exposure to risks of infection.
- (iii) In 2001, the government developed the *National Guidelines for Voluntary Counseling and Testing* (RoK-MoH, 2001c). The guidelines aimed at ensuring the provision of standardized and good-quality VCT services. VCT counsellors are trained using the national VCT curriculum. They are trained to administer and read the same-day, the rapid HIV test. This allows test results to be shared before clients leave the facility. Voluntary counselling and testing (VCT) is described as

a powerful weapon against the spread of HIV/AIDS, and a key entry point for needed medical, psychological, social, and legal interventions for HIV-positive persons and their families. Interventions include treatment and prevention of opportunistic infections; prevention of mother-to-child transmission of HIV; home-based care; orphan support; and post-test clubs (USAID, 2003).

- (iv) Recently in 2003, the government facilitated the development of “*Adolescent Reproductive Health and Development Policy*” (RoK, 2003a). The policy was published in May 2003, and launched in October 2003 by the National Council for Population and Development (NCPD) of the Ministry of Planning and National Development, jointly with the Division of Reproductive Health of the Ministry of Health. It recognised the need to access information and services to adolescents.

Despite efforts by the government, Kenya’s youth have been denied IEC and quality reproductive health services for years (Eschborn, 2002). This denial is associated with high HIV prevalence among young people aged 15 – 24 years (Neckermann, 2002). Also, despite the effectiveness of the VCT strategy, VCT services may only benefit adolescents aged 18 years and above due to policy restrictions (see Section 6.2.1).

## **2.2 Definitions of adolescent**

### **2.2.1 Adolescence: In search of a Definition**

Adolescence is a relatively new concept. There is no standard or universal definition of adolescence. Terms such as youth, adolescents, young people and teenagers are used interchangeably to describe “adolescents and young people” (Popcouncil, 2001). Different theoretical viewpoints are provided about adolescence.



Attempts to define adolescence within the life course framework are restricted to chronological age classification, biological classification, historical accounts, socio-historical and social-cultural perspectives and legal classifications, demographic, physical, psychological, and behavioural markers. Adolescence is thus a dynamic concept and no single definition may be applicable world-wide given the various classifications and markers (Dehne and Riedner, 2005).

Furstenberg (2001) noted that existing differences across nations reveal the degree to which adolescence has cultural, social and political dimensions. According to Dehne and Riedner (2005), adolescence is only just emerging in some cultural settings, while in others it is already well established. McCauley and Salter (1995) argued that universal definitions of adolescence should – at best – be restricted to describing adolescence as a “period of transition” in which although no longer considered a child, the young person is not yet considered an adult”. The unique differences of adolescents at different stages and the challenges presented by lack of distinct definition of adolescence have been observed. The question of “who is an adolescent” remains unclear.

### 2.2.2 Chronological age definition of adolescence

The World Health Organisation (WHO) and UNFPA define ‘adolescents’ as persons aged between 10 and 19 years and classify ‘young adults’ aged 15 – 24 in the ‘youth’ category. ‘Young people’ is a combination of these two overlapping groups covering the range 10-24 years (WHO/UNAIDS, 1997; UNFPA, 2003a). In contrast, the United Nations Children’s Fund (UNICEF) refers to persons up to the age of 18 as children. Adolescence is also classified according to stages that mark the beginning to the end of adolescence, including youth. For example, Green and Davey (1995) described adolescence in developmental terms as a period of transition from childhood to adulthood that takes place between the ages of 10 – 19 years.

Adolescence stage is also categorised according to age-sets. These include early adolescence (11 – 14), middle adolescence (15 – 17) and late adolescence (18 – 21). The health goals of adolescents at each stage are notably different (Elster and Kuznets, 1994). Millstein et al. (1993) observed that younger adolescents may focus on delaying the onset of normative adult behaviours, while at a later stage the goals may focus on diminishing potential negative consequences of these behaviours.

There are differing views about the chronological age characteristics of adolescents. Neckermann (2002) noted that pubescent and post-pubescent age groups display common characteristics, and that it is possibly effective for methodology purposes to group teenagers and people in their early twenties together. This view is refuted by Green and Davey (1995) who argued that the age-range cannot be defined in precise terms and that the phase of life that is called ‘adolescence’ was only distinguished from childhood or adulthood during the late 19<sup>th</sup> Century. The latter view is affirmed by the Popcouncil (2001) who noted that even the five-year cohort (10 – 14, 15 – 19) is unreasonably large. This study used the WHO classification of adolescent and covered adolescents aged 13 – 19 years (i.e. from the first day of 13<sup>th</sup> year to the last day of 19<sup>th</sup> year). The inclusion criterion was also determined by the fact that in Kenya, secondary school education usually starts at age 14.

### 2.2.3 The legal definition of adolescence and the ‘mature minors’

Legal and ethical issues arise about adolescence. The issue of parental or guardian consent is often raised about provision of reproductive health services for adolescents. Adolescents under 18 years of age are considered as minors since they have not attained the legal age of consent. Accordingly, they cannot consent to reproductive health services and can only be offered the services with parental or guardian consent. In many countries, state laws do not recognise the legal rights of minors to provide informed consent for general health services. However emancipated

minors, also known as mature minors may give consent. The mature minors who although are under the legal age of maturity, can consent to reproductive health services. For example, adolescents aged 10 – 19 old can give independent consent for reproductive health services if their capacities for understanding have sufficiently evolved (Dickens and Cook, 2005). Informed consent means that the individual can understand the risks and benefits of the proposed treatment and treatment alternatives, and decide voluntarily whether to proceed with the physician's recommendations (Elster and Kuznets, 1994).

Mature minors are described as adolescents under the age of 21 who demonstrate the cognitive maturity to understand the risks and benefits of a proposed medical treatment and its alternatives, and who can voluntarily decide whether to undergo treatment. The services that mature minors may consent to include diagnosis of pregnancy and pre-natal care, contraceptive services, diagnosis and treatment for STDs, and alcohol and drug treatment (Elster and Kuznets, 1994). In this case, there is no chronological "age of consent" for medical care but a condition of consent, meaning capacity for understanding. Like adults, mature minors enjoy confidentiality and the right to treatment. Minors capable of self-determination may grant or deny assent to treatment for which guardians provide consent. Emancipated minors' self-determination may also be recognised, for instance, on marriage or default of adults' guardianship.

## **THEORIES AND PERSPECTIVES OF ADOLESCENCE**

This part contains the theoretical framework of the study. Adolescent health and sexuality theories that guide this study are discussed. First the lifespan developmental theory. In this theory, several approaches are discussed. These include: the historical perspective on the origin of adolescence, the biological or problem based notion of adolescence, the notion of healthy adolescence and the contemporary theorists notion. The social exclusion paradigm is also reviewed and presented. Finally, the relevance of the developmental theory of adolescence and the social exclusion paradigm is provided.

### **2.3 Developmental perspective of adolescence: the life-course approach**

Different authors have used the terms life-course or lifespan to refer to different stages in the human life cycle. Kuh et al. (2003) noted that the concept of lifespan assumes that development and aging form a continuous process from birth to death. They further noted that the distinction between life span and life course is mainly a matter of scientific history. Both terms are used interchangeably in this study.

The developmental perspective considers adolescents within the context of the lifespan and views adolescence as a mere transition to adulthood (Millstein et al. 1993). The life-course perspective holds that there is continuity among all life phases. That is, childhood, young adulthood, midlife and older adults (Merluzzi and Nairn, 1999). It also highlights the paradoxes surrounding adolescence. First, adolescence is defined as the second decade of the human life cycle and a transitional period that bridges childhood and adulthood. It is also perceived as a period that is multifaceted in nature and characterised by biological, psychological and social components, as well as emotional development (Steinberg, 2001). Because of this, writers interested in adolescence have over the years addressed many different aspects of development

during this period, including biological development, cognitive development, emotional development and social development.

Second, adolescence is seen as one of the most fascinating and complex transitions in the lifespan. Kipke (1999) noted that events at this crucial formative phase can shape an individual's life course. A third view perceives adolescence as a period characterised with opposing forces. G. Stanley Hall (1844-1924) in 1904 described adolescence as the healthiest period of the life cycle and also a time of increased risk-taking, turmoil and susceptibility to behavioural problems of puberty and new concerns about reproductive health (Steinberg, 2001; King, 2004). The paradoxes surrounding adolescence and the varying definitions are best understood by examining different definitions that are relevant to this study. These are described below.

### 2.3.1 Origin of adolescence: A historical perspective

There are differing views about the origin of adolescence as a stage in a life course. Cultural historians suggest that adolescence was invented during the early decades of the twentieth century. The opposing sociological view suggests that adolescence was identified and institutionalised during the period when many western societies were shifting from primarily agrarian to predominantly industrial economies (Furstenberg, 2001). According to this view, the extension of schooling and the emergence of a high paying labour market, accompanied by the disappearance of employment opportunities for youth, contributed to creation of a more distinct phase between childhood and adulthood. Furstenberg (2001) noted that before the twentieth century, youth remained an obscure, ambiguous and ill-defined period including children and teenagers or even young adults who remained semi dependent well into adulthood. Furstenberg (2001) observed further that the period of adolescence was universally noted after G. Stanley Hall (1904) popularised the term that drew professional and public attention to this part of a lifespan. Adolescence is thus viewed

as a stage in which changes and experiences occurring are biologically and socio-culturally determined.

### 2.3.2 The biological view of adolescence: problem-based adolescence

The biological or problem-based perspective perceives adolescence to be a problematic stage and where difficulties are experienced in managing the transition from childhood to adulthood (Kipke, 1999). The view emerged from the twentieth century when adolescence was portrayed as a period of potential difficulty, either for the young person who was presumed to have difficulty coping with the challenges inherent in the transition to adulthood; or for adults who were presumed to have difficulty in controlling and reining in adolescents energy and impulses (Steinberg, 2001).

The biological/problem-based view of adolescence was founded by G. Stanley Hall (1904). Hall is considered as the founder of the scientific study of adolescent and was influenced by Charles Darwin's *Theory of Evolution*. In his *Theory of Recapitulation*, Hall believed that the development of the individual paralleled the development of the human species. Hall's theory of recapitulation saw adolescence as a time that paralleled the evolution of our species into civilisation unlike infancy, which he saw as being equivalent to the time during human evolution when human beings were primitive like animals (Steinberg, 2001).

The biological view of adolescence stresses the hormonal and physical changes of puberty as driving forces that define the nature of the period. It asserts that adolescence is marked by a series of physical changes brought by the person's biological state (Green and Davey, 1995). According to Hall, the development of the individual through these stages is determined primarily by biological and genetic forces within the person, and hardly influenced by the environment. Hall perceived adolescence as inevitably a period of storm and stress (*Sturm und Drang* in

German), and believed that the hormonal changes of puberty cause upheaval, both for the individual and for those around the young person (Steinberg, 2001; King, 2004). According to Hall, the turbulence is biologically determined and therefore unavoidable. The best that society could do was to find ways of managing the young person whose 'raging hormones' would invariably lead to difficulties.

The problem-based approach sees adolescence as being characterised by turmoil and difficulties because of the risky behaviours that adolescents engage in during the puberty stage. It considers adolescence as a time characterised by increased risk-taking, susceptibility to behavioural problems and new concerns about reproductive health. This view describes adolescence as a time of significant changes that can lead to emotional disorders and health-risk behaviours. The risk behaviours may cause morbidity and mortality that can result in poor health outcomes. Identified health risks and problems that characterise this stage include depression, suicidal ideation, unsafe sexual behaviours, alcohol and drug use, use of tobacco products and unintentional injuries (Elster and Kuznets, 1994). The problem-based notion also observes that health problems that emerge are perpetuated at different ages. For example, cigarettes smoking, drinking alcohol, sex initiation and perceived threat of teenage pregnancy, suicidal attempts, STDs, HIV/AIDS, and deaths attributed to injuries are low or begin by age eleven and increase with advancement in age.

Hall and his followers presumed that adolescence as a problematic stage had its source in the disjuncture of biology and culture. They advanced the idea that the asynchrony of physical development and social maturation introduces the cultural dilemma of managing youth who are physically but not social adults. According to Hall, it is the treatment of adolescents as neither children nor adults that make them to turn away from the adults' world, and to regard age peers as their natural allies (Furstenberg, 2001). The breakdown of social structures with the introduction of modern economies created a situation whereby parental oversight declined as the families relied

increasingly on outside institutions, most notably the school and community. This process reinforced the power of the peers, as youths are socially channelled into settings and institutions that generally do not afford the same level of social control provided inside the familial household (Furstenberg, 2001). Critics of Hall's hypothesis argue that Hall overstated what had occurred. They nonetheless acknowledge Hall's contribution in foreshadowing processes that came about in later decades, as well as setting the base for the social construct of adolescence. Furstenberg (2001) observed that the cultural construct of adolescence took root earlier in the US society and in Anglophone nations than in Continental Europe where parental and community controls remain relatively high. The historical perspective of adolescence acknowledges the institutionalisation of adolescence practices.

Nonetheless, Hall introduces two aspects that are crucial in understanding adolescents. One is that adolescents develop physical and social maturation that characterise adults, but are at the same time culturally and socially incompetent to do adult roles and responsibilities. This inconsistency creates the problems experienced during adolescence. Another aspect is that adolescents may experience challenges during the transition period that may result to emotional disorders and health-risk behaviours.

### 2.3.3 The notion of 'healthy adolescence'

The notion of 'healthy adolescence' refutes the notion that adolescence is a troublesome, difficult or wayward phase. Instead, this notion sees adolescence as the physically healthiest developmental period in the life cycle and lacking major health problems (Perry, 2000). The proponents of the "healthy adolescents" notion believe that adolescence is not an inherently stressful period. Rather, they assert that adolescents enjoy a particularly good state of health, and that they experience a relatively troublesome free and healthy transition to adult life. Thus the concept of "healthy



adolescents” (Elster and Kuznets, 1994). They also argue that the difficulties highlighted by the problem-based perceptions are grossly exaggerated (Green and Davey, 1995). Further, they argue that conflicts either within the individual or with parents or other authority figures are minimal and that the problems of a few adolescents are not characteristic of the group as a whole.

The notion of healthy adolescents emerged following medical observations that adolescence stage is not characterised by chronic illness or disability. Also, observations revealed that morbidity rates for certain organic diseases like heart diseases and cancer, which typically afflict adults, were historically low among adolescents. The proponents of this view further observed that the effects of health disorders that may arise during adolescence like obesity, usually cause severe health problems later in life and not during the adolescent stage.

#### 2.3.4 Sociological theory of adolescence

The sociological theory of adolescence explains how adolescents as a group come of age in society, and how the coming of age varies across historical epochs and cultures. The focus of sociological theorists is on relations between generations. They emphasise problems that young people have in making the transition from adolescence to adulthood. The focus thus is moving through adolescent to adulthood. Steinberg (2001) while quoting Kurt Lewin (1951) and Edgar Friedenberg (1959) noted that the difficulties that adolescents experienced in transiting into adulthood arose because adolescents are treated like ‘second class citizens’ (see Steinberg, 2001). This view was supported by the contemporary theorists who stress that many adolescents are prohibited from occupying meaningful roles in society and therefore experience frustration, restlessness and difficulty in making the transition into adult roles.

Other sociological theorists of adolescence consider the intergenerational conflict or the generation gap. Steinberg (2001) further quoted Karl Mannheim (1952)

and James Coleman (1961) and observed that, adolescents and adults grow up under different social circumstances and therefore develop different sets of attitudes, values and beliefs. According to Mannheim, the modern society changes so rapidly and as such, there will always be problems between generations because each cohort comes into adulthood with different experiences and beliefs. Coleman argued that, adolescents develop a different cultural viewpoint (counterculture) that may be hostile to the values or beliefs of adult society. Emphasis is thus on the broader context in which adolescents come of age, rather than on the biological events that define adolescence.

### 2.3.5 Contemporary theory of adolescence

The contemporary theorists consider the health threats of the present day adolescents. Steinberg (2001) noted that contemporary scholars are less likely to align themselves with single theoretical viewpoints and that they are likely to borrow from multiple theories that may derive from different disciplines. They integrate central concepts drawn from biological, psychological, sociological, historical and anthropological perspectives to understand the way the social context in which young people mature interacts with the biological and psychological influences on individual development.

This perspective asserts that adolescence need not be inherently problematic. The contemporary theorists' perspective recognises the role that biological factors play in shaping the adolescence experience. It however argues that factors that come into play are not merely the biological factors like hormonal changes, somatic changes or changes in reproductive maturity (Kipke, 1999; Steinberg, 2001). Rather, societal influences are co-factors for adolescents exposure to risky behaviours. The co-factors include unemployment, poverty, disintegration of neighbourhoods as units of social support, declining availability of parents and other adults to nurture and support

adolescents, greater opportunities for encounters with violence, and increased exposure to HIV infections.

Contemporary development theorists of adolescence emphasise the direct and immediate impact of puberty on adolescent psychological functioning. They highlight the interplay between biological and sociological factors during adolescence. Steinberg (2001) noted that the onset of puberty is characterised by external signs underlying biological changes in the reproductive organs, which ultimately enable most individuals to produce fertile eggs or sperms, and in girls to become pregnant and carry a baby to full term. These outward physical changes are commonly held to be a sign of 'growing up'. Green and Davey (1995) observed that in a wider sense, adolescence as a socially recognised phase cannot begin without the outward physical changes or the secondary sexual characteristics that include development of breasts for girls and facial hair in boys, and enlargement of the genitals and growth of pubic hair in both sexes.

The contemporary view highlights the increased realisation that today's adolescents are involved in health behaviours with potential for serious consequences, as well as health-risk behaviours at earlier ages than past generations of adolescents. This notion emphasises the role of intervention in preventing negative health outcomes that may arise because of the risks that adolescents are exposed to. It further recognises that the health threats of adolescents are predominantly behavioural than biomedical. Further, it argues that adolescent stage need not be potentially problematic and that it is an important time to intervene to encourage adolescents to adopt health lifestyles that they may maintain into the adult years. The need to focus on adolescents is observed. Steinberg (2001) observed that interventions introduced during the adolescent years could affect their health outcomes during the adult and senior years. Contemporary notion emphasises the need to develop and implement preventive strategies to respond to challenges threatening the health of adolescents; thus enhance the role of medicine in behavioural health (Elster and Kuznets, 1994). Kipke (1999) observed that parents, teachers, community members, service providers and social institutions (including

policies) can promote healthy development among adolescents and intervene effectively in shaping their future health.

## **2.4 The social exclusion paradigm**

Social exclusion is a relative concept that has variously been defined. Existing definitions that are relevant to this study include the following:

1. “Social exclusion is a multidimensional, dynamic concept, which emphasises the processes of change through which individuals or groups are excluded from the mainstream of society and their life chances reduced” (Lorraine, 2005).
2. “Social exclusion is a relative concept in the sense that an individual can be socially excluded only in comparison with other members of a society: there is no ‘absolute’ social exclusion, and an individual can be declared as socially excluded only with respect to the society it is considered to be a member of.” (Bossert, D’Ambrosio and Peragine, 2005).

This study contends that adolescence although a period in the life-course is also a social and cultural construct. The ways in which adolescents are viewed vary across settings and contexts (Villarreal, 1998) and from one society to another. For example, entitlement to access reproductive health care and services, though an integral part of an individual’s growth and development is socially and culturally defined and varies from region to region. This is enhanced through social control mechanisms and structures and sometimes by laws and policy restrictions. For example, the criteria for inclusion and exclusion in provision of reproductive health services are socially defined and influenced by values, cultural norms and traditions adhered to by different communities. These are often reflected in existing reproductive health policies that guide adolescent health programmes.

It is important to understand the extent to which adolescents access and utilise preventive reproductive health services, as well as the factors influencing their access and use of the services. This is particularly important because health behaviour may be socially patterned and culturally defined, and so is the criterion for inclusion and exclusion from using or benefiting from services. For examples, adolescents who live in communities that resist provision of adolescent sexual and reproductive health (ASRH) services may be socially or structurally excluded from accessing and utilising existing services. Stone and Ingham (2002) in a study conducted in the United Kingdom noted that, “although early pregnancy and motherhood can be a positive experience for some British young women, childbearing during the early teenage years often results from social exclusion, causes social exclusion or both”. Ahlberg (1996) also noted that “societal values and norms on issues of sexuality at macro- and micro-levels have prevented young women from benefiting from the available reproductive knowledge and services because of cherished values of chastity”.

The social exclusion of adolescents from sexual and reproductive health services may be manifested in gender differences, restrictions on age or marital status, rural-urban imbalances, inadequate adolescent reproductive health policies, and societal barriers. For example, the social meanings attached to sexuality and gender, masculinity and femininity directly affect a person’s experience of sexuality (IWHC, 1994). Definitions of gender roles, male and female sexuality, power relationships, and the meanings of RTIs are transmitted, maintained and reproduced by the family and by society (IWHC, 1994). It is important to note that although adolescent boys and girls initiate sex early, the effects are felt differently. Thus, the assumption that adolescents would feel comfortable to request for support from their parents or their caregivers may be deceiving particularly in communities where provision of ASRH care is not socially accepted. Given the secrecy surrounding sexuality matters, adolescents may find it difficult to request support and may not openly share sexuality matters with their parents or older adults. Thus socio-cultural and structural barriers may lead to exclusion

of adolescents from preventive reproductive health services. The thinking behind the social exclusion paradigm is that lack of planning for adolescent health services and the consequent exclusion of adolescents from services is detrimental to enhancement of their sexual and reproductive health.

## **2.5 Relevance of selected theoretical perspectives of adolescence to this study**

The life course (lifespan) developmental perspective is concerned with the human development process from conception to death. This study restricts itself to adolescence stage which, according to Léonie (1996) has often been ignored or neglected. The developmental perspective of adolescence is relevant to this study because it provides the intellectual and methodological tools needed to understand issues surrounding adolescent sexuality. The perspective adopts a life course approach and sees adolescent sexuality as part of the normal human growth path in which individuals develop needs and wants as they grow. The life course approach considers that adolescents have unique sexual and reproductive health needs whose gratification is determined by several socio-cultural, policy and structural factors.

The fact that reproductive health starts from childhood and that the needs of both men and women differ in each life stage is accepted. The life course perspective is relevant because it highlights the need to understand the present and future reproductive health needs of adolescents. The sexual behaviour of today's adolescents has implications for their future reproductive health. Thus providing a continuum of care is needed to meet the different reproductive health needs of individuals throughout their lifespan.

The contemporary view recognises the need for intervention to avert health problems that may arise during adolescence. First it recognises the “healthy adolescents” notion that adolescents are in the healthiest stage of the lifespan and may

lack major health problems. It however also borrows the “problem-based adolescent” view that adolescence experience stress and storm. It further asserts that a combination of biological and socio-cultural factors expose adolescents to sexual health risks. Thus there is need to intervene to provide adolescents with quality health care services. However, several factors may come into play in influencing effective intervention efforts. These are highlighted in the sociological view and the social exclusion paradigm. The social exclusion notion highlights societal, structural and institutional factors that perpetuate adolescents inability to take advantage of available reproductive health services to protect themselves from sexual health risks facing them. Further, societal perceptions and expectations of adolescence determine the kind of reproductive health services that are provided to adolescents.

## **ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH CONCEPTS AND ISSUES**

This part presents selected concepts of adolescent sexual and reproductive health (ASRH). They include sexual and reproductive health, reproductive health care, and preventive reproductive health. It also highlights the issues surrounding ASRH. These include policy issues, ambivalence and controversies about adolescence and ASRH service related aspects.

### **2.6 Adolescent Sexual and Reproductive Health Concepts**

#### **2.6.1 Sexual and Reproductive Health (SRH)**

The UNFPA observes that concerns about reproductive health starts from childhood and lasts throughout the life-cycle. However, the needs of both men and women differ in each life stage. Women bear the greatest burden of reproductive health problems. Research has shown that reproductive health problems account for approximately 36% of the total disease burden among women of reproductive age (15 - 44 years) compared to an estimated 12.5% in men in developing countries (World Bank, 1993). Sexual and reproductive health means more than just the reproductive organs and reproduction. The need to understand reproductive health within the context of relationships between men and women, communities and society is underscored. This is because reproductive and sexual health status of individuals is affected by complex web of factors ranging from sexual behaviour and attitudes, societal factors, biological and genetic predisposition, and economic, cultural and psychosocial determinants (Cook and Dickens, 2000). Sexual health can also be influenced by mental health, acute and



chronic illnesses and violence (Butler, 2004). The ICPD plan of action thus defined reproductive health as:

A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (DFID, 2004; United Nations, 1995).

Harding and Taylor (2002) observed that health cannot be defined merely as absence of disease. Rather, social psychological elements are equally important. Sexual health, although an integral part of reproductive health, goes beyond reproductive health. It encompasses problems of STIs including HIV/AIDS, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Reproductive health embraces certain human rights (United Nations, 1995). The British Medical Association (BMA, 2003) noted that: -

At its simplest, sexual health is compromised when sex is forced or unwanted and/or it has undesirable health or reproductive consequences such as the transmission of an STI or the conception of an unwanted pregnancy.

The WHO recognises that successful promotion of sexual health requires a comprehensive programme of activities, encompassing the health and education sectors, as well as the broader political, economic and legal domains. In each area, action is needed to remove challenges to sexual health and to promote factors that support it. The WHO further suggests that addressing sexual health at the individual, family, community or health system level requires integrated interventions by trained health providers and a functioning referral system. It also requires a legal, policy and regulatory environment where the sexual rights of all people are upheld.

## 2.6.2 Reproductive Health Care

In terms of care, it is argued that reproductive health requires that a continuum of care be provided to meet the health needs of individuals throughout their lifespan. Hence, the ICPD defined reproductive health care as:

the constellation of methods, techniques and services that contribute to reproductive and sexual health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases (DFID, 2004; Girard, 1999).

It is argued that effective reproductive health care addresses these problems from birth with appropriate and culturally sensitive education and health care programmes (WHO, 2000b). For example, sexually active adolescents who lack accurate knowledge about reproductive health, and lack access to reproductive health services, including contraception, cannot protect themselves from pregnancy and STI/HIV (WHO, 2000b).

In relation to care, health has been defined as the extent to which an individual or group is able on the one hand, to realise aspirations and satisfy needs, and on the other to change or cope with the environment. Health is therefore seen as the resource for everyday life and not the object of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. The assumption that the definition makes is that individuals or groups of people often know their health needs and therefore have to negotiate or access means of satisfying them. This may however often not be the case particularly on issues of sexual and reproductive health. Unless individuals know their needs, and are able to define them within the social and cultural settings, they are unlikely to address them.

### 2.6.3 Preventive Reproductive Health

The term preventive reproductive health draws from the understanding that health services are categorised into preventive and curative services. Terms such as health education and health guidance are used to describe preventive health. The Guidelines for Adolescent Preventive Services (GAPS) (Elster and Kuznets, 1994) use the term health guidance as one that encompasses health education, health counselling and anticipatory guidance. Preventive care broadly refers to care that would prevent an illness. This study emphasises preventive care mainly for prevention of STIs, HIV/AIDS, pregnancy and early sexual debut. In Kenya, adolescents and young people aged 15 to 24 years form the group mostly affected by STIs and HIV/AIDS. It is therefore important to emphasise preventive care to control the spread of STIs and HIV/AIDS, and reduce new infections. In this study, the terms “preventive reproductive health services” and “sexual and reproductive health services” are used interchangeably.

### 2.7 Issues Surrounding ASRH

There are a range of factors that influence adolescents use of preventive reproductive health services. Strategies to improve access to preventive reproductive health care for adolescents can be assessed using several criteria. That is, services should be available, visible (convenient and recognisable), quality based, confidential, affordable, flexible (meeting diverse needs), and co-ordinated (Cohen, 2002). Challenges to access and use of preventive reproductive health services by adolescents may include lack of privacy and confidentiality, insensitive staff, threatening environments, an inability to afford services, and the fact that services do not often cater for the needs of unaccompanied minors, or are restricted to married adults (UNAIDS, 2001). Neckermann (2002) observed that finding out what keeps young people from using existing public health services reveals exactly what should be done to make them

attractive to them. The reasons for avoidance of public sexual and reproductive health (SRH) services by adolescents could include the following factors:-

### 2.7.1 Ambivalence about adolescent sexuality

Adolescent sexual and reproductive health (ASRH) is often surrounded with ambivalence and controversy. In Africa for example, efforts by governments and international organisations to provide sex education or Family Life Education have met resistance particularly from religious circles (Naré, Katz and Tolley, 1997). In a study of mystery clients conducted in Senegal, Naré, Katz and Tolley (1997) found lack of clarity about available contraceptives and whether they were limited to married couples only. In many African societies parents, community and religious leaders are divided on issues pertaining to adolescents' sexuality, with some openly rejecting the teaching of sex education in schools. The expectation among religious groups is that individuals should conform to moral and religious principles, contrary to which they would face "divine punishment". The subject of sexuality is considered as taboo. Consequently, adolescents are "living within a prohibitive silence that says no to sex before marriage and therefore no preventive services and information" (Ahlberg, 2000).

Activities relevant to reproductive health have historically been regulated by moral or principle based law (Cook and Dickens, 2000). Sexual relations and human reproduction are areas in which religious authorities have been accustomed to exercise more influence. According to Cook and Dickens (2000), religious authorities invoke the belief that human conception and birth are directly regulated, and that religious authorities have been specifically called to interpret and express truths that are divinely revealed to them. Thus the emergence of the concept of reproductive health that is of secular origin and one that requires implementation by pragmatic rules presents special challenges to religious authorities. The discomfort and opposition expressed by

religious authorities regarding ASRH services remains an obstacle to enhancement of laws designed to achieve reproductive health goals.

### 2.7.2 Service availability

Accessibility to reproductive health services is considered an essential component in fulfilment of individuals' right to health in all its forms and at all levels. Accessibility to health facilities and health services is determined by components such as non-discrimination, physical accessibility, affordability and access to information (Hogerzeil, 2003). Theoretical models that describe access view it as a fit between pre-disposing factors on one side, and enabling and health system factors on the other. Pre-disposing factors include individual perceptions of an illness, population specific cultures, as well as social and epidemiological factors. Enabling factors refer to the means available to individuals for using health services. Health systems factors refer to resources, structures, institutions, procedures and regulations. According to Klein et al. (2001), access to preventive health services could increase healthy habits and in turn minimise behaviour risks that adolescents are exposed to. However, the potential for alleviating health problems by targeting young people has been largely ignored (Goodburn and Ross, 2000). Regrettably, the risky behaviour of adolescents tends to increase while their participation in health care tends to decrease (Cohen, 2002).

### 2.7.3 Quality of reproductive health care and service environment

Alderman and Lavy (1996) emphasised the need to look at the quality of health services. They noted that in deciding whether to seek care and which provider to consult, households base their choice on many factors, such as availability of drugs, doctors, hours, and clinical service, the adequacy of equipment and the physical condition of health care facilities. Despite the widespread agreement on the value of providing health

services of adequate quality, the care available to adolescents in the developing world is far from satisfactory. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking. Also adolescents right to privacy, confidentiality, respect and informed consent is often not considered (United Nations, 1999).

Utilisation of health services has to do with quantity and procedure of health care services. Documented operational factors that affect use of sexual and reproductive health services include the following: high cost of care and services, inconvenient hours of operation, affordable transportation, travel time and opportunity costs linked to it, perceived quality of care and provider behaviour (Hocklong et al. 2003). Operational constraints also present challenges for service providers, even when there is willingness to provide care. Neckermann (2002) observed that if public health facilities are not able to deliver basic health services to the general population, it would be hard to make them youth-friendly.

Among the factors which have been cited as reasons for under-utilisation of reproductive health services include poor relationships between health care professionals and their clients, long waits, administrative red tape, lack of emotional support and privacy, differences in language and culture between health professionals and their clients, rude medical staff, and the often-expected 'gift' for medical attention (Naré, Katz and Tolley, 1997). While quoting Mensch (1993), Naré, Katz and Tolley observed that interpersonal process is the vehicle by which health care is implemented and on which its success depends. Thus, the relationship between the patient and provider should be characterised by privacy, confidentiality, informed choice, concern, empathy, honesty, tact [and] sensitivity. Mensch further observed that the dimension of health infrastructure cannot be ignored and that there is need to focus on such elements as equipment and facilities, staff and training, supervision, record-keeping and supplies. However, according to Mensch, few studies have looked at the infrastructure to

determine the quality of care being provided, and that there are few studies on the quality of care of fixed facilities.

#### 2.7.4 Confidentiality, parental involvement in ASRH

Confidentiality is defined as “the privilege and private nature of information provided during the health care transaction” (Elster and Kuznets, 1994). Public health professionals have long realized that confidentiality is crucial for certain sensitive topics like mental health, drug treatment programs and reproductive health. Confidentiality and privacy goes hand-in-hand. In situations where services are not discrete or are already stigmatised, adolescents may find it difficult to seek care (Naré, Katz and Tolley, 1997). Cohen (2002) underscored the importance of confidentiality. They noted that most adolescents are eager to talk about their health concerns with a physician if assured that the information will remain confidential. Elster and Kuznets (1994) also observed that when parental involvement is required, teens would often go without the care they need rather than tell a parent. They further noted that providers should establish office policies regarding confidential care for adolescents and how parents would be involved. Elster and Kuznets also observed the need for health professionals ‘to clearly communicate to adolescents and their parents a firm commitment to the principle of confidentiality, and to explain that only very serious risk to the health of the adolescent would override that commitment’. The need for guidance among parents in meeting the unique physical and emotional needs of adolescents has also been noted (Cohen, 2002; Elster and Kuznets, 1994).

### 2.7.5 Addressing inequalities in adolescents sexual and reproductive health care.

Reduction in social inequalities in health is viewed as an important way of addressing social exclusion (Santana, 2002). However, most prevention programmes and approaches do not consider the particular vulnerabilities of adolescents and are not tailored to meet the special needs of adolescents. Instead they tend to be directed towards meeting the needs of adults or children (WHO, 2000b; United Nations, 2000). Santana (2002) argued that, assuming that disadvantaged groups present more health needs than the general population, it is important to know in more detail not only their health service utilisation patterns but also their satisfaction with health services.

Research has shown that adolescents may encounter embarrassment at needing or wanting reproductive services and experience discomfort in using the services. This is particularly because of the belief that the services are not intended for adolescents. Adolescents may be ashamed to use services especially if the visits follow coercion or abuse. They may also have fears of medical procedures and contraceptive methods including side effects and get concerned over lack of privacy and confidentiality. Thus, as Hogerzeil (2003) observed, health facilities and services must be respectful of medical ethics, and culturally appropriate and sensitive to gender and life cycle requirements. Addressing these challenges calls for clear policies and guidelines. The policies would indicate the commitment of governments to address reproductive health matters and concerns of adolescents. It is important therefore to understand the nature and type of existing adolescent reproductive health policies. This study sought to understand how the above challenges, among other factors, influence access to PRHS reproductive health services by adolescents in Murang'a Kenya. The following chapter describes the study sites and the methodology used to obtain the needed information.



## **CHAPTER 3**

### **MATERIALS AND METHODS**

This chapter describes the methodological approaches used in the study. It presents a description of the study site, study design, and methods of data collection and analysis. The chapter is separated into two sections. The first section situates and describes the context of the study area. This includes a justification of the choice of the study area, description of the geographical location and social and demographic characteristics of the area, and the health care and education sectors in Kenya. The second section presents a detailed description of the research process. This includes the study design, sample selection and methods used in selecting the study sample, and data collection and analysis.

#### **3.1 The Study Area: Kenya and Murang'a District**

##### **3.1.1 Geographical location of Kenya**

The selected study area is Murang'a District located in the Central Province of Kenya. Kenya is situated in the Eastern African region of sub-Saharan Africa. It lies along the Indian Ocean with a coastline of about 1000km on the Indian Ocean. It borders Somalia to the north-east, Ethiopia to the north, Sudan to the northwest, Uganda to the west, and Tanzania to the south. Kenya lies along the equator between latitudes 4.21 degrees north and 4.28 degrees south and between longitudes 34 degrees east and 42 degrees east. The country covers a total surface area of 582,646 square kilometres comprising 569,297 square kilometres of land, and 13,350 square kilometres of open water. Variations in altitude provide a wide range of climatic conditions. Mt. Kenya has a permanent snowcap. Other climatic conditions include the narrow coastal plain, the semi-arid region of the West and North, the highlands including the Great Rift Valley

and the plateau surrounding Lake Victoria. The coastal belt is hot but moderated by the strong south-east and north-east monsoon winds. Temperatures fall as one moves inland towards the highlands that enjoy a temperate type of climate. These highlands and the Lake Victoria basin have two rainy seasons: the long rains from March to June, and the short rains from October to December. The rains are heaviest in the high potential agricultural areas (RoK, 2003b).

The capital city of Kenya is Nairobi, which is also the chief manufacturing centre. Mombasa is the second largest city and Kenya’s principal seaport. Other cities include Kisumu the chief port on Lake Victoria; Nakuru, a commercial and manufacturing centre in the Eastern Rift Valley; and Eldoret, an industrial centre in western Kenya. Kenya’s most valuable natural assets are rich agricultural land and a unique physiography and wildlife. The highly diverse wildlife boosts the tourism industry (Library of Congress, 2005). Figure 3.1 shows the location of the study site Murang’a in the map of Kenya.

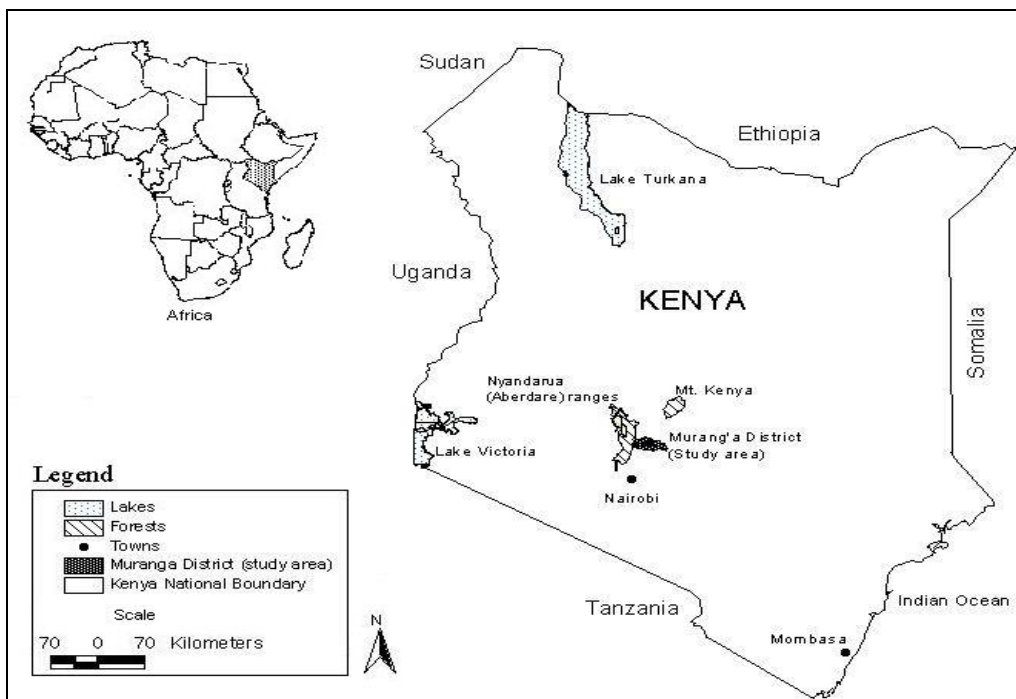


Figure 3.1 Map of Kenya showing the location of Murang’a District

### 3.1.2 Geographical location of Murang'a District in Kenya

Murang'a District is one of the seven districts in Central Province of Kenya. The district is largely rural and to a small extent urban. The Central Province is the second largest of the eight provinces in Kenya. The province is located north of Nairobi and covers the area around Mt. Kenya. Murang'a lies between Nairobi and Mt. Kenya. It is located about 80 km northeast of Nairobi and lies on the eastern slope of the Aberdare Range in the Central Highlands. The district borders Nyeri, Maragua, Kirinyaga, and Nyandarua Districts. Thika and Kiambu are other districts in the Central Province. Murang'a District is made up of four administrative divisions namely Kiharu, Kahuro, Mathioya and Kangema. Each division is further divided into administrative locations and further into sub-locations, the smallest administrative units. Figure 3.2 shows the location of Murang'a District in the Central Province.

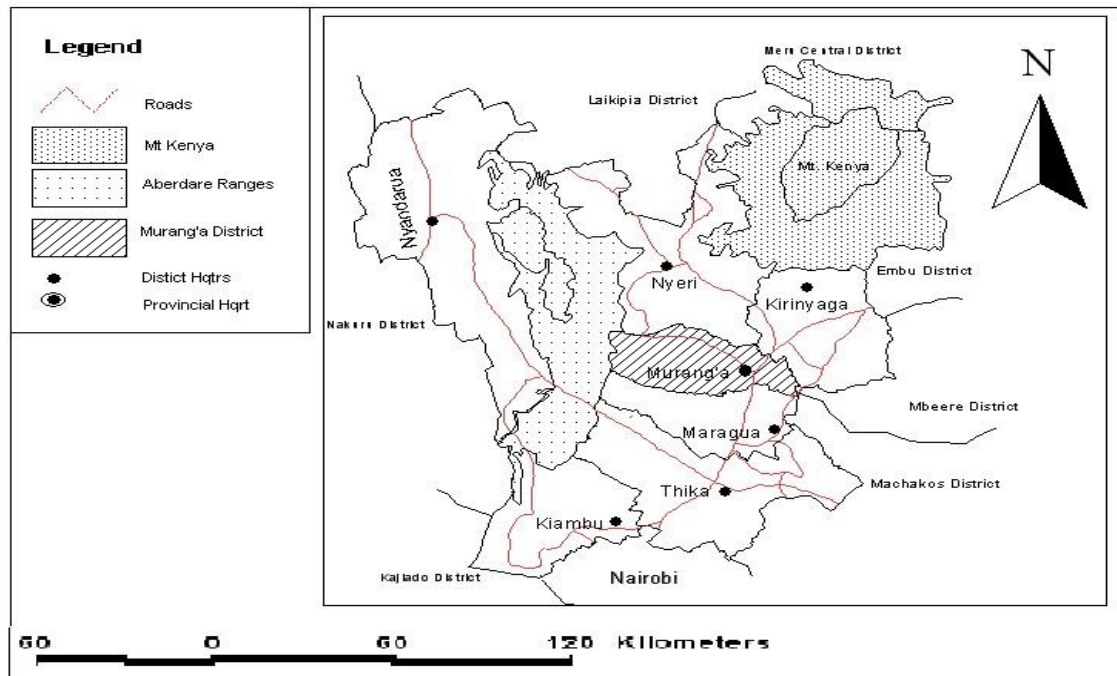


Figure 3.2 Map of Central Province showing the location of Murang'a District

### 3.1.3 The choice of the study area: Murang'a District

The choice of Murang'a District was purposive because of several factors. Murang'a District provides a fair representation of rural and peri-urban situations where data on the factors affecting access and utilisation of preventive reproductive health services (PRHS) by adolescents can be carried out. Murang'a district health care system lies third in Kenya's hierarchy level of health care services delivery (see Section 3.1.5). The district has a network of health care facilities which include district hospital, sub-district hospitals, divisional health centres and dispensaries. Apart from the public health centres, Murang'a District has other health care providers drawn from the private sector, religious institutions and Non Governmental Organisations (NGOs). These form a network of private clinics, mission hospitals, NGO health centres and community based dispensaries that are linked to the government which licenses their operation. The MoH through the network of Maternal and Child Health and Family Planning (MCH/FP) clinics provides reproductive health care services in Murang'a District. The main services include FP and contraceptives, condoms, education, antenatal and post-natal care, and child delivery services. Curative services like STDs treatment are provided at the outpatient service points.

Both adults and adolescents access reproductive services in the same service points. This makes it difficult for adolescents to seek services that are used by the adults especially because parents are often strongly opposed to distribution of contraceptives to young people (Ahlberg, 1991). The structure of service delivery does not enhance privacy and confidentiality for adolescents to seek services freely. The shortage of qualified health staff in Murang'a District restricts integration of services that would enhance confidentiality. Most rural dispensaries have one or two staff that provides curative and preventive services. The health providers are forced to adopt time saving mechanisms to cope with large number of patients and clients. The measures include setting specific times for specific health needs. Sometimes clients with presumed

similar needs sit in the same room thus denying them privacy, confidentiality and right to quality care.

Murang'a District, like the rest of Kenya, has experienced diverse socio-cultural changes in traditions and life events of the community. Murang'a District is predominantly inhabited by the Agikuyu ethnic community. Traditionally among the Agikuyu, adolescents depended on the adults for provision of information on sexuality. Sex education was traditionally taught as part of the initiation process. However, the traditional social fabric that guaranteed adolescents information on sexuality has changed. Presently, there is little interaction about sexuality matters between adolescents, their parents and guardians (Brockman, 1997; Ruto, 1999). This lack of interaction has resulted in lapses in information sharing about sexuality matters, which is a break from the past.

Another compelling factor for the choice of Murang'a District is the rising rate of teenage pregnancy and HIV/AIDS infection rates in Central province. In 1998, Murang'a had one of the lowest HIV/AIDS prevalence of 7% compared to the national prevalence estimated as 13 – 14% (RoK-MoH, 2001c). This has however maintained an upward trend. In 2002, HIV/AIDS prevalence had risen to 10% compared to the national prevalence of 15% (USAID, 2002). It is estimated that over 1,500,000 Kenyans have died from AIDS since the beginning of the epidemic and that approximately 200,000 Kenyans develop AIDS each year. Most of those affected are the young people (RoK-MoH, 2001a). However, the 2003 KDHS data showed a decline in national HIV prevalence to 7%, with that of Central Province being 4.9% (CBS et al. 2004).

Murang'a District lacks adequate data on reproductive services for adolescents. This lack of data was a prime consideration for the choice of Murang'a. Although I am aware of three studies on adolescents reproductive health that have been conducted in Kenya, the studies have not addressed the issues of accessibility and utilisation of reproductive health services by adolescents in Murang'a District. The studies were

conducted by Ahlberg et al. (2001), Nzioka (2001), and Njeru and Njoka (1997). The study by Ahlberg et al. (2001) focused on the perceptions of sexual risks and sexual practices among adolescents in Murang'a District and Sweden. Although the study identified gaps in policy as hindrance to provision of services to adolescents, it did not address the issues of availability, access and use of PRHS by adolescents.

The study by Nzioka (2001) was conducted in the eastern part of Kenya and not in Murang'a District. It looked at the perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections. Like the study by Ahlberg et al. (2001), the study by Nzioka did not address issues of access and use of reproductive health services by adolescents. The study by Njeru and Njoka, and which I participated in as a research assistant, focused on the integration of STD/HIV and MCH/FP services in Kenya. Although the research did not focus specifically on adolescents, it exposed me to issues of reproductive health services provision. I then identified ethical, structural and institutional barriers that, if not addressed, were likely to affect access, use and provision of PRHS among adolescents. These observations were however outside the scope of the study by Njeru and Njoka and were not based on scientific evidence. I was thus prompted to undertake the present empirical study.

Another consideration for the choice of Murang'a District was my personal experience as an adolescent studying in the district. When my colleagues and I fell sick or needed medical care, we received services from the school matron or cateress and were sometimes referred to hospital by the school to see a recommended doctor. In most cases, the school matron accompanied us to hospital and to the doctor. The referral procedures were often lengthy and in most cases involved disclosure of our sickness to get permission to leave school for hospital. The school matron also handpicked and conducted pregnancy tests on students suspected of being pregnant. If found pregnant, they were reported to the school authorities and expelled from school. The way health matters were handled in school made us to have suspect relationships with the persons-in-charge of our health because we feared they would disclose our sickness to the

school authorities. As a result, many of us delayed to seek care and this was sometimes fatal. I, for example, lost my desk-mate when in form two because of delay in getting treatment and referral to hospital for appropriate care. Thus from a personal experience, I was endowed with information about possible factors that may impede free access and utilisation of reproductive health care by in-school adolescents.

In addition, the exposure and personal experience gained through my growing and studying in Murang'a District put me at an insider's position in conceptualising the study. This insider's position gave me a comparative advantage in investigating complex social and culturally sensitive issues related to adolescent sexuality and reproductive health; having lived the experiences of the participants (Glaser and Strauss, 1967). I had the insider knowledge of the community and familiarity with the district health care system and structures; the cultural practices of the study community, and the language used particularly the use of proverbs in communicating sexuality issues. This made entry point and contact setting easy. This study aims at establishing the level of use of reproductive health care services by adolescents in Murang'a, and the barriers they experience in accessing and utilizing the services. As far as I know, no other person has previously conducted a similar study in Murang'a. No one else, to my best knowledge, has asked the questions and in similar words as in this research. There is therefore every justification to carry out this study.

#### 3.1.4 Demographic and social characteristics of Kenya and Murang'a District

Kenya has an estimated population of 28.7 million people according to the 1999 national census, with an estimated annual growth rate of 2.1%, and total fertility rate (TFR) of 3.9 (WHO, 2002). The population density is 142 per sq miles. In 2002, Kenya's population was estimated to be 30.3 million (USAID, 2002). The population is projected to reach 36.5 million by 2010 and 39.7 million by 2015. The 1999 census estimated the population of Murang'a District as 348,304 (IEA, 2002). This forms 9.4%

of the population of Central Province estimated as 3,722,159 (CBS, 2003). Kenya has a young population with almost 44% of the population being less than 15 years of age (CBS et al, 2004). The population pyramid is wide-based, with those below 25 years constituting 18.8 million, which represents about 66% of the total population. According to the 1999 Population and Housing census, adolescents (persons aged 10-19) and the youth (persons aged 10-24 years) as defined by the WHO, constitute about 25.9% and 36% of Kenya's population respectively (RoK, 2003c).

There have been improvements in demographic indicators in Kenya. Kenya was the first sub-Saharan country to adopt a national family planning program. Since the late 1970s, contraceptive prevalence has doubled. Remarkable gains include recorded decline in total fertility rates from 8.1 births per woman in 1977-78 to 4.7 in 1998, and increase in contraceptive prevalence rate from 7% in 1978, to 39% in 1998 (CBS, 2003). The 2002 total fertility rates were 4.7 Current estimates on fertility range from 3.1 to 5 births per woman (Library of Congress, 2005).

Kenya's population lives mainly in the rural areas. More than 56% of Kenya population lives below the poverty line (RoK-MoH, 2005) and estimates of unemployment rate approach 50%. Murang'a remains the poorest district in the Central Province. Poverty rates in the district continue to rise over the years. In 1997, for example, poverty rates were estimated at 38.62% and rose to 43.46% in 2000 (Mwabu et al. 2003). The main occupation in the district is agriculture, which includes subsistence farming and growing of cash crops, mainly tea and coffee.

Kenya is a land of cultural diversity with different ethnic groups totalling up to 40 in the country, with each having unique cultural practices, languages and familial relationships. People of African descent make up about 97% of Kenya population. Small numbers of persons of Indian, Pakistani and European descent, live in Kenya. There are also Arabs along the coast. The Kikuyu are the largest ethnic community and make up 22% of Kenya's population. They are largely concentrated in the Central Province and parts of the Rift Valley Province. Murang'a District is predominantly



occupied by members of the Kikuyu ethnic community. Other predominant tribes include Luhya, Kalenjin, Kamba, Gusii and Luo. Kenya has two official languages, English and Swahili. Many indigenous languages are also spoken.

Most of the inhabitants in Murang'a District are Christians and a few belong to other religious sects. This reflects the national situation where about two-thirds of Kenya's population is Christian, a quarter follows indigenous beliefs and the remainder are Muslim or Hindu. About 38% of Kenyan population are Protestants, 28% Catholics, 7% Muslim and 26% followers of indigenous beliefs and another 1% of smaller religious groups (Kuria, 1992; Rowntree et al. 2000).

### 3.1.5 The health care system in Kenya and Murang'a District

Kenya's health care system comprises a network of 5,945 health facilities organized in a pyramidal pattern that represents three levels (MoH, 2006). Each level plays distinct roles. The Ministry of Health (MoH) headquarters is situated at the top. It sets policies and coordinates the activities of NGOs. It also manages, monitors and evaluates health care policies formulation and implementation in the country. Kenyatta National Hospital in Nairobi, and Moi Teaching and Referral Hospital in Eldoret are at the top of the public healthcare system (Muthaka et al. 2004). The second hierarchy is the provincial level, which is an intermediary between the national and the district level. It oversees implementation of health care policies at the district level, maintains quality standards, coordinates and controls the districts health activities. In addition, it monitors and supervises the District Health Management Boards (DHMBs), which further supervise the operations of health activities at the district level. The provincial general hospitals are positioned at the provincial/middle level.

The district health services, where Murang'a District lies, are third in Kenya's hierarchy of health care services delivery. Concentration at this level is on delivery of health care services, and generation of own expenditure plans and budget requirements

based on guidelines from the headquarters through the provinces. The district level has the largest number of health facilities. These include district hospitals, sub-district hospitals, divisional health centres, dispensaries, and health clinics/posts. All these act as treatment and referral centres. Facilities become more and more sophisticated in diagnostic, therapeutic and rehabilitative services at the upper levels (WHO, 2004b; WHO 2002-2005).

The major players in the health sector are the government represented by the Ministry of Health (MoH) and the Local Government, private sector and non-governmental organisation (NGOs). The government is the major financier and provider of health care services in Kenya. Out of over 5,945 health facilities in Kenya, the government through the Ministry of the Health and the Ministry of Local government controls and runs about 2,290 (39%) health facilities. The NGOs and mission organisations run 1,015 (17%) health facilities, and the private sector the remaining 2,640 (44%) health facilities. Overall, the public sector controls about 50% of the hospitals, 80% of the health centres, 92% of the sub-health centres and 62% of the dispensaries. The NGO sector is dominant in health clinics, maternity and nursing homes and medical centres. Both the public and the NGO sector have an almost equal representation of hospitals (MoH, 2006; Muthaka et al. 2004).

The health situation in Kenya, like in other developing countries, is deteriorating and the health sector faces major challenges. Reproductive health challenges of maternal mortality, HIV/AIDS, STDs, and teenage pregnancies remain. Factors linked to health deterioration in Kenya include: poverty, high HIV/AIDS incidence rates, poor economic performance, malaria and other diseases (RoK-MoH, 2001a). Deterioration in health threatens the reproductive health gains made over the years. A reversal trend has been observed in recent years in health indicators. In 2003, the Kenya Demographic and Health Survey (KDHS) revealed that the use of contraceptives had stagnated at 39%, leading to an upward trend in TFR (CBS, 2003). In the 1990s, Kenya had one of the highest life expectancy rates in sub-Saharan Africa. Between 1989 and 1993 the life

expectancy increased from 49 years to 60 years. However, this level fell in 1998 to 57 years, and the downward trend is expected to continue due to HIV/AIDS (USAID, 2001). The life expectancy was estimated in 2002 to be 44.4 years (WHO, 2002).

Kenya is signatory to several international legal instruments intended to protect human rights like the 1994 ICPD Plan of Action. However, the health care for all notion remains as mere rhetoric. The WHO and international human rights law recognises the fundamental right to health care. However, the constitution of Kenya does not mention or refer to the right to health care, and does not include it in the list of protected rights in the Bill of rights (RoK-MoH, 2001d). This renders health care inaccessible to many Kenyans and fails to demonstrate government's commitment. It also results in inequalities in access to health care. In Kenya, only 42% of the population have access to health facilities within 4 kilometres and 75% within 8 kilometres (MoH, 2004). The situation is worse in the rural areas where only 30% of the population have access to health facilities within 4 kilometres radius. However, such access is available to 70% of urban dwellers. The quality of available health services is also inadvertently low due to inadequate supplies and equipment, lack of personnel and weak regulatory systems and standards (WHO, 2004c). The Kenya Health Policy Framework (1994) identified the critical problems of Kenya's health sector as: - lack of finances, inadequate capacity of the public health-care system, and inequitable distribution of key health personnel with a notable concentration in urban areas and shortages in the rural areas.

Kenya has no universal health insurance system. The government employs and pays the salaries of the hospital staff and provides medical supplies and equipment to the public hospitals, health centres and dispensaries. However, the government funding is low and is supplemented by patients who have to pay user-fee through a cost-sharing scheme (RoK-MoH, 2001d). In the absence of a health care scheme, adolescents have to pay for their services. This may present financial barriers for adolescents who have to disclose their sexual health care needs to their parents in order to get financial assistance to pay for services. This situation may be different for adolescents when they are in

school. In the absence of a national health care scheme, parents pay medical fees to schools. Schools take the responsibility for ensuring the health of students who fall sick or need medical care. Most schools have a resident, non-resident or a recommended health professional who attend to students medical needs. The choice of Murang'a would therefore make it possible for a study to be conducted to establish the extent to which adolescents are using reproductive health care services, and the barriers they experience in accessing and using PRHS in school situations and in health facilities.

### 3.1.6 The education system in Kenya and Murang'a District

Kenya's literacy rate is estimated to range between 75 and 85 percent, with the female literacy rate being about 10 percent lower than that of the male (Library of Congress, 2005). Kenya's education system is divided into primary (standard 1 – 8), secondary (form 1 – 4) and post-secondary education. The government is the main player in the education system. Other players include religious organisations, private sector and communities (self-help). Kenya's education administrative system is organised at three levels. The top organ is the government represented by the Ministry of Education (MoE), then the provincial level and the district level. The MoE sets education policies, the education syllabus and curriculum in partnership with key partners, particularly the NGOs and religious organisations. The provincial level oversees implementation of education policies at the district level and coordinates district education activities. The district level implements the syllabus and curriculum and inspects schools.

There are two types of secondary schools in Kenya, namely public and private schools. The public secondary schools are funded by the Government or communities and are managed through Board of Governors (BoG) and Parent-Teacher Associations (PTA). The private schools are established and managed by private individuals or organisations. This study covered district and provincial secondary schools in Murang'a

District. Secondary schools in Kenya are categorised into national, provincial, district and regional/local schools. There are two methods (streams) of admitting students to secondary schools in Kenya. These include the government and the private streams. Admission to either of the streams is determined by student's performance. Those with good grades are admitted to the government stream and pay fewer fees because they are subsidised by the government. The students whose grades are below the government's cut-off points are given a chance to join secondary schools but are admitted to the private stream. These do not receive subsidies from the government and therefore pay higher fees. The admission process follows a quota-system. National schools maintain equal representation of students from all parts of Kenya, whereas provincial and district schools admit most students from their provinces and districts respectively. The local schools admit students coming from their regions. However, all schools can admit students from any part of the country within the private stream, that is, outside of the government set quotas.

There has been remarkable growth in secondary education. The number of secondary schools has increased from 151 at independence (1963) with a gross enrolment of 30,120 students, to 3234 schools in 1999 with a gross enrolment of 661,824 students (MoH, 2004). However, the number of schools is inadequate to cope with increased population and increased demand for education. The 1999 Ministry of Education (MoE) estimates indicate that only 27% of the secondary school age group who complete primary education proceed to secondary schools. This represents a primary-secondary school transition rate of only 46%. The slow growth of secondary school institutions has contributed to many adolescents missing out on secondary education (MoH, 2004).

Kenya's education sector is faced with challenges that affect enrolment and quality of education. The 1990 Jomtien meeting re-affirmed education as a human right and adopted the World Declaration on Education for All (EFA). Despite the government commitment, enhancing girls' education and enlarged vision of basic education have yet

to be realised in Kenya (Abagi, 1999). Access and retention in education has stalled, the education quality has plunged, and teachers earn far less in real terms. About 20-25% of candidates who qualify and are selected for secondary education do not take up the places because of lack of fees. Many households are struggling to meet the cost of educating their children. An average family in Kenya living in an urban setting spends about 30-40% of its income on education, while an average family in a rural setting spends up to 60%. The costs include school fees, recurrent expenditures like textbooks, stationery, furniture, and school uniform. The quality of education is affected by overloaded curricula, lack of teaching materials, poor teaching approaches, poor or inadequate supervision, and low morale of teachers (Abagi, 1999). The government of Kenya recently made efforts to address the challenges facing the education sector. In 2003, the government started the free primary education program to ensure increased enrolment and retention levels. Although enrolment and retention have increased, the quality of education has been further compromised due to the high number of pupils per teacher. The government is faced with deepened challenges of staff shortages and lack of materials and equipment, including lack of learning space.

### 3.2 Research Process and Study Design

The cross-sectional qualitative study used a combination of methods in sampling, data collection and analysis techniques. The research process was undertaken in stages. Activities included literature search and review, development of study proposal, data collection, transcription of interviews and data analysis, dissemination and writing of the dissertation. Table 3.1 shows the research process. Activities are described further in detail.

Table 3.1 Sampling frame and sample selection of in-school adolescents

<b>Time Frame</b>	<b>Activities</b>	<b>Outputs</b>
I: Proposal Development <i>2003 April – 2004 January (Germany)</i>	<ul style="list-style-type: none"> <li>• Searching and review of relevant literature</li> <li>• Development of research proposal (including study objects, proposed methodology)</li> <li>• Development of data collection instruments</li> </ul>	<ul style="list-style-type: none"> <li>• Complete study proposal</li> <li>• Data collection instruments (for adolescents and health providers/key informants)</li> </ul>
II: Phase one: Field data collection <i>2004 February – May (Kenya)</i>	<ul style="list-style-type: none"> <li>• Contact setting and obtaining research permit and necessary authorisation.</li> <li>• Recruitment and training of research assistants.</li> <li>• Conduct interviews with in-schools adolescents.</li> <li>• Conduct interviews with health providers.</li> <li>• Conduct interviews with key informants.</li> </ul>	<ul style="list-style-type: none"> <li>• 114 adolescent interviews</li> <li>• 25 health providers interviews</li> <li>• 18 key informant interviews</li> </ul>
III: Transcriptions & Analysis <i>2004 June – mid August 2005 (Germany)</i>	<ul style="list-style-type: none"> <li>• Transcriptions of adolescents, health providers and key informant interviews</li> <li>• Coding, data entry of adolescents data into SPSS and analysis</li> <li>• Analysis of health providers &amp; key informants data</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews transcripts: - 114 adolescents 25 health providers 18 key informants</li> <li>• Draft report</li> </ul>
IV: Phase Two: Dissemination <i>2005 August – November (Kenya)</i>	<ul style="list-style-type: none"> <li>• Dissemination of preliminary findings with adolescents, health providers, key informants and relevant stakeholders.</li> </ul> <p><i>Purpose:</i></p> <ul style="list-style-type: none"> <li>• Share research findings with study participants, fill in data gaps, and validate the study findings.</li> </ul>	<ul style="list-style-type: none"> <li>• Dissemination forums for in-school adolescents in seven secondary schools as in stage II.</li> <li>• Dissemination workshop for health providers, key informants &amp; stakeholders.</li> </ul>
V: Finalise <i>2005 December – 2006 July (Germany)</i>	<ul style="list-style-type: none"> <li>• Further analysis, finalise writing of the dissertation, submit and defend.</li> </ul>	<ul style="list-style-type: none"> <li>• Dissertation</li> </ul>

### 3.2.1 Proposal formulation and development of data collection instruments

This study is based on data obtained through primary and secondary sources. The preparatory phase of this study was undertaken at the School of Public Health, University of Bielefeld in Germany. This included searching and reviewing of relevant literature, and designing of the research instruments. I obtained secondary data through extensive search, review and analysis of relevant literature and published documents. The sources of secondary data included journal articles, books, research reports, policy documents, working papers, conference proceedings and Internet sources. The data provided background information about adolescent reproductive health, the existing reproductive health policies, and possible barriers to care. I used the information to form the study purpose and research questions, to describe relevant study concepts and themes, and to strengthen the research objectives. I also identified relevant theories that were suitable in explaining conceptual issues raised by the study, and in supporting findings and generalisations emanating from the data.

I carefully designed two sets of interview questionnaires containing open-ended questions (Appendix A) to be used in generating the needed information from the adolescents, the health providers and the key informants. The study intended to gather data directed towards understanding the perspectives of adolescents and the health care providers about factors that influence access and use of PRHS by adolescents. The study also sought an understanding of the extent to which ethical, structural and institutional barriers, among other factors, influenced access and use of services by adolescents. In addition, the study sought to understand the policy framework that guided provision of services to adolescents. The interview questionnaire for adolescents consisted of five (5) structured demographically oriented questions, twenty-nine (29) structured open-ended questions. The interview questionnaire for the health providers and key informants consisted of three bio-data questions, and 13 structured open-ended



questions. Additional questions were added and asked to interviewees from the MoH and MoE as appropriate.

The study findings are expected to give a better understanding of the level of utilisation of reproductive health care services by adolescents in Murang'a, and of the constraints and barriers adolescents face in accessing and utilising preventive reproductive health services. The study is expected to provide proposals to the government and non-governmental organisations (NGOs) that if adopted, would tackle the barriers faced by adolescents in accessing and utilizing their services, and enhance the use of reproductive health services by adolescents in Murang'a, Kenya. The study is also expected to contribute to knowledge about reproductive health policies for adolescents in Kenya and to propose ways of strengthening the policies.

### 3.2.2 Contact setting and research authorisation

The fieldwork in Kenya was divided in two phases. The first phase was the field data collection, and the second the dissemination and data validation phase (see Section 3.4.3). The study design is provided in Figure 3.4. The first phase of the field research was conducted between February and May 2004 with support from the German Academic Exchange Service (DAAD). Fieldwork activities were divided in two parts. The first part entailed contact setting, acquisition of necessary clearance and written authorisation, recruitment and training of research assistants, sample selection and pre-testing. The second part entailed data collection.

Before commencement of the field data collection, I got a research permit from the Ministry of Education, Science and Technology in Nairobi, Kenya, which is the national research co-ordinating body. This was followed by contact setting phase which aimed at obtaining necessary clearance and authorisation, identifying the research subjects and informing them about the planned research, its purpose, themes and objectives. Another aim of contact setting was to make appointments for data collection.

The phase started with obtaining of further clearance and written authorisation from the MoH district representatives, the District Education Office, and the schools Principals. I visited Murang'a District hospital and contacted the hospital Matron and the District Medical Officer of Health (DMOH). I informed them about the planned study and obtained written authorisation to go to the health facilities in the district. I then contacted the office of the District Public Health Nurse (DPHN) and obtained information and list of health facilities in the district. The next step entailed contacting the health providers in selected health facilities. At the same time, I contacted the district education office to obtain written clearance permitting me to gain entry to the schools.

### 3.2.3 Ethical considerations

I was conscious of the ethical issues and guidelines for research on reproductive health involving minors (WHO, 2003b). This study targeted adolescents who were in the age category of minors. I was thus ethically bound to observe and adhere to the stipulated guidelines. I obtained the necessary authorisation and clearance before commencement of the study. Although parental or guardian consent is required when undertaking research with minors, this was not possible because the target of this study were the in-school adolescents. I considered the district education representatives and the school authorities as the rightful guardians. I however obtained informed verbal consent from the adolescents before commencement of the interviews because they had the ability to understand information regarding the issues raised in the study (Dickens and Cook, 2005; Elster and Kuznets, 1994; MRC, 1999). I informed them in detail about the study purpose and made them aware that participation was voluntary, and that they were free to decline or end the interviews at any time if they had compelling reasons to do so. I emphasised and assured them that their decision would not affect their relations with the school or with the research team. I also informed them that the

interviews would be audio-taped, that the information obtained would be held with confidentiality, and that it would not be used for any other purpose other than the study.

I safeguarded the confidentiality of the study subjects by conducting the interviews in private rooms and in offices. The interviews took place in situations that enhanced confidentiality and which were comfortable for the researcher and adolescents (Conrad, 2002). This enhanced participant's sensitivity and co-operation (Marshall and Rossman, 1995). Further, I labelled the transcribed tapes in a way that disguised participant's identity at all stages of data collection, management and analysis. I did not promise or give any monetary compensation to the study participants. However, I informed them that they would benefit from the study results which I later shared with them after completing the analysis of preliminary findings (see Section 3.4.3).

### **3.3 Study Sample and Sampling Procedures**

Before selecting the study sample, I first identified the population that formed the sources of data as required of all qualitative studies (Wamboldt, 1992). These included adolescents in schools, health providers from selected health facilities and senior officers and persons representing government departments, NGOs, CBOs, and FBOs. I used systematic and purposive sampling techniques to select the sample of interest. Figure 3.3 below shows the location of the study sites in Murang'a District including the schools and health facilities covered in the study.

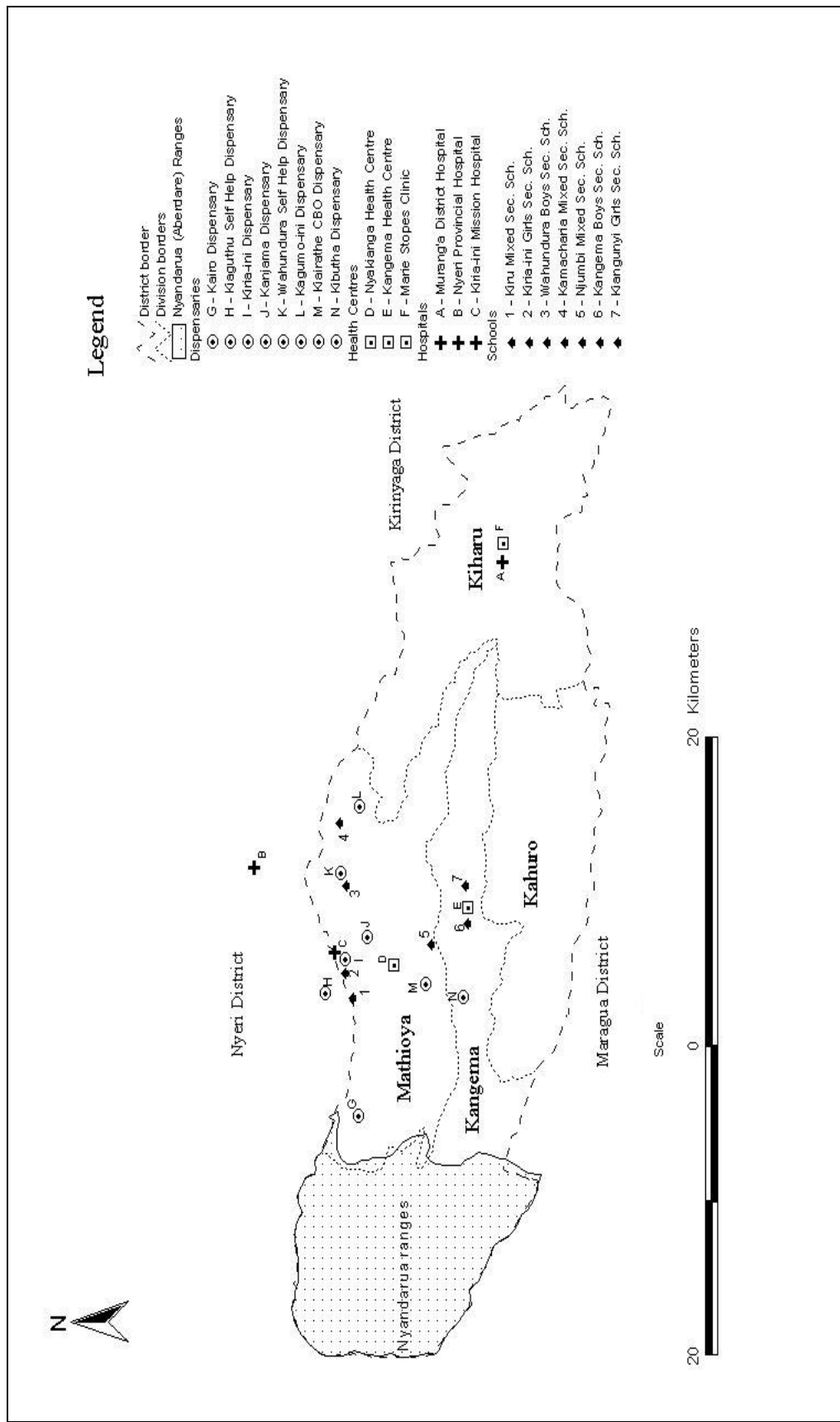


Figure 3.3 Murang'a District administrative units showing data collection points

### 3.3.1 Selection of schools and sample of in-school adolescents

Adolescents in school were the focus of this study. This was in recognition of the fact that adolescents spend most of their time in schools and undergo adolescence development and transition during their school life. It is also in schools that adolescents have close interaction with their peers who may influence their sexual health behaviour. The schools are thus critical in shaping reproductive and sexual behaviour of adolescents, and in providing reproductive health information and services that can help them meet their reproductive and other health concerns.

To select the adolescents sample, I first obtained the list of schools in Kangema and Mathioya Divisions from the district education office. The list contained forty (40) schools. Among these, 14 were boys schools, six were girls schools and the remaining 20 were mixed schools. From these, I used gender as a criterion to select two girls' schools, two boys' schools, and two mixed schools (see Table 3.2). I also used the Ministry of Education (MoE) classification of schools to select district and provincial schools. The aim was to get a fair sample of public schools that had district, provincial and national representation of the adolescent population. Kangema and Mathioya Divisions had a good representation of provincial, district and local schools, thus providing a good range of schools to choose from. The selected schools were Kiria-ini Girls, Kiangunyi Girls, Kangema Boys, Wahundura Boys, Njumbi Mixed and Kiru Mixed secondary schools. In addition, I identified and selected Kamacharia Mixed secondary school for pre-testing. The data from the pre-tests are not included in the analysis. Selection of schools was followed by visits to the schools. I contacted the school Principals to introduce the study purpose and myself, to get further clearance to interview adolescents, as well as set the dates for conducting the interviews. I also obtained class lists of students in the various schools. The interviews were scheduled in the afternoons and on weekends to avoid interruption of the learning programmes.

The sample of adolescents targeted secondary school boys and girls aged between 13 and 19 years. I considered them as valuable source of information because they were capable of bringing out the needed information. They are the owners of this study because it was their lives that were being investigated. They belong to the age group highly at risk of contracting HIV/AIDS and STDs, and suffer the effects of teenage pregnancy like illegal abortions and school dropout due to pregnancy. They also belong to a group that experience constraints if services are not available, easily accessible or affordable. The choice of adolescents therefore enabled generation of first-hand information about the extent to which they used preventive reproductive health care services. They are thus the best at proposing strategies that, if adopted, can improve their services.

From the selected schools, I used systematic random sampling technique to sample adolescents. I used the lists of students in the various classes (forms 1 – 4) to systematically select 128 adolescents. The aim was to get a representative sample of adolescents in the selected schools. I intended to obtain a sample of four adolescents per class that would have equal representation of boys and girls. This process involved working out the sampling interval by dividing the total number of adolescents per class with the required sample size of four. I wrote down the numbers corresponding to the sampling interval on pieces of paper of the same size and weight to determine where to start. Kiria-ini girls, for example, had 530 students distributed as follows; Form one – 144, Form two – 120, Form three – 134, and Form four – 132. I divided the class totals by four and got a sampling interval of 36, 30, 34, and 33 respectively. I used the sampling interval to select four students per class accordingly. For example, the Form one class had 144 students and a calculated sampling interval of 36. I wrote down numbers 1 – 36 on small pieces of paper, folded them, put them in a small box, and asked the research assistants to pick one. The picked number determined the starting point. I then added every 36<sup>th</sup> number to get the required sample of four adolescents. I repeated this process in selecting the sample in the form two, three and four classes until

I got the desired sample of four girls in each class and a total of 16 in all the classes. I repeated the same process in the other five schools and attained a final sample of 128 from 2525 adolescents (i.e.  $N=2525$  and  $n=128$ ) as shown in Table 3.1 below. The table shows the selected sample of adolescents by schools and class. It also shows the sampling frame and sampling fraction. The sample of adolescents in the mixed schools was higher because it included both genders.

With the help of the teachers, I then called the selected adolescents in one room. I introduced the research team and myself to them and informed them about the purpose of the study. I informed them about their role as participants and that I was doing the research as part of my doctoral study programme. Once their verbal consent was obtained, we began to conduct the individual interviews. The face-face interviews were conducted in private rooms, on one-to-one basis and without the teachers and other students to safeguard the privacy of the participants, and to create a free environment that would ensure that their confidence was enhanced.

Table 3.2 Sampling frame and sample selection of in-school adolescents

School <sup>2</sup>	Class Totals	Sampling Fraction (Sampling frame ÷ 4* or 8 <sup>♦</sup> )	Total Class Samples
Kiria-ini Girls	Form 1 - 144	36	4
	Form 2 - 120	30	4
	Form 3 - 134	34	4
	Form 4 - 132	33	4
Kiangunyi Girls	Form 1 - 144	21	4
	Form 2 - 120	16	4
	Form 3 - 134	18	4
	Form 4 - 132	17	4
Kangema Boys	Form 1 - 162	40	4
	Form 2 - 147	37	4
	Form 3 - 123	31	4
	Form 4 - 94	23	4
Wahundura Boys	Form 1 - 85	21	4
	Form 2 - 65	16	4
	Form 3 - 58	15	4
	Form 4 - 31	8	4
Kiru Mixed (Boys)	Form 1 - 66	16	4
	Form 2 - 20	5	4
	Form 3 - 22	5	4
	Form 4 - 27	7	4
Kiru Mixed (Girls)	Form 1 - 22	5	4
	Form 2 - 21	5	4
	Form 3 - 26	6	4
	Form 4 - 25	6	4
Njumbi Mixed (Boys)	Form 1 - 79	20	4
	Form 2 - 103	25	4
	Form 3 - 104	26	4
	Form 4 - 91	23	4
Njumbi Mixed (Girls)	Form 1 - 79	20	4
	Form 2 - 90	22	4
	Form 3 - 84	21	4
	Form 4 - 66	16	4
Total student population	N = 2525	Final sample selection n = 128	

<sup>2</sup> Note: Kamacharia mixed secondary school is not included. It was used for pre-test.

\* In one gender schools

♦ In mixed gender schools



### 3.3.2 Sample of the health providers

I used purposeful sampling technique to select the sample of health providers and key informants. The aim was to get a sample capable of providing rich information (Sandelowski, 2000) based on the providers and key informants practical experience with adolescents, and their familiarity with reproductive health policies. Their selection was also based on their potential to provide data on the range of reproductive health services offered in Murang'a District, and those that are offered to adolescents. The selected sample would thus generate invaluable data about available reproductive health care services for the adolescents, on the extent to which adolescents in Murang'a sought and used PRHS, and on the barriers and constraints that adolescents faced in accessing the services. They would also provide information about reproductive health policies that guide provision of PRHS for adolescents.

To obtain information from the health providers, I first identified and purposefully selected the health facilities to be covered. I obtained a list containing 39 health facilities in Kangema and Mathioya Divisions from the deputy District Public Health Nurse (D-DPHN). The health facilities included one district hospital, three health centres and 28 dispensaries. Others were one NGO health centre, one mission hospital, three church based dispensaries, and two community based dispensaries.

The sample of the health institutions thus comprised 14 institutions selected from the 39 health care facilities. I selected Murang'a district hospital because it represents the highest level of the district health care structure and forms the link between the district and the provincial level. At the divisional level, I selected two facilities namely, Kangema health centre and Nyakianga health centre. I further selected seven dispensaries at the regional (local) level (five government and two community based). These included Kiria-ini dispensary, Kagumo-ini dispensary, Kanjama dispensary, Kairo dispensary, Wahundura self-help dispensary, and Kiarathe CBO dispensary. In addition, I covered Kiaguthu self-help dispensary located at the border of

Murang'a and Nyeri Districts. I included it because it served communities from both districts and the health providers referred to it during the interviews. Other selected facilities included the Marie Stopes clinic because it was the only NGO health facility in Murang'a District that provided reproductive health services. I selected Kiria-ini Mission hospital because it doubled as a health centre for many people living in Mathioya Division. It would also offer invaluable information on the linkage between religion and provision of PRHS to adolescents.

I included the Nyeri youth clinic situated at the Nyeri Provincial general hospital because several of the health providers and a few adolescents referred to it. Although outside Murang'a District, the inclusion of the Youth clinic in the study was important. It would provide a good understanding of the kind of services provided to adolescents in the province, the level of utilisation of PRHS by adolescents, and the challenges that providers encounter in providing PRHS to adolescents. It was also capable of generating information that would guide policies and programmes for ensuring provision of quality services to adolescents. The inclusion of the youth clinic was also guided by the grounded theory (Glaser, 1992; Straus and Corbin, 1990). The aim was to obtain information until no new information was forthcoming, thus reach saturation as stipulated by the grounded theory (Dick, 2002). The coverage of the Nyeri youth clinic led to further leads and inclusion of the national level representation. I contacted a senior health expert at the department of Community Health, University of Nairobi to get complementary information and national perspective of reproductive health policies in Kenya. Another aim was to get a deeper understanding of how the policies influence implementation of adolescents health programmes at the grassroots, district, provincial and national levels.

After the selection of the health facilities, I contacted the health providers in charge of the facilities and booked appointments for conducting the interviews. They represented every level of the district health care system. At the Murang'a District hospital, the health officers included the District Medical Officer of Health (DMOH),

the District Public Health Nurse (DPHN) and the deputy (D-DPHN), the District AIDS/STDs Co-ordinator (DASCO), and the district nurse in-charge of MCH/FP clinic. The divisional level was represented by two Nursing officers in charge of health centres, one HIV/AIDS voluntary counselling and testing Counsellor (VCT counsellor/nurse), one Kenya enrolled community health nurse (KECHN) in charge of MCH/FP clinic, one Public health officer (PHO), and one Public health technician (PHT).

The regional level was represented by five Kenya enrolled community health nurses (KECHN) four of whom were in-charge of their dispensaries and performed additional administration duties. In addition to provision of health services, they were responsible for acquisition of drugs and equipment, submission of monthly returns to the DPHN, and submission of HIV/AIDS and STDs data to the DASCO. Other selected health providers included one hospital Matron, one Kenya enrolled community health nurse, and a Clinical officer based at Kiria-ini mission hospital. Others were three Enrolled community health nurses (ECHN) representing three CBO dispensaries, and one nurse representing Marie-Stopes clinic. Others included one nurse/youth counsellor working at the Nyeri youth clinic and one senior health expert. The characteristic of the selected health facilities and sample composition of the health providers are presented in Table 3.3 below.

Table 3.3 Selected health facilities and sample composition of health providers.

Selection Levels	Type of institution & Name of the institution	Designation	Total interviewed
National level	Department of Community Health, University of Nairobi (University teaching department)	Senior Health Economics	1
Provincial level	Nyeri youth clinic located (MoH) at Nyeri provincial general hospital	Youth counsellor (nurse)	1
	Kiaguthu self help dispensary (CBO)	Kenya enrolled community health nurse (KECHN)	1
District level	Murang'a district hospital	District Medical Officer of Health (DMOH)	5
		District Public Health Nurse (DPHN)	
		Deputy District Public Health Nurse (D-DPHN)	
		District AIDS and STIs coordinator (DASCO)	
		District nurse in-charge MCH/FP	
	Marie-Stopes clinic (NGO)	KECHN	1
Sub-district level	Kangema health centre (MoH)	Clinical officer/nurse in-charge VCT counsellor	5
	Nyakianga health centre (MoH)	Nurse in-charge MCH/FP Public health officer Public health technician	
Community/ local level	Kagumo-ini dispensary (MoH) (x2)	KECHNs	6
	Kairo dispensary (MoH)		
	Kanjama dispensary (MoH)		
	Kibutha dispensary (MoH)		
	Kiria-ini dispensary (MoH)		3
	Kiria-ini mission hospital (Church based)	Hospital administrator KECHN Clinical officer	
		Kiarathe dispensary (CBO)	KECHNs / MCH/FP
	Wahundura self help dispensary (CBO)		
Total			25

### 3.3.3 Sample of the key informants outside the health care system

The key informants sample included senior officials representing government departments. These were expected to give views about available reproductive health programmes in the district and the extent to which the programmes addressed health problems of adolescents. They were also expected to contribute information about health policies that influenced provision of services to adolescents. The key informants complemented the data obtained from the health providers and adolescents, thus giving a full picture of the situation of adolescent health services in the district. The government departments that were covered included the following. The district department of education represented by the Deputy District Education Officer (DDEO). The department is charged with the tasks of overseeing the implementation of education curriculum and education policies in the district. Others included the District Education Officer in charge of coordination of guidance and counselling and HIV/AIDS programmes in the district, and the Zonal Education Officers in charge of supervising implementation of the school curriculum. Other departments included that of Gender, Sports, Culture and Social Services represented by the District Social Development Officer (DSDO); and the District Information department represented by a youth representative.

I contacted the DSDO and District Development Officer (DDO) to get information about organisations working on health aspects in Murang'a District. Through them, I identified and contacted four community based organisations (CBOs) and two religious/faith based organisations (FBOs) and made appointments to conduct interviews. The CBOs included the Community Initiative Support Organisation (CISO), Murang'a Centre for Adolescents, Graduate for Community Development (GCD), and Care for the Needy. The FBOs were Murang'a Catholic Diocese and Murang'a Anglican Church youth programme. The sample characteristics of key informants in the study, and their respective organisations are presented in Table 3.4 below.

Table 3.4 Sample composition of key informants and their respective organisations

Selection Levels	Type and name of institution/organisation	Designation	Total interviewed
<i>Government departments</i>			
District Level	Department of Education (District education office)	Deputy District Education Officer	2
		District guidance and counselling officer	
	District gender, sports, culture and social services office	District Social Development Officer	1
	District information office	Trainee journalist / Youth representative	1
Sub-district level	Department of Education	Divisional education officers - Mathioya (x3)	5
		Zonal education officers – Kangema (x2)	
<i>Church based organisations (FBOs)</i>			
District Level	Departments of the Murang'a Catholic Diocese	Family life program coordinator	3
		Youth program coordinator Health program coordinator	
	Diocese of Mount Kenya Central, Murang'a Anglican Church	Youth program coordinator	1
<i>Community based organisations (CBOs)</i>			
District Level	Murang'a centre for adolescents	Organisation leaders	3
	Graduates for community development (GCD) (x2)		
Sub-district level	Community initiative support (CISO)	Organisation leaders	2
	Care for the needy		
Total			18

### **3.4 Data Collection: Phase One**

#### 3.4.1 Recruitment, training of research assistants and pre-testing

Prior to the actual data collection, I identified, commissioned and trained three research assistants to help with administration of adolescent interviews. The three, all graduates, had previous research experience. I trained them on the study themes, aims and objectives and introduced them to data collection and recording methods. The team gained practical exposure in data collection and recording process by piloting and pre-testing the questionnaire. Pre-testing also helped the research assistants to become familiar with the questionnaire (McCormick and Schmitz, 2001). After the pre-tests, I held debriefing sessions with the assistants to get feedback about the clarity and consistency of concepts, terminologies and questions in the questionnaire. We identified a few questions that were not clear and made necessary adjustments to the questionnaire. I also got feedback from the assistants about their experience with tape recording. We identified and corrected problematic areas. This prior experience and exposure helped to strengthen and improve the data collection process. The debriefing sessions also helped to identify emerging issues and areas that needed further probing. It also enhanced teamwork spirit.

#### 3.4.2 Data gathering

The primary data for the study was obtained through field research. I used the methodological triangulation approach (Thomas, 2002) to obtain data from different study subjects namely from adolescents, health providers and key informants, and from different sources. The aim was to get a broader perspective of the complex and sensitive issues that often shroud adolescent reproductive health and sexuality. I also achieved this by use of different data collection methods that included interviews, unstructured

observations and documents analysis. Conducting in-depth interviews allowed probing (McCormick and Schmitz, 2001). This helped to gain a more complete picture on the factors influencing adolescents access and utilisation of PRHS. I also collected the data at different levels in the district and to a small extent, the provincial and national level.

I used structured open-ended interviews to collect information from the adolescents, health care providers and key informants using different sets of questionnaires (Appendix A). The interviews were conducted in English, which is the language of instruction in Kenya secondary schools and also the official language. There were occasional interjections in Swahili and in Kikuyu languages especially during probing or when the respondents used proverbs and sayings to explain an issue. I gathered the data for adolescents from the selected schools using a structured questionnaire. All adolescents were asked identical questions in the same sequence. The interviewers probed when necessary. The individual interviews were conducted through face-face interactions. The aim was to gather information that would describe the reproductive health concerns of adolescents, their knowledge about available preventive reproductive health services, their level of use of the services, and the barriers and challenges they encountered in accessing and utilising identified services. I also collected their personal data on age, sex, education, religious affiliation and family status.

I collected the data from the health providers and key informants using a structured interview schedule. The health providers and key informants were asked similar questions to generate the needed data. Additional questions seeking specific information from the MoH and MoE representatives were added and asked as appropriate. The questions focused on specific aspects of reproductive health services and policies that guided provision of PRHS for adolescents.

This study aimed at getting information from the study subjects in their own words (Gilgun, 1994). This was achieved by tape-recording of all interviews to enhance



data completeness, validity and reliability. Note-taking was done when necessary. The recorded tapes were labelled for easy identification and accessibility.

### 3.4.3 Other data sources: observation and policy documents

Another source of primary data was unstructured observations. For example, I observed the physical structure and institutional set-up of the health facilities and the placement of condom dispensers. I collected other primary data through documents analysis. I obtained the Policy paper on *Adolescent Reproductive Health and Development* (RoK, 2003a) from the National Council for Population and Development (NCPD) and the *National Guidelines for voluntary counselling and testing (VCT)* (RoK, 2001c) from the DASCO. The documents were relevant for the study. The former contained information that showed governments attempt to address adolescents reproductive health needs, and the latter the guidelines for provision of VCT services.

### 3.4.4 Dissemination of preliminary findings: Phase two

I conducted a second phase of the fieldwork between September and October 2005. All the schools that were covered during the field data collection were visited. Adolescents who had been interviewed were requested to participate in the dissemination forums. During both exercises (data collection and dissemination), many adolescents expressed gratitude to the research team and noted that they benefited from the exercise. They saw and used the research process as an opportunity to raise personal health concerns. They noted that the research had availed them an opportunity to share their concerns. The research process was thus informative not only for the researcher but also therapeutic for the adolescents. A dissemination workshop was also held with the health providers, representatives of government departments, NGOs, community based organisations (CBOs) and religious based organisations (FBOs) in Murang'a

District. The dissemination forums with the adolescents, and the workshop with health providers and key informants, aimed at sharing and discussing the preliminary study findings, filling study gaps, and data validation.

#### 3.4.5 Theoretical justification for choice of methods

This study was guided by the grounded theory to explore different dimensions and gain a broad perspective of the issues under investigation. The theory is suitable in qualitative health research in examining the social context of health care (Conrad, 2002). It permitted maximum interaction with the adolescents, health providers and key informants who provided answers to the research questions. The lack of data about adolescent sexuality and reproductive health in the study district made the theory appealing. It allowed collection and interpretation of original data from and with the research subjects. I had some *theoretical sensitivity*<sup>3</sup> because of the previous experience in reproductive health research. This further qualified the use of grounded theory as the best placed method given such a disposition. The study aimed at collecting information from the study subjects until saturation point was reached. The data validation phase ensured that the information needed to effectively answer the research questions was gathered, and that no new information was forthcoming.

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<sup>3</sup> A researcher's personal quality desirable in grounded theory and defined as the awareness of the subtleties of meaning of data emerging from previous reading and experience with or relevant to an area of study (Strauss and Corbin 1990).

## **3.5 Data Management and Analysis**

### **3.5.1 Interviews transcription and categorisation**

I transcribed the interviews verbatim into written question and answer form. No attempt was made to summarise, paraphrase or correct bad grammar (McCormick and Schmitz, 2001). The transcriptions lasted on average two hours per interview with the longest taking 3 hours 30 minutes, and the shortest 40 minutes. Data analysis began with studying and coding of interview excerpts. This enabled conceptualisation and categorisation of key themes emanating from the data. Initial reading through the transcription excerpts of adolescents data showed a pattern that yielded similar responses. I developed a codebook based on emerging categories (Guest, Bunce and Johnson, 2006). I added categories in the coding system as they emerged. I then used the codebook to systematically categorise and code the interview transcripts of adolescents data. I applied the codes to transform the data into numerical quantitative form. This process is called quantitative coding of qualitative data (Trochim, 2004). McCormick and Schmitz (2001) in a manual for value chain research on home workers in the garment industry observed that:

The coding of open-ended questions requires more attention and researcher involvement. Unless the survey is so large as to make this impractical, it is usual for all open-ended responses to be listed. The researcher then reviews the list and prepares a set of categories. The categories depend to a large extent on the purpose of the study and of the particular question. A question soliciting reasons for using a particular supplier may, for example, in one context have responses reduced to only two categories (economic reasons and social reasons) while in another, up to ten categories might be needed.

Trochim (2004) observed that all qualitative data can be coded quantitatively and that this does not detract from the qualitative information. Trochim further noted

that quantitative coding of qualitative data is achieved by assigning meaningful numerical values and performing classification of the text responses. The values can then be manipulated to help achieve greater insight into the meaning of the data and to help examine specific hypothesis. Trochim also noted that quantitative coding gives useful additional information and makes it possible to do analyses that couldn't be done with qualitative coding like looking at similarities among the themes, and even performing simple correlation matrix and multivariate analyses. According to Trochim, quantitative coding of qualitative data opens new possibilities for interpretation that might otherwise go unutilised.

### 3.5.2 Analysis of adolescents data using SPSS

Following McCormick and Schmitz (2001) and Trochim (2004) guidelines, I entered the categorised and coded data in the SPSS program. I used the SPSS data to generate frequencies and percentages, and where necessary cross-tabulations. I presented the frequencies, percentages and cross-tabulation in descriptive form such as tables and graphs. Similarly, I analysed the data on personal information using SPSS. The use of SPSS was considered appropriate first because the sample size was large (n=114) and second, because I obtained the data using a standard questionnaire. The use of numbers added considerable value to this research and made it easier to read the results 'at-a-glance' as observed by McCarry and Baxter (2004).

### 3.5.3 Qualitative content analysis of in-depth data

In this study, as in other qualitative research, data analysis is inductive and the findings emerge from the data. I analysed the in-depth data from adolescents, health providers and key informants using qualitative content analysis; a method often used to analyse qualitative data (Sandelowski, 2000) and to enhance external validity

(Wamboldt, 1992). Qualitative analysis allows researchers to find out why certain trends in data have occurred and to complete the story that quantitative analysis provides. Qualitative analysis entails the use of research techniques that help answer the question "why" and provide greater understanding of the reasons behind quantitative trends and results. Qualitative analysis often includes consideration of indicators and factors that may not be easily quantifiable (UoM, 2002).

The process entailed step-by-step analysis of the transcription interviews (see Appendix B). This entailed formulation of a definition criterion derived from the research questions. It also entailed determining the aspects of the textual material (transcribed data) to consider. I worked through the transcribed interviews and developed tentative categories. I then used elaborate coding and continuous comparisons to develop the analysis, allowing the categories to emerge from close reading and analysis. I revised the categories as I continued with data analysis (feedback loops) and eventually reduced these to main categories (Mayring, 2000). I developed empirical generalisations from the data by categorising the data thematically and creating new themes as they emerged (Conrad, 2002). I identified meanings, themes, patterns, connections and contrasts and compared them until I reached saturation, where no new themes were emerging. For example, I compared the interview excerpts from adolescents data with those of the health providers and key informants data. That is, comparing data with data and looking for commonalities and differences within the data to get conceptual categories (Charmaz, 2002).

I interpreted the data to find descriptive patterns and attached meanings in the information given by the study participants. I further selected transcription excerpts from the adolescents, health providers and key informant interviews to support the study findings and discussions in chapters 5, 6 and 7. I further compared the data (study results) with other studies (triangulation). The process enhanced data reliability and provided abundant information to support the study findings on the factors influencing access and utilisation of PRHS by adolescents in Kenya. The findings pointed to the

need for a policy to enhance access and utilisation of preventive reproductive health services.

#### 3.5.4 Constraints experienced during fieldwork

Several challenges were encountered during the fieldwork period. Restriction of school interviews to after-school hours posed time constraints. The interviews were conducted on weekdays from 4.00pm to 8.00pm and weekends from 10.00am. School interviews were further restricted to one day with a maximum of two days per school. This constrained the process further and resulted in interview sessions continuing to as late as 8.00pm. To counter the challenge, I commissioned an additional research assistant and ensured that reliable transport was available. I made careful considerations in the choice of schools. I included schools that were in areas that were accessible at all times to ensure movement and safety of the research team. This, however, did not bias the choice of schools because the district and provincial schools in Mathioya and Kangema Divisions are located in areas that are accessible through tarmac and all-weather access roads.

Interviewing adolescents proved a worthwhile undertaking. Many expressed appreciation for the research. However, a few were timid, shy and had difficulties expressing themselves and giving information freely. I also did not interview targeted key informants at the reproductive health unit at the national level. Efforts to reach the officers through telephone and personal visits to their offices yielded no success.

The interview recording process presented challenges because three health providers declined to be tape-recorded. I thus wrote down the interviews. This was time consuming because of interruptions to allow note-taking. I read through the notes immediately after the interviews to ensure completeness of the information and safeguard against loss of valuable data. Figure 3.4 below shows the study design, the data collection process and the levels of sample selection. The design used in this study

is used and popularised by the Institute for Development Studies (IDS), of the University of Nairobi, Kenya. I learnt and got exposed to the design at IDS where I worked as a Project Assistant.

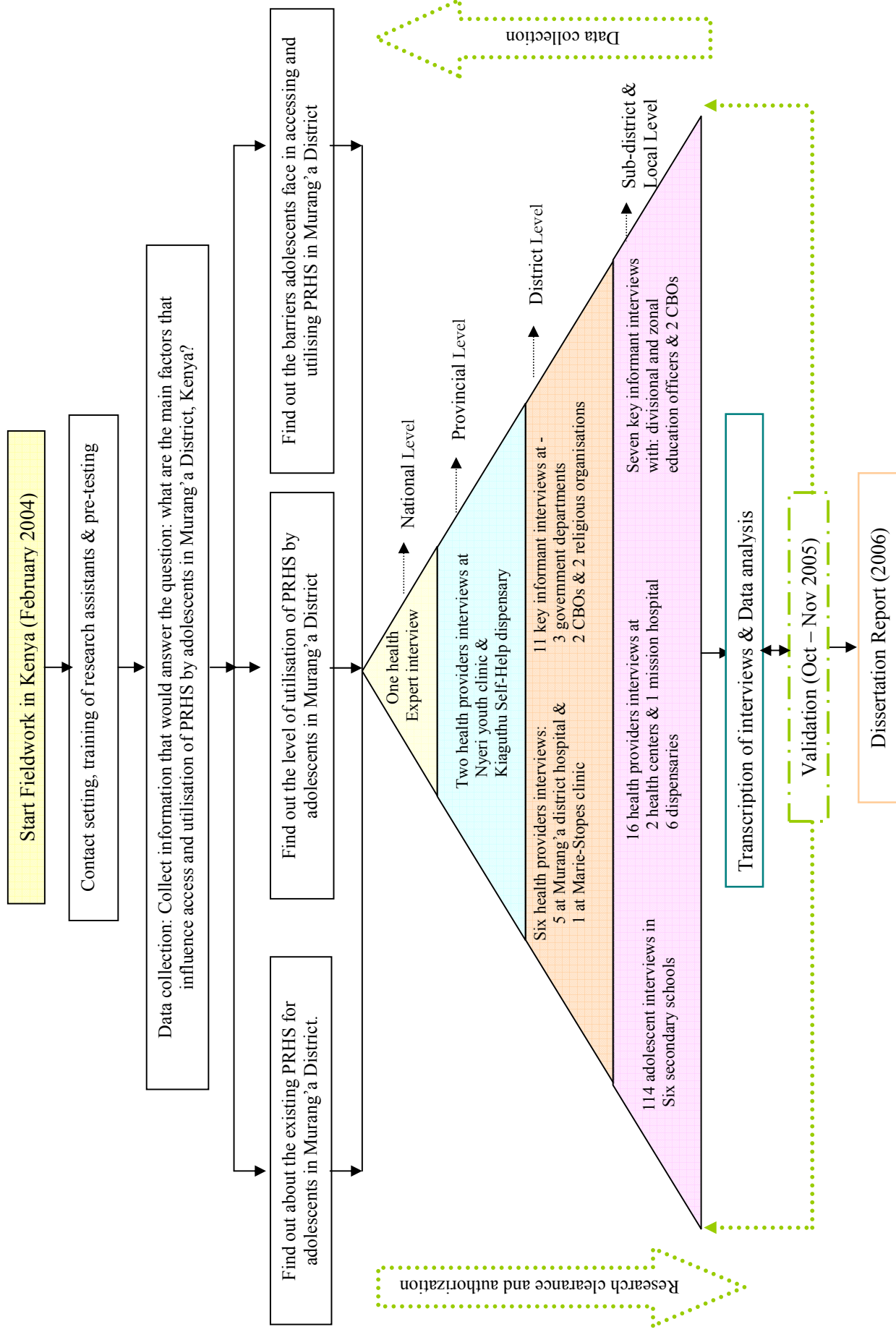


Figure 3.4 Research process & study design



## **CHAPTER 4**

### **RESULTS: PERSPECTIVES OF ADOLESCENTS**

#### **4.1 Overview**

This chapter presents the results of the interviews conducted among the sampled adolescents. The chapter is based on data obtained from 114 interviews (see Table 4.1) with adolescent boys and girls in six schools namely, Kiria-ini Girls secondary school, Kiangunyi Girls secondary school, Kangema Boys secondary school, Wahundura Boys secondary school, Njumbi Mixed secondary school, and Kiru Mixed secondary school. Although the study intended to obtain equal samples of adolescents in the various classes (see Table 3.2), the adolescents who participated in the research were 114 (Table 4.1) yielding to a response rate of 89%. The shortfall in the interviews, from the intended 128 interviews, resulted due to the following reasons. Six adolescents (two from Njumbi Mixed and four from Kiru Mixed secondary schools) terminated the interviews prematurely. In addition, time constraints hindered completion of six planned interviews in Njumbi and Kiru mixed secondary schools, whereas two interviews yielded poor information and were discarded. The response rate of 89% is nonetheless ideal to permit analysis and data reliability.

This chapter describes the demographic characteristics of the adolescents and the results of adolescent interviews. The results are presented thematically focusing on the key research questions. They are also summarised in tables and figures. In some tables, the 'n' does not total to 114. These are cases where there was no response, or where only the valid response of multiple responses is shown. In such cases, the number of the adolescents who responded to the question is indicated.

Table 4.1 Frequency of the adolescents sample by sex, school and class

SEX	SECONDARY SCHOOL	FORM				TOTAL
		One	Two	Three	Four	
Boys	Kangema Boys	4	5	4	4	17
	Wahundura Boys	4	4	4	3	15
	Kiru Mixed	2		4	5	11
	Njumbi Mixed	3	4	3	4	14
	<i>Sub-total</i>	<i>13</i>	<i>13</i>	<i>15</i>	<i>16</i>	<i>57</i>
Girls	Kiria-ini Girls	4	4	4	4	16
	Kiangunyi Girls	4	4	3	5	16
	Kiru Mixed	4	2	3	3	12
	Njumbi Mixed	2	3	4	4	13
	<i>Sub-total</i>	<i>14</i>	<i>13</i>	<i>14</i>	<i>16</i>	<i>57</i>
<b>TOTAL</b>		<b>27</b>	<b>26</b>	<b>29</b>	<b>32</b>	<b>114</b>

#### 4.2 Demographic characteristics of the Adolescents

Data on the demographic characteristics of the adolescents were obtained during the interviews. The adolescents were sampled from six schools and from various classes i.e. form 1 - 4. Out of the 114 adolescents interviewed, 57 were male and 57 female. Table 4.1 shows the distribution of the adolescents sample by gender, schools and class. The average age of the adolescents was 16.7 years. The youngest was 14 years old and the oldest 19 years old. Close to three-quarters of the adolescents (71%) were Protestants and belonged to Presbyterian and Evangelical churches, a quarter (27%) were Catholics, and 2% belonged to other religious groups. About their home district, two-thirds (64%) were from (lived in) Murang'a District. The remaining one-third (36%) were from Nairobi, Nyeri, Maragua, Kirinyaga, Kiambu, Thika, Nakuru, Eldoret and Taita-Taveta Districts. Three-quarters of the adolescents (76%) lived with both parents, whereas a quarter (24%) lived with a single parent or relatives. Table 4.2 shows the characteristics of the adolescents interviewed in the study.

Table 4.2 Demographic characteristics of the adolescents in the study

Characteristic	Frequency (n=114)	%
Sex		
Boys	57	50.0
Girls	57	50.0
Age in years		
14	11	9.7
15	13	11.4
16	25	21.9
17	32	28.1
18	20	17.5
19	13	11.4
School		
Kiria-ini Girls	16	14.0
Kiangunyi Girls	16	14.0
Wahundura Boys	15	13.2
Kangema Boys	17	14.9
Njumbi Mixed	27	23.7
Kiru Mixed	23	20.2
Class		
Form 1	27	23.7
Form 2	26	22.8
Form 3	29	25.4
Form 4	32	28.1
Religion		
Protestant	81	71.0
Catholic	31	27.2
Other	2	1.8
Home district		
Murang'a	73	64.0
Other	41	36.0
Living arrangements		
Live with two parents	87	76.3
Other	27	23.7

### 4.3 Health Concerns among the Adolescents

The adolescents were asked about their main health concerns. The aim was to find out whether they had specific reproductive health concerns that would require them to seek preventive reproductive health care. Adolescents had multiple health concerns. They raised health concerns on the following aspects: - sexual behavioural concerns, psychosocial and emotional concerns, maturation and developmental concerns, interpersonal concerns, concerns about drug use and abuse, and societal-related concerns. The results are summarised in Figure 4.1.

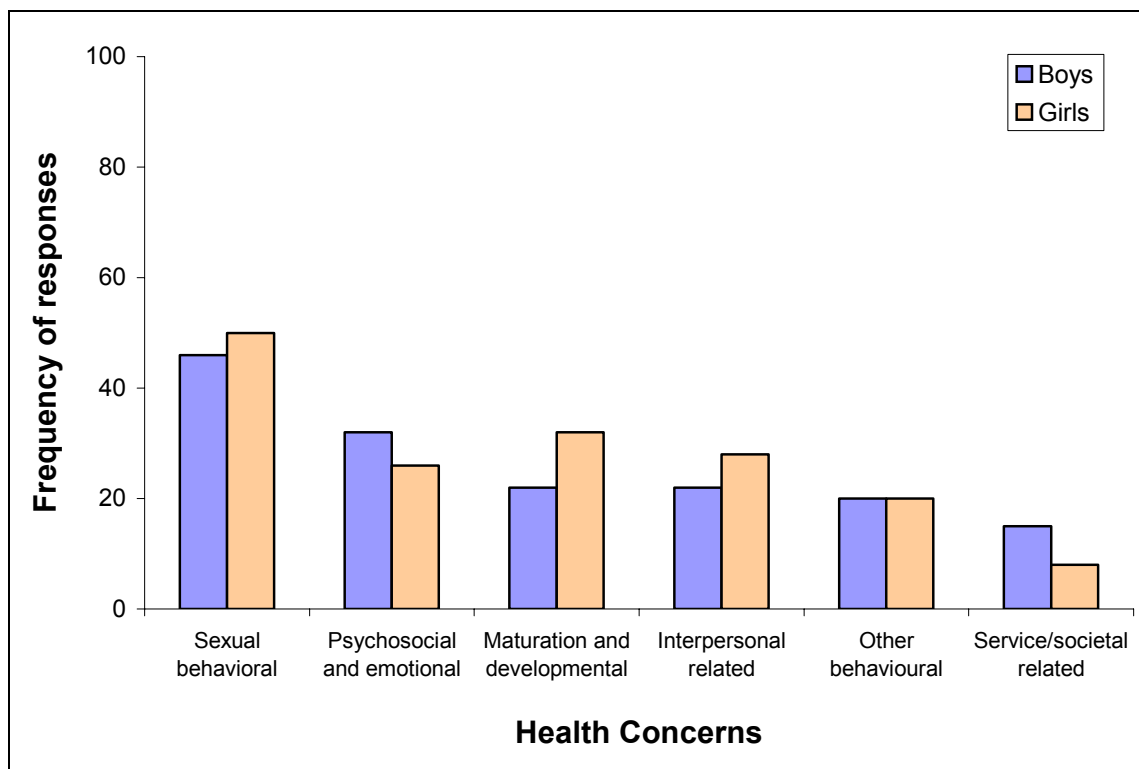


Figure 4.1 The health concerns raised by the adolescents by gender

Most of the adolescents (84.2%) raised sexual behavioural concerns. Out of the 114 adolescents, 68 (59.6%) expressed fear of contracting HIV/AIDS, 51 (44.7%) had fear of contracting STDs, whereas 48 (42.1%) had concerns about teenage pregnancy. These included 13 boys who raised concern about causing pregnancy or about their siblings getting pregnant. Twenty-seven adolescents (23.7%) worried about sex experimentation among adolescents.

About half of the adolescents (50.9%) had psychosocial and emotional concerns. Of the 114 adolescents, 27 (23.7%) were concerned about negative peer influence that made adolescents to engage in early sex or other risky behaviours. Another 27 adolescents (23.7%) were concerned about relationships with the opposite sex. They indicated that they experienced increased attraction to the opposite sex and desire to form relationships. Seventeen adolescents (14.9%) also indicated that they experienced loneliness and mood swings. In addition, they indicated feeling like outcasts and feared being alienated by their friends if they did not have girlfriends or boyfriends.

Close to half of the adolescents (47.4%) raised maturation and developmental concerns. Twenty-two (19.3%) of the adolescents, particularly the boys, had concerns about increased sexual desires and having pains in the genitalia. A few girls (11.4%) had concerns about painful menstruation, whereas 15 (13.2%) expressed concern that some girls lacked sanitary pads. They observed that sanitary pads were costly and unaffordable for some girls, and that some girls used toilet papers and old clothes. They associated the lack of sanitary pads to poverty and parental ignorance about the needs of adolescent girls. Seventeen adolescents (14.9%) indicated that they were shy about their physical body changes and having pimples on their faces.

Close to half of the adolescents (43.9%) had interpersonal concerns. Thirty-one adolescents (27.2%) were concerned about relating with their parents, teachers and friends. They reported having fear and difficulties in sharing their problems with their parents, teachers, siblings and friends. They feared that if they shared their problems with their parents, their parents would suspect them of having indulged in sex. They

also expressed lack of trust of their teachers and friends and feared that their problems would be disclosed or shared. Twenty-seven (23.7%) also noted that they were denied freedom by their parents to do what they wanted.

The adolescents also raised other behavioural, service and societal related concerns. Forty adolescents (35.1%) expressed concerns about drug use and substance abuse. They mentioned alcohol, cigarettes, cannabis and hard drugs like cocaine as common substances that were abused mainly by boys. Nineteen adolescents (16.7%) were concerned about lack of awareness about available services and the high cost of services. They noted that there were no VCT Centres in the rural areas where adolescents could access counselling and support services, as well as information about their reproductive health concerns. The adolescents noted that they had no one to advise them. A few adolescents (4.4%) were also concerned about increased rape incidences, the negative effects of using contraceptives, and the persistent practice of female genital mutilation (FGM). The results of specific health concerns of the adolescents are summarized in Table 4.3.

Table 4.3 Specific health concerns raised by the adolescents in the study  
(Results of Multiple Responses)

Health Concerns Categories	Specific Health Concerns	Frequency			% of Total
		Boys n=57	Girls n=57	Total n=114	
Sexual health concerns	Fear of contracting HIV/AIDS	33	35	68	59.6
	Fear of contracting STDs	30	21	51	44.7
	Concerns about teenage pregnancies	13	35	48	42.1
	Concerns about sex experimentation	12	15	27	23.7
Psychosocial and emotional concerns	Negative peer influence	14	13	27	23.7
	Relationships with the opposite sex	16	11	27	23.7
	Experiencing loneliness and outcast feelings	10	7	17	14.9
Maturation and developmental concerns	Increased sexual desires	11	11	22	19.3
	Shy about body changes	9	8	17	14.9
	Painful menses	0	13	13	11.4
	Lack of sanitary pads	2	13	15	13.2
Interpersonal concerns	Fear of sharing problems with parents, teachers and friends	14	17	31	27.2
	Being denied freedom by parents to do what they want	12	15	27	23.7
Other behavioural concerns	Drug use and abuse among adolescents	20	20	40	35.1
Services and societal related concerns	Ignorance about services and where to seek care	14	5	19	16.7
	Societal concerns (FGM, rape, early marriages, poor role models etc)	2	3	5	4.4

#### **4.4 Response to Adolescents Health Concerns**

Another aim of this study was to find out whether there were efforts being made to address the health concerns raised by the adolescents. Adolescents were asked about their awareness about efforts by the government, NGO's or other agencies to address their reproductive health concerns. Sixty-three percent of the adolescents indicated that the government through the Ministry of Health had made efforts to respond to their reproductive health concerns, 46.5% cited the schools interventions and 36.8% interventions by religious organisations mainly the churches. Another 22.8% cited interventions by the media and 21.1% cited NGOs, CBOs, individual counsellors and People Living with AIDS (PLWAs).

The remaining (10%) of the adolescents thought that there were no efforts being made to address their concerns. They cited high levels of teenage pregnancy, laxity by the government to curb sexual exploitation of girls and to deal with prostitution as their reasons. They noted that inaction by the government failed to provide good role models for adolescents. The adolescents also noted that they lacked a forum through which they could share their concerns. They felt that the Ministry of Health assumed that adolescents were always healthy and lacking major health complications. A few also thought that the efforts by NGOs to provide condoms were inappropriate. They observed that they received inadequate information about condoms effectiveness, and that such efforts failed to address the real issues and concerns of the adolescents. The views of the adolescents on efforts by various institutions to address their health concerns are presented in Figure 4.2.



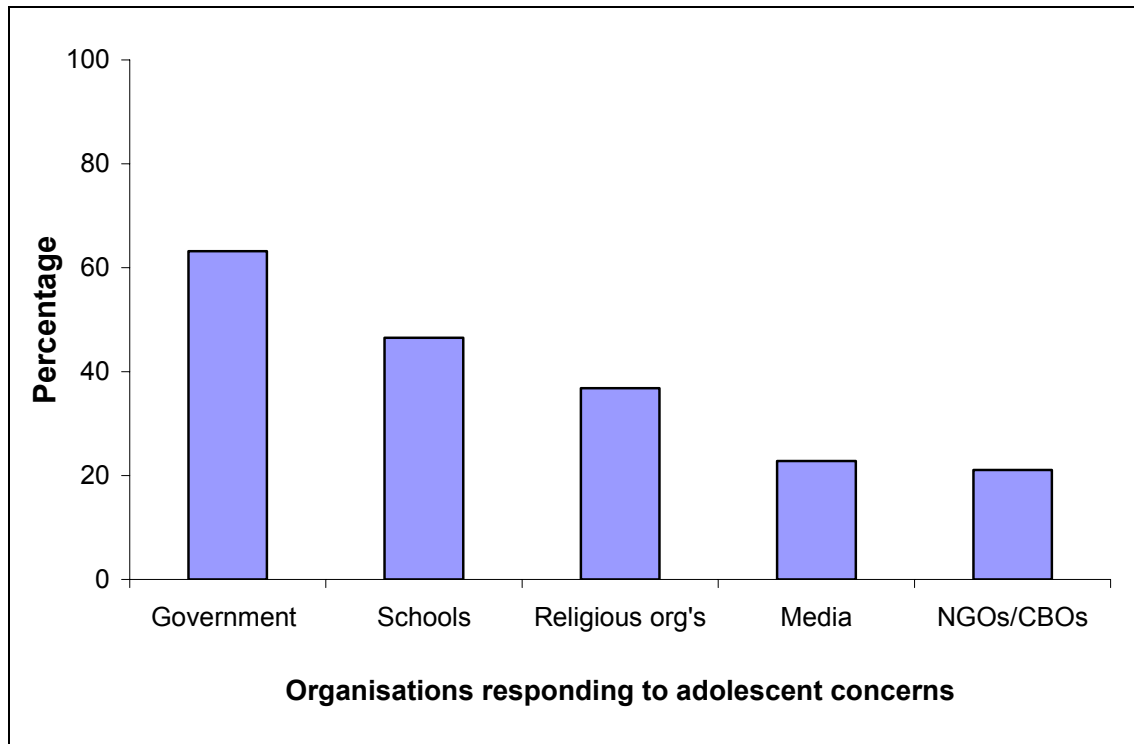


Figure 4.2 Institutional response to reproductive health concerns of the adolescents

About the type and nature of responses, most of the adolescents reported that the government, religious organisations, NGOs and CBOs responded by addressing HIV/AIDS issues. They named specific response efforts as: mass education on HIV/AIDS prevention and management, voluntary testing and counselling, treatment of the infected persons, and care of persons affected by HIV/AIDS. The adolescents also noted that the named organisations responded by offering guidance and counselling to adolescents on dangers of unplanned pregnancy, abortion and peer pressure, as well as providing information to them about STDs, and body changes and development.

The adolescents further noted efforts by the government, NGOs and CBOs to curb drug and substance abuse, and to set rules that regulated rape and prostitution. Other cited efforts included provision of free primary education by the government, as

well as provision of contraceptives and child support by NGOs. In addition, the adolescents also cited efforts by the media to provide information, education and communications (IEC) materials on HIV/AIDS, and other reproductive health topics. They cited examples of books, magazines like the *Young Nation* and *the Parents*, and the *Straight Talk* radio programme. This information is summarized in Figure 4.3.

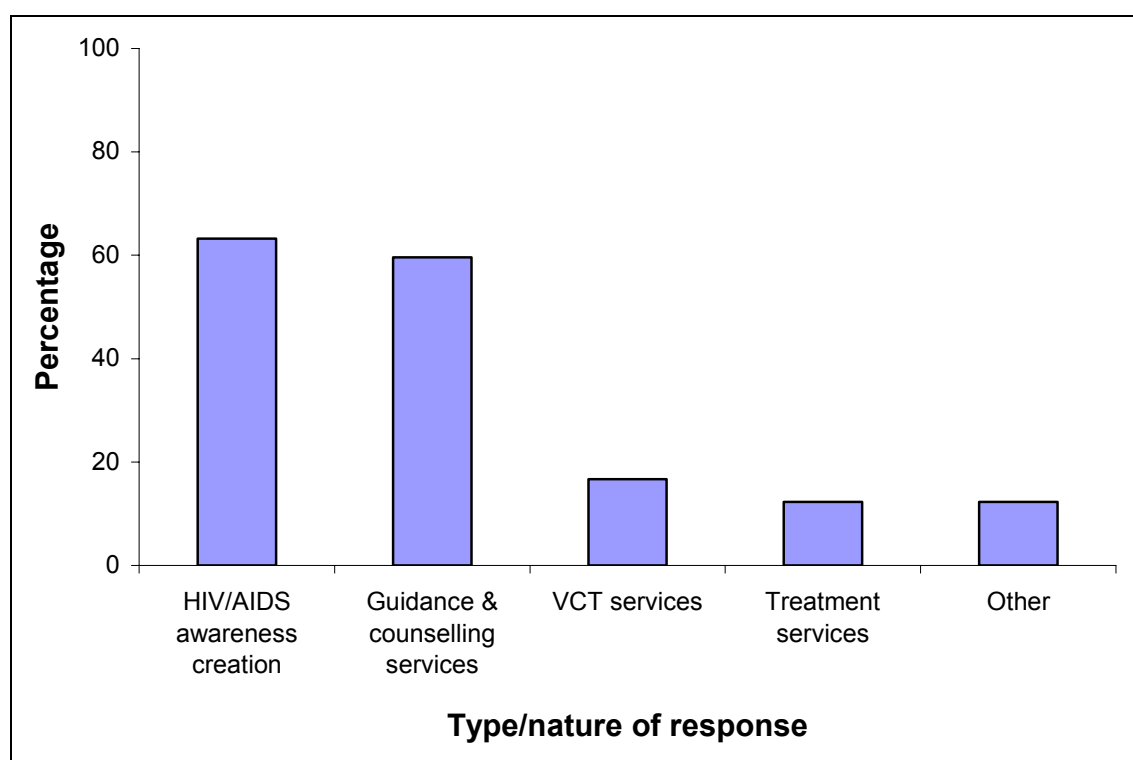


Figure 4.3 Adolescents views on institutional response to their health concerns

## **4.5 Availability of Preventive Reproductive Health Services (PRHS)**

Another aim of this study was to generate data on whether there existed any reproductive health services for adolescents. Adolescents were asked to: (a) indicate whether they had knowledge of organisations that offered reproductive health services in Kenya and in Murang'a District, (b) indicate their source of knowledge about these organisations, and (c) describe the kind of reproductive health services that were offered by the mentioned organisations.

### **4.5.1 Adolescents knowledge of organisations offering reproductive health services in Kenya**

Two-thirds of the adolescents (65%) indicated having knowledge of organisations that provided reproductive health services whereas the remaining one-third (35%) indicated having no knowledge (Figure 4.4). Of the adolescents who indicated being aware about such organisations, 38% cited VCT centres and 27% health facilities like government hospitals, health centres and dispensaries, church supported health facilities and private clinics. Eighteen percent cited NGOs, CBOs and religious groups and individual counsellors. A further 7% cited the National Aids Control Council (NACC) and the National Agency for the Campaign against Drug Abuse (NACADA). The two agencies conducted awareness campaigns about HIV/AIDS and drug abuse respectively. The adolescents also cited national and international initiatives like international conferences and the World Aids Day. A few adolescents (4%) cited the mass media as key source reproductive health information. The adolescents cited their source of knowledge about the mentioned organisations as the mass media, churches, schools, friends, parents, relatives, through advertisements by the organisations, posters and billboards. Also, some assumed that all health facilities provided the services.

#### 4.5.2 Adolescents knowledge of organisations offering adolescent-specific reproductive health services in Murang'a District

Adolescents were then asked whether they had knowledge about institutions that specifically provided PRHS for adolescents in Murang'a District, and to indicate the kind of services that were provided. The aim was to understand whether there were specific services available for adolescents in the district (Figure 4.4). Half of the adolescents indicated having awareness of organisations that provided health services for adolescents. They however, noted that these services did not specifically target adolescents. Rather, that adolescents who needed to use the services could obtain them through public health services. The other half of the adolescents indicated lack of awareness about specific reproductive health services that adolescents could use in Murang'a District. They indicated that they lacked knowledge about the district health services, whereas some indicated that they were from other regions and therefore lacked awareness about reproductive health services available in Murang'a District.

Of the adolescents who indicated having awareness of organisations offering services for adolescents in the district, 33% mentioned government health facilities like Murang'a District hospital, Kangema sub-district health centre, Nyakianga sub-district health centre and dispensaries. They also named church based health facilities like Kiria-ini mission hospital, private clinics and pharmacies. Another 11% named Murang'a VCT centre, 12% CBOs like Community Imitative Support Organisation (CISO) and Kagumo-ini moto moto, individual counsellors, and Marie-Stopes Clinic. Another 6% named church youth seminars. The adolescents also named reproductive health services located in other regions like the Nyeri youth clinic, VCT centres and adolescent health centres located at the national hospital - Kenyatta. Figure 4.4 shows the results of adolescents knowledge about possible sources of PRHS in Kenya and Murang'a District.

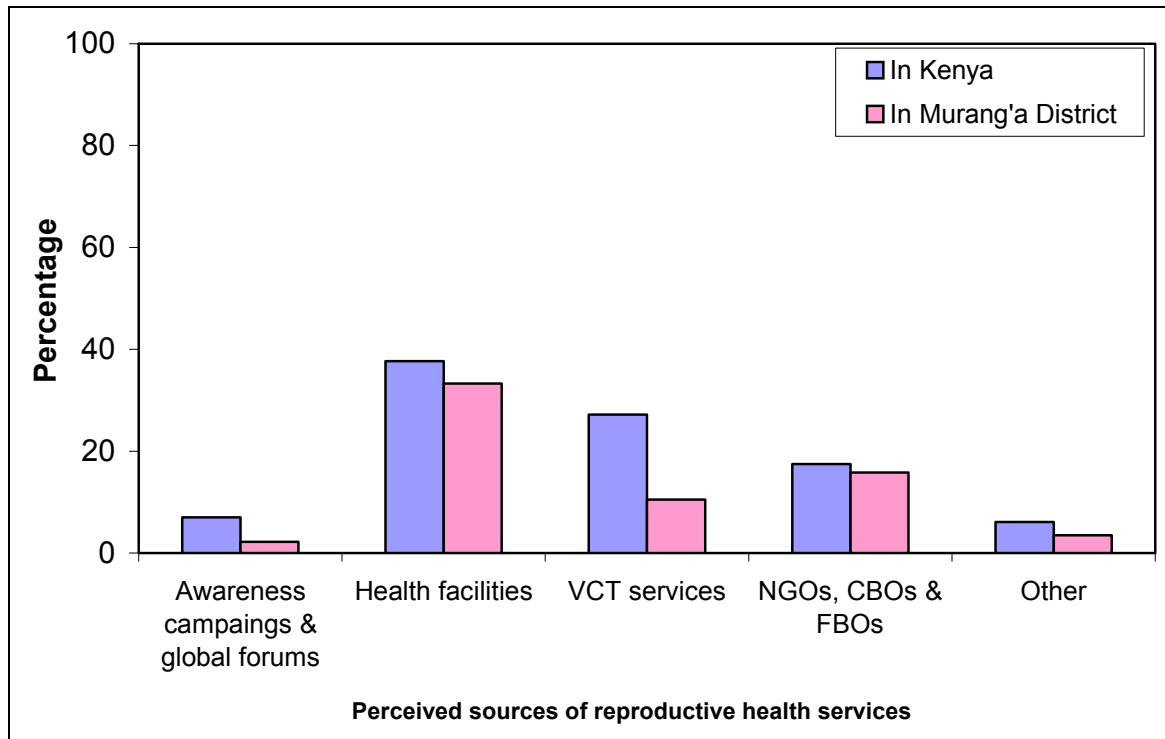


Figure 4.4 Adolescents views about sources of PRHS in Kenya and Murang'a

#### 4.5.3 Nature of available reproductive health services in Kenya and Murang'a District

***In Kenya:***

A higher proportion of the adolescents (35%) cited provision of information and awareness creation about HIV/AIDS, condoms distribution and HIV testing and counselling as the major services offered by the named organisations. Twenty-one percent of the adolescents mentioned that the organisations provided counselling and advice services about the dangers of early sexual initiation, STDs, unplanned pregnancies, abortions, contraceptives, drug abuse and advise about relating with

parents. Another 8% of the adolescents cited treatment of diseases like STDs and 3% mentioned other services such as financial support of organisations offering awareness and education about HIV/AIDS, conducting pregnancy tests, and fighting female genital mutilation (FGM).

***In Murang'a District:***

Regarding the type of PRHS offered by the cited organisations to adolescents, 36.8% of the adolescents mentioned information, talks and video shows on HIV/AIDS, HIV testing and counselling services, and information about condoms. Another 16.7% named treatment of diseases like STDs and referral services, whereas 14.0% mentioned youth guidance and counselling seminars on sexuality issues like unwanted pregnancies, appropriate dressing and dangers of drug abuse. A few of the adolescents (7.9%) named other services like supporting organisations offering awareness and education about HIV/AIDS, supporting AIDS orphans, providing sanitary pads and maternity services.

**4.6 Schools Response to Adolescent Health Needs**

This study specifically sought information about in-school health services for adolescents. This was based on the assumption that many adolescents spend their adolescence period in school. The adolescents were specifically asked to describe the health services that schools provided for them. Most of the adolescents (86.0%) noted that their schools had made efforts to respond to their health concerns. They cited the school services as follows: (a) guidance and counselling, (b) provision of sexuality information about HIV/AIDS, STDs and teenage pregnancy, (c) formation of family groups, growth groups, academic families and HIV/AIDS clubs, and (d) provision of curative and referral services. A few adolescents (4.4%) noted that their schools had not

done much to address their health concerns. Another 9.6% indicated lack of awareness about available school health services because they had newly joined the schools and had little information about their schools health services.

Despite the cited interventions by the schools, the adolescents generally expressed that they did not feel free to share their reproductive health concerns with their teachers due to lack of trust of their teachers, and fear that their problems might be shared. The views of the adolescents about the type of available school health services are summarised in Figure 4.5 below. This is followed by detailed description of the specific services offered by the schools.

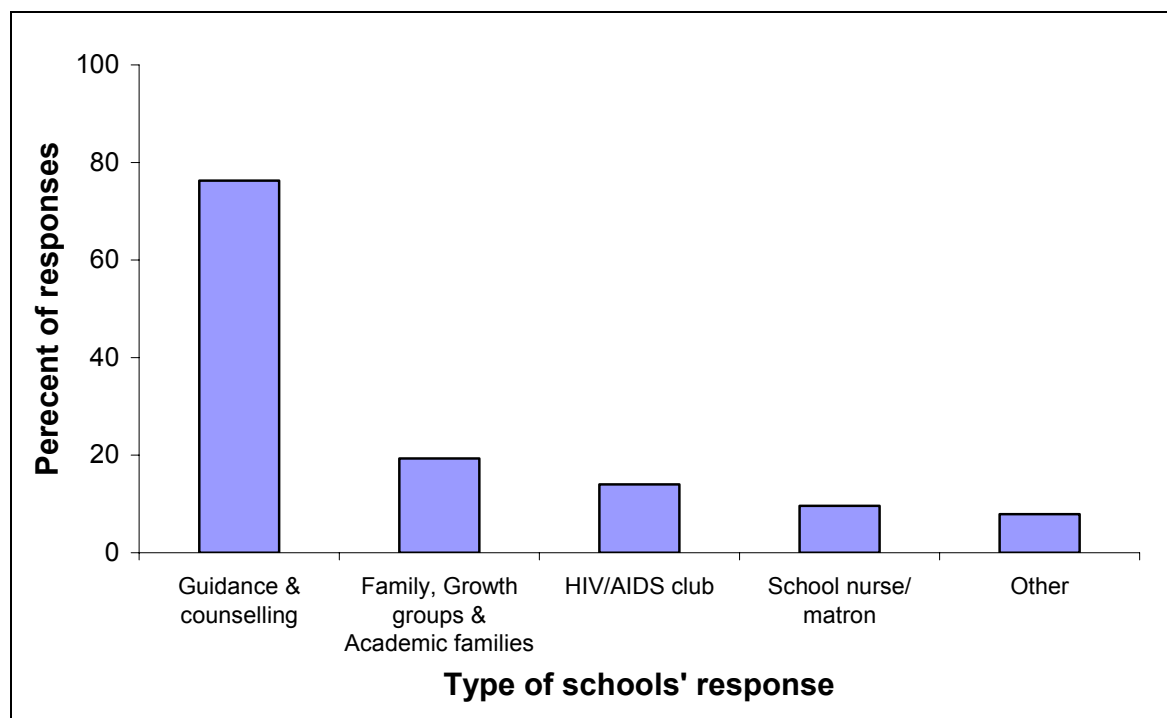


Figure 4.5 Views of adolescents on schools' responses to their health concerns

#### 4.6.1 Guidance and counselling

All the six schools were reported as having guidance and counselling. Most of the adolescents (76.3%) reported that their schools provided them with group (and sometimes individual) guidance and counselling on various reproductive health topics. The adolescents from the mixed schools noted that they sometimes received separate guidance and counselling for boys and girls. The adolescents further indicated that in-school guidance and counselling was provided by their guidance and counselling teachers, and by guest counsellors who included professionals, and representatives of CBOs and religious institutions. The adolescents named the topics covered during guidance and counselling as follows: avoiding risky sexual relationships, awareness creation about HIV/AIDS, and drug use and substance abuse. They also noted that they were guided on how to cope with the challenges of adolescence like avoiding teenage pregnancy and STDs, menstruation, choosing friends, and avoiding negative peer influence. The adolescents also indicated that they received counselling on career guidance, about the importance of education, how to relate with teachers, how to avoid exposure to rape, and about appropriate dressing.

The frequency and regularity of the guidance and counselling sessions varied from school to school. Three-quarters of the adolescents (75.5%) noted that their schools lacked specific guidance and counselling programme, and that they often had *ad hoc* guidance and counselling sessions. Out of the 98 adolescents who responded to the question, 13.2% indicated that their schools provided weekly guidance and counselling, 4.1% that the sessions were held fortnightly, 7.1% once or twice per term or when there was a problem in school like a case of pregnancy. The results on the frequency of schools' guidance and counselling sessions are presented in Table 4.4.



Table 4.4 The frequency of school guidance and counselling sessions reported by adolescents

Frequency of Guidance & Counselling	School						Frequency (n=98)	%
	Kiria-ini Girls	Kiangunyi Girls	Kangema Boys	Wahundura Boys	Kiru Mixed	Njumbi Mixed		
Weekly	3	X	4	1	3	2	13	14.0
Fortnightly	x	X	x	3	1	x	4	4.1
Once/twice a term or in crisis	x	2	2	x	1	2	7	7.1
No specific time	12	9	9	8	14	22	74	75.5
Total	15	11	15	12	19	26	98	

(Results of multiple responses - "X" in this table means not applicable/ no response).

#### 4.6.2 Family groups, growth groups and academic families

About a fifth of the adolescents (19.3%) from three schools namely Wahundura Boys, Njumbi Mixed, and Kiria-ini Girls secondary schools indicated that their schools had *Family groups*, *Growth groups* and *Academic families* respectively. They reported that they were put into small groups composed of adolescents from all classes, and that each group was assigned a teacher who acted as the "father" or "mother" to the group. They further noted that the groups aimed at providing them an opportunity to interact with their teachers and to discuss and share problems. The adolescents indicated that they discussed and shared problems on various aspects that ranged from academic performance, problems at home and in school; and relating with teachers, fellow students and the opposite sex. They also noted that the groups gave them an opportunity to help their colleagues who had problems at school or at home.

#### 4.6.3 Integration and infusion of ASRH issues in school curriculum

A few adolescents (14.0%) from three schools - Kiria-ini Girls, Kiangunyi Girls and Njumbi Mixed secondary schools, indicated that their schools integrated HIV/AIDS issues into learning. They indicated that they had HIV/AIDS clubs that were used to educate them and to create their awareness about HIV/AIDS. Membership to the clubs was voluntary but those wishing to join were required to pay membership fee of Kshs 20 (equivalent to 0.20 Euro)<sup>4</sup>. A few of the adolescents also reported that some of their teachers talked to them about HIV/AIDS during the lessons (infusion). They indicated being told about modes of HIV transmission, how to avoid infections, importance of voluntary counselling and testing, and about other diseases like malaria, tuberculosis and STDs. They however expressed that the time allocated for the discussion of HIV/AIDS and other health issues was little, and that this did not allow them time to ask questions or discuss issues that concerned them with their teachers. A few adolescents also noted that although they were taught about reproductive health in the biology and home-science subjects, the teaching was academic and did not address their concerns. They also noted that some of their teachers seemed to shy away from teaching them openly about sexuality issues.

#### 4.6.4 Schools' health care and referral services

A few of the adolescents (9.6%) from four schools indicated that their schools provided them with curative services at school as well as referral services to the nearby health facilities if they needed further treatment. The adolescents from Kiria-ini Girls, Kiangunyi Girls, and Njumbi Mixed secondary schools reported that their schools had resident nurse, matron or cateress who were in-charge of their health. Those from

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<sup>4</sup> Exchange rate: 1 Euro equivalent to 97 Kenya Shillings. 09 March 2005

Kangema Boys indicated that their school had a clinic, and that a non-resident nurse or doctor visited the school twice weekly to attend to their health needs.

#### **4.7 Adolescents need for PRHS**

The views of the adolescents were sought about their need for sexual health services. Adolescents were asked to indicate their desired services and to identify the service needs of boys and girls. All adolescents expressed overwhelming desire to be offered preventive reproductive health services. About a third of the adolescents observed that if there were adolescents health services, they would get informed about their general health (31.5%), what to expect during adolescence (29.2%), and where they can obtain services (20.2%). Another 20.2% of the adolescents observed that they would be informed about the dangers of sex experimentation or what some termed as “doing bad things”, and 13.5% on how to avoid contracting HIV/AIDS.

The adolescents also felt that having adolescent specific services would help them learn how to prevent STDs (10.1%) and unwanted pregnancies (6.7%), and how to avoid bad company (negative peer pressure) which exposed them to doing “bad things” like going to discos (7.9%). Further, they felt that this would also enable them to freely share their sexual health problems with the health providers (15.7%) and that they would learn about the dangers of drug abuse (5.6%). A few adolescents (5.6%) stressed that their parents and teachers would also have a chance to provide them with sexual health information, whereas 3.4% felt that they would learn about condoms efficacy and what to do if raped. The reasons for adolescents desire for preventive reproduction health services are presented in Table 4.5.

Table 4.5 Reasons cited by adolescents for their desire for PRHS  
(Results of multiple responses)

Cited reasons	Frequency (n=89)	%
Would be advised and informed about		
Their general health	28	31.5
What to expect during adolescence	26	29.2
Where to seek health care services	18	20.2
Dangers of sex experimentation	18	20.2
How to avoid HIV infection	12	13.5
How to avoid STDs	9	10.1
How to avoid unwanted pregnancy	6	6.7
How to avoid peer pressure	7	7.9
Dangers of drug use	5	5.6
Would be advised by parents and teachers	5	5.6
Would freely share problems with health providers	14	15.7
Other	3	3.4

#### 4.7.1 The type of needed services

Adolescents were asked to specify the services they wished to be provided with. They indicated having basic and special needs they wished could be addressed. Thirty-two percent wished to be educated about the dangers of HIV/AIDS. They also expressed the need for VCT services in the rural areas. They added that persons found to be HIV positive should be advised on how to live positively and how to prevent further infections, and that those found to be negative should be advised about how to avoid getting infected. The adolescents also wished to be informed about relating with

the opposite sex and how to avoid peer influence. They wished to be provided with individualised guidance and counselling. Further, they noted that those offering guidance should openly share (straight talk) with them sexual health issues, and be willing to solve the problems affecting adolescents. They further observed that they could learn more if they were provided with books containing information about sexuality issues.

Adolescents had other unique service needs. The girls wished to be informed about the dangers of premarital sex and how to avoid them, and what to do if raped. A few girls felt that boys abuse drugs and that they should be advised against this. The girls also wished that seminars could be organised to teach them about growth and development. They wished to be informed early about menstruation so that this does not come to them as a surprise. They noted that some girls cried when they begun to menstruate due to lack of prior knowledge. They also wished to be informed about how to deal with painful and irregular periods. The lack of interaction between adolescents and their parents was noted. The girls indicated that they often shared menstruation related problems with their friends, and even with the boys, but did not share such problems with their parents. They wished to be informed about personal hygiene and cleanliness, and for sanitary pads to be provided to girls who lacked them. Additionally, the girls wished to be informed about STDs and how to deal with unintended pregnancies. They noted that girls feel guilty if they get pregnant, that they might fail to seek antenatal care, and that this might lead to complicated delivery. They further suggested that girls should be educated about the dangers of abortion, and that guidance and counselling should be provided to those who became pregnant. A few of the girls also felt that girls should be advised against the use of contraceptives, and that the government should intervene to stop early marriages and protect girls against violence.

The boys wished to be advised on how to overcome sexual desires, to deal with homosexuality tendencies, to be informed about the effects of drugs like cigarettes and alcohol, and how to avoid them. A few of the boys thought that sexual health services

should be provided to girls because the girls, unlike the boys, have sexuality problems. They also felt that boys should be informed about how to report rape cases. The specific needs of girls and boys are presented in Table 4.6.

Table 4.6 The specific sexual health service needs cited by adolescents  
(Results of multiple responses)

Felt service needs by adolescents	Girls (n=57)		Boys (n=56)		Total (n=113)	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
<b><i>Need for information &amp; advice on the following:</i></b>						
Dangers of HIV/AIDS	19	33.3	18	32.1	37	32.7
Individual guidance & counselling (straight talk)	15	26.3	19	33.9	34	30.1
Seminars on growth and development	17	29.8	9	16.1	26	23.0
Relating with opposite sex/socialising with peers	8	14.0	17	30.4	25	22.1
Dangers of premarital sex	11	19.3	10	17.9	21	18.6
Dealing with teen pregnancy/dangers of abortion	20	35.1	X	X	20	17.7
Be informed about available services & provided with IEC materials	8	14.0	11	19.6	19	16.8
Advice on how to overcome sexual desires	X	X	15	26.8	15	13.3
Boys to be informed about dangers of drug abuse	3	5.3	8	14.3	11	9.7
Adolescents to be informed about STDs	9	15.8	X	X	9	8.0
Sanitary towels to be provided for girls	8	14.0	X	X	8	7.1
Others (VCT, rape, career guidance)	8	14.0	3	5.4	11	9.7

(“*f*” here means frequency and “X” means no response.

One boy did not respond to the question thus n=56)

## **4.8 Use of Preventive Reproductive Health Services by Adolescents**

The adolescents were asked whether they had used any reproductive health services. The aim was to assess whether adolescents' knowledge about available services resulted in their use of the services. They were asked (a) to describe the services they had used, (b) to indicate where they accessed the services and their reasons for the choice of the services, (c) whether they were accompanied to the services and (d) whether the services were accessible and affordable. Adolescents were also asked what they liked about the services to establish their level of satisfaction with the services. They were also asked to suggest areas for improving access and utilisation of PRHS by adolescents.

### **4.8.1 Type of used services**

Thirty-six (31.6%) out of the 114 adolescents reported having used preventive reproductive health services. Out of these, 23 adolescents indicated that they had accessed services in Murang'a District and 13 in other regions. The services that the adolescents indicated having used were as follows: health facilities which included government health facilities, private hospitals and clinics; VCT services, services from the CBOs and individual counsellors, and the church youth seminars. A few adolescents cited information from the mass media and some indicated that they had consulted their parents and teachers. Adolescents had also used school guidance and counselling services which were often compulsory. These results are summarized in Table 4.7.

Table 4.7 Type of services that adolescents reported having used  
(Results of multiple responses)

Type of used services	Frequency (n=114)	%
Public health facilities (MoH)	7	6.1
Religious-based/NGO health facilities	8	7.0
VCT services	2	1.8
CBOs and individual counsellors	11	9.6
Church youth seminars	9	7.9
Other	4	3.5

A higher proportion of the adolescents who had used services rated guidance and counselling as their highly utilized service. They received guidance and counselling in the following areas: - general health; how to prevent HIV/AIDS, STDs, and early sexual engagement; how to exercise self control, relating with parents and peers, about condoms use, as well as advise on drug use and abuse. The adolescents cited other received services as HIV/AIDS counselling and testing services, treatment of diseases like STDs, circumcision services for the boys, and training as peer educators.

#### 4.8.2 Reasons for choice of service provider

The adolescents cited their reasons for the choice and use of the services as follows: (a) to learn how to avoid problems that occur in adolescence and to be informed about health issues in general e.g. STDs, (b) because the services were near their homes, schools or churches and were therefore easily accessible, (c) the schools required them to undergo medical check-up before admission to form one, (d) their parents required them to seek services like VCT (e) they liked the facility because the staff were nice, welcoming, friendly, ‘motherly’ and not rude (f) to get circumcision



services or because they preferred private clinics. This information is summarized in Table 4.8.

Table 4.8 Reasons cited by adolescents for their choice and use of PRHS  
(Results of multiple responses)

Reasons for choice of used service	Frequency (n=114)	%
To learn about adolescence/other health issues	15	13.2
Facility was near home, school or in church	10	8.8
Required by the school or parents to seek service	11	9.6
Staff were nice, welcoming, caring and friendly	6	5.3
Other (e.g. circumcision services)	2	1.8

#### 4.8.3 Decision making on choice of services and whether to use PRHS

Adolescent were asked whether they made the decision to use preventive reproductive health services. Regarding the school guidance and counselling services, the adolescents indicated that these were largely compulsory and that they did not decide whether to attend or not. Most adolescents who had used the out-of-school services indicated that they used the services because they were concerned about their health and wished to learn how to cope with the challenges of adolescence. A few of the adolescents indicated that they were prompted by their churches to attend youth seminars, whereas others mentioned that their parents, school and friends prompted them to use services from the health facilities. The results of adolescents choice of the out-of-school services are summarised in Table 4.9.

Table 4.9 Reasons cited by adolescents for their choice of out-of-school PRHS  
(Results of multiple responses)

Reasons for adolescents choice of out-of-school PRHS	Frequency	%
Prompted by self	19	16.7
Prompted by the church	19	16.7
Prompted by the parent	9	7.9
Prompted by the school	7	6.1
Other	5	4.4

#### 4.8.4 Being accompanied to health services

The adolescents who had used the services were asked whether they went alone to seek care or were accompanied. Six adolescents indicated that they went alone, eleven indicated that they attended the church youth seminars in groups, four were accompanied by a friend, and eight indicated that they were accompanied by parent(s), relatives or siblings.

#### 4.8.5 Accessibility and affordability of services

The adolescents were asked whether they faced difficulties in locating the health services. All the adolescents who had used the services indicated having no difficulties in locating them. They indicated that the in-school services were accessible because the teachers, the school matron or nurse were in school, or because the guest counsellors came to their schools. Adolescents also indicated having no difficulties in locating the non-school services. Twenty-seven adolescents indicated that the facilities were near their homes or school. Two indicated that their parents accompanied them to the

facilities, and another two that they were accompanied by a friend and therefore encountered no problems in locating them.

Adolescents were further asked whether they paid for the services. The aim was to establish whether they faced financial barriers. They indicated that in-school services like guidance and counselling and church youth seminars were free. Sixteen adolescents who had used services from the health facilities indicated having paid for them. The service fee ranged from Kshs 20 (0.20 Euro)<sup>5</sup> to Kshs 4000 (ca. 40 Euro). The highest paid fee was for the institutionalised circumcision services<sup>6</sup>. Five adolescents described the fees as affordable, and another five felt that the fees were expensive particularly for the laboratory services and institutionalised circumcision. Adolescents also felt that membership fee for the HIV/AIDS club, although small, was prohibitive. Six adolescents were unsure about the amount paid because their parents paid for the services.

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<sup>5</sup> Exchange rate: 1 Euro equivalent to 97 Kenya Shillings. 09 March 2005

<sup>6</sup> This is a new form of religious-based male circumcision. The boys come together (seclusion) for about two weeks. During this time, they undergo circumcision. They are also offered sexuality education for example, about HIV/AIDS, STDs, drug abuse, and relating with girls. 'The teachings are given by teachers and resource persons from hospitals depending on the needs of the group.' They aim at educating the initiates about dangers of sex experimentation, and to remove the myth that boys should engage in sex after healing to prove their manhood, a practice referred to (among Kikuyu) as *kwhura mbiro* or *kuhura mbiro* – literally translated as 'cleaning the soot' off the wound (Ngesa, 2005). One key informant while referring to the practice reported:

"...when boys undergo circumcision there is what they call "*kuhura mbiro*". The boys who have just undergone circumcision have to have sex with a lady who has had an experience in having sex with a number of men. This is done to prove that he is a man. Because of this, so many health problems are coming up due to this".

*Another key informant representing an FBO reported:*

"...we are calling it "*Old Times*". The adolescents are able to marry the old and new values...the youths form age groups which keep them together... Even girls, we need to give them something special. This has not yet started and we are thinking whether we will make them pierce their ears.

#### 4.8.6 Satisfaction with used services

Adolescents were asked to indicate what they liked about the services they received. Out of 36 adolescents who responded to the question, 27 indicated that they were happy because they received the services they needed like treatment, laboratory tests or pre-HIV test counselling. Seventeen adolescents reported that they were satisfied with the services because the health providers and counsellors were welcoming, friendly, and open; and that they gave them information and counselling about HIV/AIDS, menses, relationships with the opposite sex, and how to avoid unintended pregnancies. Seven adolescents cited the reasons for satisfaction as: clean and organized facilities, enhanced privacy and confidentiality, short waiting time, free services, and being attended on first-come first-served basis. Twelve adolescents cited other reasons as being equipped with guidance and counselling skills. They observed that they could use the skills to counsel their peers, and that the group sessions enabled them to learn from each other. Another cited reason for satisfaction was being awarded peer counsellor certificate.

A few adolescents expressed dissatisfaction with the services. They cited their reasons as: not being provided with enough information about STIs and relating with the opposite sex, being forced by parents to undergo HIV testing from a VCT centre, and not being offered pre-and-post test counselling.

#### 4.8.7 Reasons for non-use of preventive reproductive health services

Seventy-nine adolescents who had not used reproductive health services were asked why they had not used them. The aim was to understand the reasons for non-use of PRHS among the adolescents. The adolescents cited reasons for non-use of services as: having not had a need (40.5%), lack of awareness about available services (13.9%), feeling that reproductive health services are for adults and not for adolescents (5.1%),

and fear that health providers would judge them as being too young and unmarried to use adult services. Adolescents indicated that they were embarrassed to use services (3.8%) especially because they had to explain to the doctors or nurses their problems before receiving services.

Regarding the non-use of VCT services, 10.1% of the adolescents cited lack of time to go to the VCT centres, and 10% indicated being certain of their negative HIV status and that they did not need the tests. A further 6.3% feared that HIV results might be positive and that they would not know how to handle this. Other cited reasons for non-use of VTC services included not having been taken to the centres by their parents (3.8%), and consulting friends or praying when they had problems (6.8%). This information is summarized in Table 4.10.

Table 4.10 Reasons cited by adolescents for non-use of PRHS  
(Results of multiple responses)

Reasons for lack of use of services	Frequency (n=114)	%
Have not had a need to use services	39	34.2
Lack of awareness about adolescents services	20	17.5
Not aware that young and unmarried persons like themselves can use services e.g. counselling		
No knowledge about services for adolescents in Murang'a		
Embarrassed to use services/ sexuality issues embarrassing	11	9.6
Why not used VCT services?		
Lack of time	8	10.1
Confident that they are HIV negative	8	10.1
Fear that HIV results might be positive	5	6.3
Other (have not been taken by parents, just pray when have sexual desires, consult friends, do not trust teachers)	9	7.9

#### 4.8.8 Unmet reproductive health needs

Adolescents were asked whether they had ever had reproductive health needs but did not know where to get information or seek help. The aim was to find out whether the adolescents had unmet sexual health needs that required them to access and use PRHS. The adolescents who responded to this question were 88. Of these, about 2/5 (39) indicated having had unmet sexual health needs, whereas 3/5 (49) indicated not having unmet needs. The girls who indicated having had unmet needs cited painful menses, vaginal discharge and itching, and lack of sanitary napkins. The boys cited unmet sexual health needs as increased sexual desires, pain in the genitals, and bleeding after circumcision. Adolescents also cited challenges in relating with the opposite sex as another unmet need. They indicated that they experienced increased desire to form relationships or wanted to end them. The girls wondered why boys pressurised them to form relationships. The boys wondered why girls were not receptive to their advances. A few indicated having emotional imbalances and anger. The results are summarised in Table 4.11.

Table 4.11 Unmet reproductive health needs among the adolescents

Unmet need	Frequency (n=39*)
Painful menses	10
Sexual desires	10
Relating with the opposite sex	9
Pain in the genitals	7
Vaginal discharge and itching	6
Other	5

(\*only 39 adolescents indicated having had an unmet need)

#### 4.8.9 What if adolescents had sexual health needs?

Adolescents were also asked what they would do if they had sexual health needs. Of the 81 adolescents who responded to the question, 48.1% indicated that they would seek professional help. Twenty-five percent (24.7%) indicated that they would not take action, and 27.2% had mixed reactions. Adolescents who indicated that they would take responsive measures observed that they would seek professional help from doctors and health professionals, school services, VCT centres, and counselling from churches and from PLWAs. They also indicated that they would consult their older friends and siblings who may have experienced similar situations, their parents, as well as purchase drugs from pharmacies. They indicated that they would prefer a big hospital where the health providers did not know them, and where they would not be asked many questions. They also would choose facilities where medicine, laboratory services, and HIV testing services were available. In addition, they would visit facilities where they knew which providers they would see, for example, if the name of the provider was written on the door. Some also indicated that they would use services that were near their homes.

Adolescent who indicated that they would not seek care, or were unsure, reported that they would not know what to do or where to seek help, that they would not feel free to share their problems with their parents, the school authorities or even with the health professionals. Three girls also indicated that they would be shy to confide their sexual health problems with male health providers. The results are presented in Table 4.12.

Table 4.12 Views of adolescents on what they would do if they had reproductive health needs  
(Results of multiple responses)

What adolescents would do	Frequency (n=81)	%
Would seek help i.e. would;		
Go to doctor/ health professional	32	39.5
Consult school principal, teachers, matron	15	18.5
Consult older person, friend, sibling	14	17.3
Consult parents	11	13.6
Use VCT services	3	3.7
Seek counselling from church, PLWAs	4	2.4
Would not seek help, i.e. would;		
Would not know what to do	23	28.4
Would not tell parents	15	18.5
Would not seek school services	10	12.3
Would not go to doctor	8	9.9
Would feel shy to go to male doctor	3	3.7
Self medication (over-the-counter/ pharmacy)	3	3.7

#### 4.9 Suggestions for improving Adolescents access and utilisation of PRHS

Adolescents were asked to suggest ways for improving their access and utilisation of preventive reproductive health services. The aim was to elicit proposals and recommendations for strengthening PRHS for adolescents. Adolescents indicated the need for improvement of school health services, the public sector adolescents health services, and to target communities and the parents through the religious organisations. Figure 4.6 presents the views elicited from the adolescents.



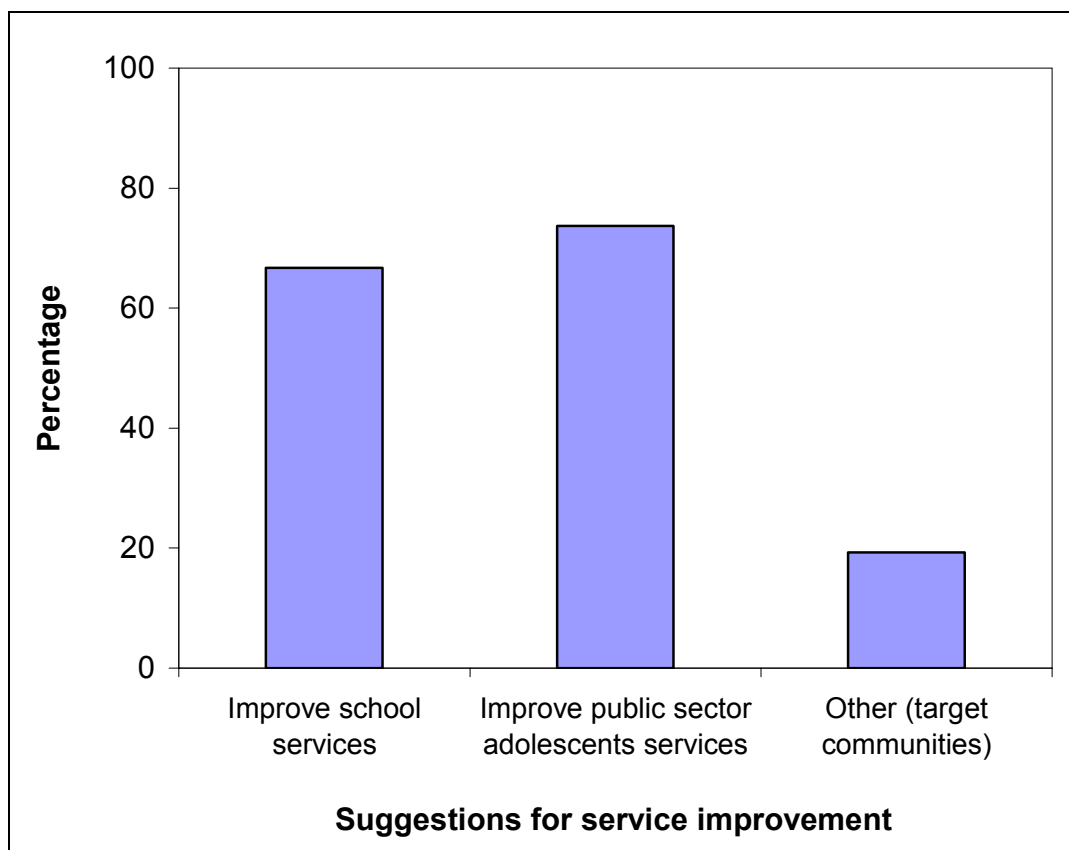


Figure 4.6 Suggestions of adolescents for improving PRHS for adolescents.

#### 4.9.1 Suggestions for improving school-based PRHS for adolescents

Most adolescents suggested that schools guidance and counselling services should be improved. They suggested that schools should have regular, intensive and programmed guidance and counselling services. They also wanted schools to establish family groups, growth groups and academic families; and the HIV/AIDS clubs to be open to all adolescents. They reported that they needed adequate information about HIV/AIDS, STDs, drug use and abuse, menstruation, relationships with the opposite sex,

and on condoms efficacy. In addition, the adolescents reported the need to be provided with handbooks, magazines and pamphlets containing sexuality information, especially on topics that the teachers found difficult to handle. They also expressed the need for their teachers to have and follow guidance and counselling reference books, and to diversify the guidance and counselling topics to make them interesting.

Adolescents also suggested that they should be provided with individualised counselling services because they found it difficult to share or raise some problems in the group counselling. They also suggested that schools should have separate guidance and counselling offices to ensure their privacy. They noted that they felt uncomfortable to talk to their guidance and counselling teachers in the staff rooms and in the presence of other teachers. The adolescents further suggested that the school health services should be confidential and that they should not be monitored or accompanied to the health facilities. The views of the adolescents regarding the improvement of school health services are presented in Table 4.13.

Table 4.13 Suggestions of adolescents for improving school-based PRHS.  
(Results of multiple responses)

Suggestions	Frequency (n=76)	%
Provide specific guidance & counselling on HIV/AIDS, STDs etc	43	56.6
Increase guidance & counselling and improve its quality	40	52.6
Provide separate guidance and counselling office to enhance privacy	14	18.4
Provide books, materials and magazines on sexuality matters	3	3.9

#### 4.9.2 Suggestions for improving public and private sector adolescent PRHS

Adolescents highlighted areas for intervention by the government to improve their access and utilisation of PRHS. They wanted conditions at the public sector health facilities improved. They suggested that the government should provide separate services and establish health centres for adolescents, including circumcision services for boys; and ensure that adolescents did not share or wait for services with adults. They also suggested that the government should organise regular education seminars and camps to inform them about sexuality issues.

Adolescents further suggested that parents should not be involved in their sexual and reproductive health matters, that the health providers should adopt follow-up systems for reviewing their health, and that pre-and-post test counselling should be provided when taking HIV tests. The adolescents also observed that the health providers should be sensitive to their needs, particularly when asking sensitive questions about their sexuality; that health providers should show interest in serving adolescents, and assure them that the equipment used (especially for circumcision) were safe. They also wished to be informed about where to obtain services if they needed to use them.

Adolescents further observed that the government should increase accessibility to services for adolescents in rural areas. They suggested the need to increase health facilities, to establish laboratories and VCT centres, and to provide free and low cost services to adolescents, including reducing the cost of sanitary pads. They also observed that staffing conditions should be improved, and that the government should employ trained counsellors and other professionals to serve adolescents. Adolescents also noted the need for the government to involve organisations and individuals serving adolescents, and to establish NGOs and CBOs in the rural areas to focus on adolescent health issues. They also called for government involvement of stakeholders working on

adolescent health issues and to involve PLWAs and university students in provision of services to adolescents.

Adolescents further suggested the need to consider age and gender of the health providers serving them. The girls had greater preference for female health providers and the boys for male health providers. Adolescents generally preferred younger health care providers. However, a few expressed that age and gender of the health provider was not an issue. They noted the importance of ensuring that health professionals serving adolescents were persons whom adolescents were comfortable to talk, with whom they could freely share their problems, and who could provide solutions to their problems. They however stressed that the health facilities should have both male and female staff to take care of their needs. The views of the adolescents on improvement of public sector adolescent health services are presented in Table 4.14.

Table 4.14 Suggestions of adolescents for improving public sector PRHS for adolescents  
(Results of multiple responses)

Suggestions	Frequency (n=84)	%
Provide/ initiate adolescent-friendly services	69	82.1
Improve staffing at health facilities	26	31.0
Improve access to services in rural areas	23	27.4
Consider gender of health providers	15	17.9
Consider age of health providers	8	9.5
Remove or reduce cost of services	5	6.0
Improve general conditions at health facilities e.g. ensure adolescents do not wait with adults	4	4.8

#### 4.9.3 Suggestions for improving adolescents PRHS at the community level

The adolescents also suggested the need to improve the social environment in which they lived. They suggested the need for parents' guidance and counselling services to educate parents about adolescents' sexual and reproductive health issues, and to make parents comfortable to openly share sexuality matters with them. They also noted that parents should provide good role models to adolescents, and that the government should address societal problems like rape and alcoholism. Further, they noted that adolescents should take responsibility for their health.

Finally, adolescents expressed gratitude for the study. They indicated that they had benefited from it and that it gave them a chance to share their concerns. They noted that they lacked someone to freely talk to and wished that such forums would be regular and involve many adolescents. They also requested to be informed about the study results. The suggestions by the adolescents for improving adolescent PRHS at the community level are presented in Table 4.15.

Table 4.15 Suggestions of adolescents for improving community level PRHS for adolescents  
(Results of multiple responses)

Improving adolescents concerns at the community level	Frequency (n=22)
Target surrounding environment where adolescents live	3
Provide guidance and counselling for parents and adults on adolescent health issues	8
Involve stakeholders e.g. adolescents, churches, CBOs, PLWAs, university students; provide similar forums for adolescents to share their concerns i.e. study appreciated	11

## **OVERVIEW OF DISCUSSION CHAPTERS – [5, 6 & 7]**

This study sought to establish the factors influencing access and utilisation of preventive reproductive health services (PRHS) by the adolescents in Murang'a District, Kenya. The study sought to generate information on the views of the adolescents about their reproductive health concerns and the efforts being made to address them; their knowledge about available PRHS for the adolescents in Murang'a District; the nature and characteristic of available services and their level of utilisation of PRHS. The study also sought to generate data about adolescents satisfaction with the used services, and the challenges they faced in accessing and utilising the services, and develop proposals for addressing identified challenges.

The study was undertaken against the backdrop that adolescents in Kenya, like in other developing countries, are yet to benefit from reproductive health goals set during the 1994 Cairo conference on Population and Development. I argue that adolescents' access and utilisation of preventive reproductive health services are an outcome of multifaceted factors. I also argue that beyond the lack of adolescent-friendly services; policy, ethical, institutional, structural and socio-cultural barriers interact to negatively influence the level of access and use of available PRHS by adolescents. Finally, I suggest that efforts to overcome barriers and prejudices surrounding adolescents' sexual and reproductive health would greatly improve adolescents access and utilisation of PRHS.

The following three chapters (5, 6 and 7) present and discuss the findings of the study. The chapters contain the views of adolescents, health providers and key informants. The chapters are followed by conclusions and implications for practice and future research (chapter 8). In the three chapters, the study findings are discussed from the point of view of the researcher. The discussions are supported with data (quotations) from adolescents, health providers and key informants interviews and with findings from previous studies.

## **CHAPTER 5**

### **ASRH CONCERNS, AVAILABILITY AND UTILISATION OF PRHS**

This chapter discusses the study findings on adolescents preventive reproductive health (PRH) concerns, response efforts aimed at addressing these concerns, availability of preventive reproductive health services (PRHS) for adolescents, and the level of access and utilisation of PRHS by adolescents.

#### **5.1 Adolescents PRH Concerns and Response Efforts**

##### **5.1.1 Sexual health concerns of adolescents**

This study has established that adolescents had sexual health concerns that required them to use sexual health services (Section 4.3 & Figure 4.1). Many adolescents had fears of contracting HIV/AIDS and STDs. They also had concerns about early pregnancies and early exposure to sexual debut. Further, they had psychosocial and interpersonal concerns. The findings suggest that there is need for adolescents to adequately access and utilise PRHS. Despite the evidence that adolescents have sexual health needs and concerns, this study found that adolescents did not know how to deal with these concerns. Evidence from the study showed that adolescents feared to share their sexual health problems with their parents, that they did not know where to seek care, and were afraid that health providers might be unsympathetic to their needs (Sections 4.8.7 & 4.8.9).

The findings also showed that many adolescents have unmet sexual health needs. For example, 44% of the adolescents indicated having had reproductive health needs but did not know where to seek care (Sections 4.8.7 & 4.8.8). The lack of understanding about maturation and developmental changes is a key unmet need among adolescents.

The findings from this study showed gender differences in the health concerns of boys and girls. The girls worried about unwanted pregnancies and menarche related problems, including lack of sanitary pads. Some of the girls were surprised and cried when they began to experience menses. The boys had greater concerns about increased sexual desires. They lacked understanding about why they experienced increased sexual desires and attraction to girls. Some boys associated this to male circumcision, which is a cultural practice undertaken during the adolescence period. Ahlberg et al. (1998) made similar observations in a study conducted on 'breaking the silence on adolescent sexuality for prevention of HIV/AIDS in Kenya. The authors observed that adolescents link secondary sexual characteristics to circumcision. They further noted that this was not surprising because the operation is performed at the age of spermatogenesis, when there is a physiological increase in the production of male sexual hormones resulting in increased sexual desire.

The above findings imply that adolescents were less likely to take appropriate action concerning their sexual health needs (i.e. to access and utilise services) because of lack of understanding of their sexuality. The findings point towards the need to adequately educate adolescents about maturation, growth and developmental processes across the lifespan. This would equip them with necessary awareness about their sexual health needs and limit negative reactions such as being embarrassed about seeking care or assuming that they are the only ones experiencing sexual health challenges. The findings that there were gender differences in the concerns of boys and girls concur with the observation by Dehne and Riedner (2005). Dehne and Riedner noted that adolescent girls are often far more concerned about preventing unintended pregnancy and menstrual problems than about STI symptoms, while for boys sexual health concerns often outweigh reproductive health ones. The findings of this study imply the need to engender adolescent sexual and reproductive health services.



### 5.1.2 Do adolescents then need sexual health services?

The study findings show great need for sexual health services for adolescents. All the adolescents, the health care providers and the key informants concurred on the need for adolescent preventive reproductive health services. The views obtained implied that adolescents have for long been ‘forgotten’ and excluded from reproductive health services, and that they are often left to do things on their own.

Key Informant 11, ‘...its only a day like today when you have come. You have even made us to think about the adolescents. That is an issue that does not normally come in. We do not have that kind of a forum...its not that we have forgotten them [*adolescents*]. We can remember them but because of financial constraints, you feel that “*let me leave that issue. It has its own people*”.’

Whilst acknowledging the lack of adolescent specific services, the adolescents came up with recommendations to improve access and utilisation of their services. These included the need to be offered preventive care and individualised guidance and counselling. Adolescents suggested the need for open sharing and to be provided with information and advice on sexuality matters, about general health and maturation, and how to relate with peers of both sexes. They further noted the need for adequate access to information about available PRHS for adolescents including information about voluntary counselling and testing services (VCTs); to be provided with Information, Education and Communication (IEC) materials, and circumcision services for boys. Adolescents also proposed the incorporation of parental guidance and counselling in adolescent health services.

### 5.1.3 Efforts to address adolescents sexual health concerns.

The study findings show that marginal efforts were made to address the sexual health concerns raised by adolescents (Section 4.4). The government through the Ministry of Health and the Ministry of Education had designed some intervention programmes. Religious organisations and CBOs were among the institutions cited by the adolescents that addressed their health concerns. Individual counsellors were also identified among the efforts to provide health care services to adolescents. The findings also show that school guidance and counselling focused on creating awareness and educating adolescents about prevention of HIV/AIDS, STDs and early pregnancies. They also focused on the dangers of performing illegal abortions and of drug use and abuse. In addition, adolescents were offered career guidance. Outside of the schools, the response efforts targeted entire population. There were no specific tailor made response programmes targeting adolescents. For example, the HIV/AIDS and VCT programmes served all people.

Although there were efforts to respond to adolescents health concerns, further study findings show that such efforts did not provide comprehensive preventive reproductive services that would effectively address the sexual and reproductive health needs of adolescents. The emerging views portray lack of government commitment to target and engender adolescent services. Many adolescents and health providers blamed the government for the persistent problems of unplanned and unintended pregnancies among adolescents, and the lack of adequate information regarding sexual health matters (Section 4.4).

#### 5.1.4 Summary

The above findings show that adolescents had sexual health concerns that required them to access and utilise PRHS. However, they did not know how to effectively deal with these concerns. Adolescents feared to share their concerns with their parents. They feared unsympathetic and judgemental health providers. They further lacked adequate awareness about where to seek care. Adolescents also lacked necessary understanding about maturation and emerging body changes. There were significant gender differences between the health care needs and concerns of boys and girls. Boys had greater concerns about increased sexual desires, whereas the girls worried about unwanted pregnancies and menarche related problems. Despite these concerns, adolescents have generally been “forgotten” and left to do things on their own. There are no comprehensive efforts to deal with broad sexual and reproductive health needs of adolescents. Attempts to respond to preventive reproductive health needs of adolescents have been inadequate. To improve access and utilisation of adolescent services, the following needs to be embraced.

- Provision of adequate access to preventive reproductive health services.
- Increased awareness and education of adolescents about maturation, growth and development.
- Engendering reproductive health services for adolescents.

## **5.2 Available Preventive Reproductive Health Services for Adolescents**

The study findings show lack of adolescent-friendly services in Murang'a District. Two-thirds of the adolescents (65%) indicated being aware of organisations that offered reproductive health services in the Kenya - mainly VCT centres, health facilities, schools, religious organisations, CBOs, NGOs and the media (Section 4.5.1). However, many of the adolescents expressed concern about the lack of adolescent-specific services in Murang'a District. Only half of the adolescents indicated being aware of such services in Murang'a District (Section 4.5.2). Overall, adolescents considered the health facilities as key sources of reproductive health services. Interestingly, more than a third of the adolescents (38%) thought that preventive reproductive health services could be obtained from VCT centres (Sections 4.5.1 & 4.5.2). They however, noted the lack of VCT centres in Murang'a District and indicated that these were few, far between or lacking particularly in the interior regions. The district has only four VCT centres two located at the district headquarters (Murang'a District Hospital VCT Centre and Medical Training College (MTC) Murang'a VCT Site), and two at sub-district level (Kangema Health Centre VCT Site and Muriranjas Sub-district Hospital) (RoK-MoH, 2005).

The above findings imply the need for greater interaction between the healthcare providers and the adolescents. The findings also imply that VCT services are invaluable source of preventive reproductive health services for adolescents. Despite the VCT services being invaluable, this study has established that many adolescents may be ineligible to access and use VCT services because of policy restrictions (Section 6.2.1). The findings nonetheless demonstrate the need to integrate preventive reproductive health services for adolescents with VCT services. This would ensure that all adolescents, including the 'minors', can benefit from VCT services.

### **5.3 Reasons for lack of adolescent-friendly services**

Several factors were associated with the lack of adolescent-friendly/specific services in Murang'a District. These included lack of planning for adolescent services thus creating a service gap, failure to prioritise adolescent health issues, lack of adequate data on adolescents sexual health situation and marginalisation of rural areas. These factors are discussed further in detail.

#### **5.3.1 Lack of planning and prioritisation of adolescent health services**

The government policy is to improve adolescents access to information and reproductive health services following its commitment to the Cairo Programme of Action (Sections 1.1 & 2.1.4). However, the current health care model depicts exclusion and marginalisation of adolescents from sexual and reproductive health services. The feeling among the adolescents, the health providers and the key informants was that the government had not done enough to address the reproductive health needs of adolescents. The optimism expressed by some health providers about government plans to establish adolescent-friendly services in Murang'a and other regions, was regarded by many as inadequate. The findings suggest that the government response programmes are often triggered by emerging public health challenges such as HIV/AIDS, and not merely because of the need to address the sexual and reproductive health needs of adolescents. Claims by the government that adolescents need special services were thus perceived as mere rhetoric. The respondents echoed the need for the government to include adolescents as a special category in service delivery and to set-up reproductive health services for them.

Provider 7, 'Because of the impact of AIDS, the youth group is under threat. This is however still at the level of talk. It is mere rhetoric that adolescents need special services. There is, however, no historical evidence of isolating youth as a special category in service delivery. This could be because of lack of facilities, lack of training, the current training programmes have also not included adolescent component in their training.'

The lack of prioritisation of adolescent health was associated with government's neglect of adolescent health. The respondents blamed the government for neglecting the health of adolescents whilst concentrating on competing health problems like fighting polio, TB and Malaria. The assumption that adolescents are healthy, that they lack major illnesses and have no immediate health threats make their health issues to be pushed to the periphery when setting health program priorities. This finding aligns with the developmental theorists notion of 'healthy adolescents' which asserts that adolescents experience a relatively troublesome free and healthy transition to adult life (Section 2.3.3). The findings of this study suggest that adolescents have been forgotten since the inception of health care services in Kenya.

Provider 12, '...its actually this time of HIV that we are now thinking of the adolescent and even protecting them. I think from the inception of health care, the adolescent was actually a forgotten person basically because they do not get sick so often. They are in their prime time and very healthy people. It is expected that they do not even get pregnant so they will not need MCH and they are not expected to be sexually active. Somehow somebody did not articulate how to tackle the issue of the adolescent until now because of the epidemic that we realise that so many youths are dying. That means that they are also engaged in sexual intercourse. Its now we are trying to tackle their issues.'

### 5.3.2 Lack of baseline data on adolescent reproductive health status

The lack of baseline data on the sexual and reproductive health status of adolescents and lumping of adolescent health needs with the needs of adults and children, contribute to lack of planning for adolescent PRHS. This also heightens the

assumption that adolescents have no health needs. A research is needed to ascertain the health situation of adolescents and to help proper planning. The Ministry of Health, through its network of health facilities should undertake continuous monitoring of adolescent sexual and reproductive health. Further, the Ministry of Education should address sexual and reproductive health needs of the in-school adolescents. The two ministries (health and education) should collaborate with other government departments [Children's department, the Ministry of Planning and National Development, and the department of Gender, Sports, Culture and Social services] to closely monitor sexual health related school drop-outs, as well other reproductive health outcomes of adolescents. The gathered data should be disaggregated according to age and gender, and shared with relevant departments that deal with adolescent health issues to facilitate directed planning.

The findings of this study correspond with previous studies. Kolip and Schmidt (1999) observed the need to disaggregate all health statistics by sex. They observed that sex and gender are important variables within the whole health process and that health reporting should be differentiated according to gender. Further, they argued that “without detailed information about gender-specific aspects of health, it is difficult to implement effective practices and policies” and that “sex-specific health statistics allow appropriate conclusions to be drawn for improving the health system for girls and boys.” Singh and Darroch (1999) also noted that effective policy and legal framework need to be backed up with data. Likewise, formulation of policies and development of programs on ASRH require up-to-date information on levels and trends of teenage sexual activity.

The Population Council (Popcouncil, 2001) similarly noted the need to disaggregate data according to regions, age and marital status. They observed that the lack of data on adolescent health and sexuality imply that many adolescent policies are based on premises that the lives of adolescents in developing countries are like those of adolescents in western countries. That is, mainly living at home with families, not

working, in school and unmarried. The Population Council argued that experiences of married and unmarried adolescents are different, for example on their knowledge levels about information on contraceptive use. Thus, lumping married and unmarried adolescents together presents problems because the two groups represent significantly different populations, and have varying levels of knowledge about sexuality matters. It also leads to failure to address the unique needs of married and unmarried adolescents (Popcouncil, 2001).

### 5.3.3 Imbalance and marginalisation of rural areas

Adolescents in the rural areas face greater challenges in accessing and utilising preventive reproductive health services. The rural areas, unlike the urban areas, have fewer adolescent health services. Murang'a District was particularly singled out as lagging behind the neighbouring Nyeri, Maragua and Thika Districts in the Central Province, in establishing adolescent health clinics, developing viable adolescent health outreach programmes, in general delivery of health services, as well as infrastructurally. The lag was partly attributed to lack of government support in planning for adolescent health programmes, lack of strong NGOs and CBOs in the district to focus on adolescent health, and marginalisation of the district as implied below.

Provider 8, 'When I was in Karatina [situated in neighbouring Nyeri District] we were very active. We would have the students trained. But now here, even getting a vehicle for a trainer is difficult... Murang'a District is like a forgotten district'

Key Informant 12, '...in fact I would say Murang'a is a district that has been left out...possibly it used to be a rich district because of coffee...it is one of the poorest districts at present. But it looks like most of the people still take it to be the rich district it used to be...Even in our meetings we have been calling upon anyone who can bring in NGOs that can help us in most of these areas should come in...DANIDA programme, IFAD Programme are in Nyeri and Maragua...Murang'a was left without these major donors. So it is something that I think needs to be looked into.'



The views of adolescents, health providers and key informants indicated that the needs of rural adolescents have not been well addressed. Nevertheless, the health providers and the key informants demonstrated a high interest in providing preventive reproductive health and outreach services for adolescents. This interest needs to be sustained and supported to effectively respond to adolescent sexual and reproductive health needs. The need for the government to establish adolescent health centres in Murang'a District was emphasised, as well as the need to ensure that adolescents in the interior regions have access to and can utilise preventive reproductive health services. The findings of this study imply that continued failure to address the present sexual and reproductive health needs of adolescents would lead to future poor health of adolescents. Also, this would enhance the already existing reproductive health service gap, thus lead to a missing link in the lifespan.

The findings further imply the need to establish an organisation in Murang'a District to coordinate adolescent health issues. The 'third sector', that is, NGOs, CBOs, and FBOs can greatly contribute to the improvement of adolescents' sexual and reproductive health. If well funded, strengthened and coordinated, the third sector can provide sustainable means for addressing barriers that hinder adolescents access and utilisation of PRHS. It can also supplement government's efforts to provide sexual health education to the in-and-out of schools adolescents. Most of the health providers and the key informants concurred on the need to set up an adolescent health coordinating body to enhance coordination of adolescent health services in Murang'a District. However, there were differing views regarding the type of organisation that should be established. One opinion favoured establishment of a single and independent entity.

Key Informant 11, 'we would recommend that the government should come up with a department entirely to handle the issues of the adolescents. That way, there will be somebody responsible. Just as there have been gender issue in the Culture Ministry. Just as they are concerned with the children under 18. They even have a policy for them. But for the adolescents, there is nobody taking care of them.'

A second view was opposed to the setting up of adolescent departments. They instead suggested that existing departments and 'youth' programmes, like the Youth programme within the Ministry of Gender, Sports, Culture and Social Services should be strengthened and their capacities expanded to accommodate adolescent health issues. Moreover, setting up new departments may lead to duplication of services, and overstretch the capacity of the already understaffed departments as implied below.

Key Informant 12, '...we have in our department the youth programme...it has not been fully operational because of facilities. If we could strengthen a department like that one, it would actually manage to take care of the youths. Of course in collaboration with other officers that are concerned with the youths - the education, the health. Creating a department at times is not an easy thing because we are talking of a lot of money, employing officers from the national to the district or divisional level... So I think we should strengthen what we have. And may be what we should do, is to highlight adolescents issues in those programmes and departments which are already there, and have a mechanism for monitoring what is going on.

Whereas the findings emphasised the need to incorporate adolescent health issues in the existing health structures, the limitations that entail setting up new departments were noted. The findings suggest that most health facilities lacked the financial and institutional capacity to establish and equip adolescent health centres. An ideal adolescent-friendly centre should have space and be equipped with television, videos and IEC materials. Thus, the lack of space, furniture and shortage of trained staff creates further challenges. Despite the divergent opinions, the findings demonstrate the need to coordinate adolescent health programmes in the district. The findings suggest

the need to establish a national coordination body or committee to monitor adolescent health issues in Kenya, and coordinate adolescent health programmes in Murang'a District.

#### 5.3.4 Regional variations in knowledge about available services.

Adolescents had different levels of awareness about available preventive reproductive health services. The difference related to their levels of exposure to sexuality matters as well as residential differences. The findings show that adolescents lacked basic information about available reproductive health services in Murang'a District. They also suggest that adolescents living in the urban areas have higher levels of awareness about PRHS than their counterparts in the rural areas. For example, adolescents from urban areas had more awareness about where they could seek VCT services. To the contrary, many of the adolescents from Murang'a District indicated having heard of CBOs and VCTs that offered reproductive health services in the district, but did not know about their operations and location. Some even wondered what VCTs were.

The health providers and the key informants concurred with this finding. They noted that adolescents in the rural areas exhibiting less awareness about sexuality issues, for example about HIV/AIDS, than their same age counterparts in the urban areas. The findings imply the need to tailor adolescent health services to the individual needs of adolescents, taking into account age and regional differences. Leslie et al. (2002) in a study conducted in Burkina Faso and Senegal made similar observations. Leslie et al. noted that there existed notable differences among urban, semi-urban and rural populations of adolescents regarding sexual and reproductive health knowledge, attitudes and behaviour. Further, they suggested the need for policy makers to recognise diverse needs of youth in these areas, and to tailor programs accordingly. The United

Nations (1995) also observed that adolescents have a right to sex education and to access reproductive health services that are tailored for their needs.

#### 5.3.5 Parental neglect and ignorance about adolescent health matters

Parental ignorance and neglect about adolescent reproductive health and sexuality contributed to the ignorance among adolescents about available services. The study findings show lack of parental involvement in adolescent health matters. Accordingly, adolescents had no one to inform them about existing PRHS and the need to use them. Parental neglect has its roots in the shift in the socio-cultural practices. Traditionally, for example among the Kikuyu, adolescents were taught sexuality matters by their grandparents and guardians. With changes in traditional practices, there emerged a gap because no systems were put in place to replace the traditional teaching methods. As a result, many parents are in dilemma and find it difficult to openly share sexuality matters with their children. Consequently, adolescents depend on their peers for information. The situation is perpetuated by the changing social-economic patterns and community structures whereby parents spend most of their time working for their families' upkeep. They thus have little time to understand the health challenges facing their adolescent children.

Key Informant 12, '...the community structures or family set-ups the way they are now, we may not have the time or the opportunity to communicate as well as we would or as it used to happen with the adolescents. You find that they fall into a lot of problems and sometimes they do not know who to go to...most of the people...the parents may not even know that there is a problem of drugs consumption among their children until when it is very late.

This study concurs with observations by previous scholars that parents relegate the responsibility of advising adolescents to the schools and institutions like churches. Jejeebhoy (1998) observed that adolescent ignorance about sexual and reproductive

behaviour is compounded by reluctance among parents and teachers to impart relevant information. Leslie et al. (2002) similarly noted the tendency by parents to offer adolescents information in response to negative events. In a study conducted in Burkina Faso and Senegal, Leslie et al. observed that parents did not talk with their adolescent children about sexual and reproductive health; and that when they did, this was often triggered by a wedding, a birth or the first menstrual cycle. They further noted that even then, the information given by parents to the adolescents was often vague and inadequate. Leslie et al. further noted that some parents are opposed to adolescents access to sexual and reproductive health services due to fears that adolescents are too young, and that such services would promote promiscuity and early sexual relations.

The findings further suggest the need for parents to take greater parenting role since some of the problems facing adolescents start from home and could be identified, prevented and dealt with at the family and household level. Although schools can deal with some of the problems facing adolescents like controlling drug taking, they are only complementing agencies and not 'rehabilitation centres'. There is therefore a need for parents to be educated about the challenges that adolescents experience so that they are not strangers to their adolescent children. The findings further imply the need to educate parents about sexual and reproductive health matters. The health providers and the key informants observed the need to educate parents not only about adolescent sexual and reproductive health, but reproductive health issues in general. They observed that some parents did not understand their own reproductive health needs. Accordingly, it would be difficult for them to advise their adolescent children. The adolescents made similar proposals. Most of them felt that their parents, and even their teachers, did not understand them. They proposed the need for parent's guidance and counselling to expose them to adolescent health issues.

### 5.3.6 Summary

The study findings show lack of adolescent-friendly/specific services in Murang'a District. Adolescents considered the health facilities as key sources of reproductive health services. The lack of adolescent-friendly services in Murang'a District was associated with lack of planning for adolescent services, failure to prioritise adolescent health, lack of reliable data about adolescents sexual health status, and marginalisation of the rural areas. The findings also show that Murang'a District lags behind in developing viable adolescent health services and outreach programmes. There is need for baseline data to assess and ascertain the reproductive health situation of adolescents in Murang'a District. Lessons drawn from the data should be used to devise adolescent friendly policies and help planning for adolescent health programmes. The findings further suggest the need to establish a national coordinating body, and to have a strong organisation in Murang'a District to monitor and coordinate adolescent health issues (Section 6.3.3). There is also need for more engagement of the 'third sector' and strengthening of departments, NGOs and CBOs focusing on adolescent health; and to initiate health education and counselling programmes targeting parents.

#### 5.4 School Health Services

The findings from this study show that schools had made efforts to address adolescents preventive reproductive health needs (Section 4.6). Schools offered guidance and counselling services, had *Family/Growth groups* and *Academic families*, and had integrated (infused) HIV/AIDS into learning and through HIV/AIDS clubs. The findings show that schools have caregivers who attend to the health needs of the in-school adolescents and offer them curative services. They also offer referral health services to adolescents who need additional care to the nearest health facilities. The caregivers included resident or non-resident school nurse, or resident matron or cateress.

This study identified several weaknesses in the school health services. First the lack of confidential and individualised services. The guidance and counselling services were not confidential or individualized. They were offered publicly or in groups. Only one out of the six covered schools had a separate guidance and counselling office. Consequently, adolescents were not free to openly share their sexual health concerns with their guidance and counselling teachers or with the guest counsellors, thus creating a communication barrier. The adolescents feared that their peers might tease them if they openly shared their concerns. The findings showed lack of trust and suspicion between adolescents, and the school caregivers and their teachers. Many adolescents seemed unhappy with the way their health problems were handled. The adolescents portrayed their school caregivers as unfriendly, disinterested, uncaring, rude, intrusive, unwilling to help, and lacking understanding about how to handle adolescent health problems. They cited difficulties in sharing their health problems with school caregivers.

*Interviewer: Does your school provide you with information and services that can help you meet these concerns?*

Adolescent 7:16, ‘...school nurse can also help when one has a problem. But she is not so friendly. She asks how do you know you are sick. So even when you have a problem you will not go there. Yet she is the only one who can give permission to go elsewhere for treatment.’

The lack of openness, compounded by lack of trust of teachers and fear of breach of confidentiality made the *Family/Growth groups* and *Academic families* ineffective in meeting individual sexual health needs of adolescents. Although the groups aimed at narrowing communication gap between adolescents and the teachers, as well as enhancing open sharing, the findings suggest that adolescents shared with their teachers what they perceived as morally appropriate. Some deconstructed their real problems and asked questions indirectly pretending that they asked on behalf of friends. The findings also showed lack of consistency and uniformity in the schools sexual health services. Most of the adolescents indicated that their schools held *ad hoc* guidance and counselling sessions, and a few weekly or fortnightly (Section 4.6.1; Table 4.4). The lack of consistency, uniformity and continuity creates levels of marginalisation among the in-school adolescents in access to preventive reproductive health information and services. Adolescents from schools with more and regular programmes have better access to sexual and reproductive health information than those from schools with few and irregular programmes.

The above findings point towards the need for schools to provide confidential individualized preventive reproductive health services to adolescents. This would foster open sharing, enhance professionalism in service delivery, and would in turn boost access and utilisation of preventive reproductive health services by adolescents. The findings imply the need for schools to have separate guidance and counselling office. They also indicate the need for regular, planned and coordinated guidance and counselling. Further, the findings imply the need to involve adolescents in designing and planning the guidance and counselling sessions to make them appealing and relevant to their needs.

The schools, in conjunction with the Ministry of education and the Ministry of health, need to work together to develop a common or standard curriculum or programme for adolescent reproductive health to be followed by the schools. As much as possible, the counsellors and teachers should follow a set guidance and counselling



curriculum to avoid repetitiveness. They should also allocate adequate time to allow adolescents to ask questions regarding their sexual health concerns. Further, they should provide adolescents with information packs about sexuality issues, have follow-up programmes, and hold the sessions regularly and not in response to crisis like when there are cases of unwanted pregnancy. Consequently, adolescents trust and confidence in their teachers and the schools response efforts would be enhanced.

The findings of this study show lack of complete and comprehensive school health services. Ideally school health services should encompass promotion of positive health behaviours among adolescents, management of health problems like STIs, counselling and referral services to meet individual needs of adolescents, reinforcement of health instruction with an emphasis on health promotion and prevention of STIs including HIV, and provision of health screenings (WHO, 1996). This study has established that the lack of comprehensive school health services and the lengthy referral procedures create obstacles for adolescents in meeting their sexual health needs when in school. The 'gatekeeper approach' applied by the schools cause unnecessary delay for adolescents in seeking care and denies them their right to privacy and confidentiality. This study established that some school authorities require the caregivers to accompany adolescents to the health facilities, including inside the consulting rooms. The above findings coupled with restrictive school time-tables make adolescents to avoid health services and not to openly share their sexual health concerns with the health providers.

*Interviewer: Do you have any additional information that you would like to share with me?*

Adolescent 4:94, 'Here in school you go with the matron or cateress - [*to the health facilities*]. If she enters with you, you just say that you have flu. You do not say the problem because she is very free with students. The issue of being accompanied by the school matron or cateress is a real issue here. If you go for guidance and counselling, I think that this should be strictly confidential. If its guidance she should not accompany you because she is not supposed to hear what you are saying.'

The findings of this study concur with that of Webb (1998). Webb observed that school based projects and programmes usually provide information and education but not services. Dehne and Riedner (2005) made similar observations. They noted that in East Africa, the provision of STI services in schools seems rare and not supported by official policy. They further observed that none of the training curricula for teachers developed in the region include reference to syndromic STI case management. Further, they observed that parents and school authorities resist the setting up of services for adolescents because of the notion that such interventions make adolescents more interested in sex. The findings of this study imply the need to strengthen schools health services. Schools should be helped to provide complete and supplementary services to adolescents, especially accessing them with sexuality information and counselling services.

#### 5.4.1 Summary

The findings show that schools have made efforts to respond to the sexual health needs of adolescents. Notable efforts include provision of guidance and counselling services, establishment of *Family/Growth groups* and *Academic families*, integration/infusion of HIV/AIDS education in the education curriculum, as well as provision of curative and referral services. These services are however not confidential or individualized. They also lack follow-up component. They are provided by unfriendly and unsympathetic school caregivers. The effectiveness of school health services is hampered by the following factors: lack of comprehensive school services, lack of adequate coordination between schools and health care facilities, restrictive school timetables, and lengthy referral procedures. The findings show the need to restructure the provision of preventive reproductive health services for adolescents in schools to make them adolescent-friendly, professional and enhance their access and utilisation by adolescents.

## **5.5 Utilisation of Preventive Reproductive Health Services by Adolescents**

Adolescents did not adequately utilize available preventive reproductive health services. Only about a third of the adolescents (31.6%) had used preventive reproductive health services outside of the school guidance and counselling (Section 4.8). Two interpretations could be derived from this finding. One is that adolescents are healthy and do not need to access and utilise the services as implied by the notion of 'health adolescents' (Section 2.3.3). This was also implied by about a third of the adolescents (40.5%) who cited their failure to use services as not having had a sexual health need (Section 4.8.7). The second interpretation is that adolescents have sexual and reproductive health needs, but do not access and utilise services to meet these needs. Evidence from this study greatly supports the latter view. The findings show that adolescents have sexual health needs and that they desire to access and utilise PRHS (Sections 4.3, 4.7 & 4.8.8). However, several factors prohibit their use of the services (Chapter 7).

The low utilisation of services by adolescent was associated with adolescents failure to go to health care facilities. The health providers observed that adolescents have needs but are not physically accessible because they do not seek services. The providers felt that this was a social issue that required 'breaking the bridges between the adults and the adolescents' to understand the thinking and perceptions of adolescents. A few providers expressed hope that VCT services would help opening up of the 'bridges' between adolescents and the health care systems. Others, however, noted that VCTs may not provide optimal solution to the challenges faced by many adolescents because of policy barriers that restrict access to VCT services for adolescents below 18 years (Section 6.2.1). The health providers indicated that adolescents do not seek preventive reproductive health services even when in need.

*Interviewer: What are the main services that adolescents seek from this clinic?*

Provider 5, “When they come here for the first time, they come for antenatal. They often come when they are pregnant... when we take their profile, we find that some have STIs and even HIV/AIDS...”

Provider 18, ‘...the youths do not feel free to come and tell us their problems...May be it is because we have been here for a long time, and they would not want us to know their problems. Not many come to present reproductive health problems like seeking family planning services and information. Or even when they get raped, they do not come to report.’

This study has established that adolescents visited health care facilities to seek post-exposure reproductive health services. These included antenatal (ANC) services, post-abortion care, curative services for STDs, or even HIV infection. Adolescents faced specific challenges that affected their level of access and utilisation of preventive reproductive health services. The findings also show that the lack of laboratory services, negative attitude towards services, and delay in recognising STIs especially among girls, made adolescents to delay seeking care.

Further study findings suggest that there existed gender differences among adolescents in accessing and utilising preventive reproductive health services. Seven out of 25 health providers observed that more girls than boys used reproductive health services. The services used by the girls were cited as: ANC, MCH/FP and treatment for severe menstrual pains and candidiasis. They observed that most of the adolescents who sought ANC and MCH/FP were married. The services used by the boys were cited as: to obtain condoms, occasional treatment for STI, and urethritis. The health providers indicated that STI cases among adolescents were few and had declined over time. They associated this to the success of HIV/AIDS awareness programmes. They however noted that the few STI cases were mainly among girls largely because of their physiological make-up, and that boys preferred to seek services from the private health facilities.

*Interviewer: What are the main services that adolescents seek from here?*

Provider 5, "...no boys come to the clinic. It is only the girls. May be if there was an adolescent clinic, we would include adolescent counselling and this would probably attract the boys. As for now, we do not have adolescent counselling as a specific service...The number of girls seen at the clinic is higher than that of the boys. This is because girls are more exposed than boys especially when they are in school. Also for most of the girls' growing up is a bit complex. Most of the girls come here asking questions about their reproductive health. Others come with complaints about STDs. The boys don't come here when they have STDs. They go to private clinics".

The findings of this study align with previous studies that indicate that girls face greater reproductive health challenges than boys (Leslie et al. 2002; RoK-MoH, 2001a). The femininity and masculinity theory could also explain the observed gender differences in access and utilisation of preventive reproductive health services among adolescents. Kolip and Schmidt (1999) noted that 'boys are the "weaker sex" up to puberty since they are more often sick and present to a doctor', and that 'this health-related gender ratio is reversed in adolescence'.

### 5.5.1 Summary

The above findings indicate low use of preventive reproductive health services by adolescents. Although the theory of 'health adolescents' could explain why few adolescents had used services, there was compelling evidence to suggest that adolescents had sexual and reproductive health needs and that they desired to access and utilise PRHS. However, a multiplication of factors prohibited their use of services. Evidence has shown that adolescents do not go to the health facilities even when they have sexual health needs and are therefore not physically accessible to the health providers. Thus, the health providers lack an opportunity to provide them with

preventive reproductive health services. The findings also suggest that adolescents seek post-exposure reproductive health services as opposed to preventive reproductive health services. The findings have also shown the gender differences in accessing and utilising preventive reproductive health services.

## **CHAPTER 6: TOP BOTTOM APPROACH**

### **ADOLESCENT REPRODUCTIVE HEALTH POLICIES VIS-À-VIS ACCESS AND UTILISATION OF PRHS**

Another purpose of this study was to establish whether there were adolescent preventive reproductive health policies. The aim was to establish the extent to which the existing policies affected access and utilisation of preventive reproductive health services by adolescents. This chapter contains the discussion of the study findings on existing adolescents' reproductive health policies, and how the policies influence adolescents access and utilisation of preventive reproductive health services (PRHS).

#### **6.1 Adolescent Reproductive Health Policies**

##### **6.1.1 Knowledge of adolescent reproductive health policies among providers**

The health providers and the key informants lacked adequate knowledge about existing reproductive health policies for adolescents. They indicated not being aware of favourable policies on adolescent reproductive health. Consequently, they lacked the necessary understanding of what was expected of them when serving adolescents. Although the health providers indicated lack of awareness about adolescent reproductive health policies, they noted the lack of legal barriers to provision of reproductive health services to adolescents. Further, although they lacked written literature about the existing policies, they had however been verbally sensitised about the reproductive health policies relating to adolescents reproductive health services. Many providers indicated that they had received verbal guidelines and directives from

the Ministry of Health on the need to offer reproductive health services to adolescents irrespective of age, gender or marital status.

*Are there some policy guidelines or restrictions that you... follow?*

Provider 18, ‘...we were taught in a seminar that reasons such as age, parity and menstruation should not stop us from giving family planning. Even if they are school children, we should give them family planning. When she comes, even if she wants depo even if 14 years you give.’

Further findings showed lack of clear understanding about the reproductive health concept among some health providers. Although several of the health providers indicated there being no policy restrictions, their views pointed to their awareness about family planning policies and not reproductive health policies as a whole. Some equated reproductive health as being synonymous to family planning. When asked about the reproductive health policies they were aware of, some health providers indicated that they had no policies on adolescent services but only on family planning. Accordingly, they indicated that they did not provide family planning services or that they considered family planning services inappropriate for adolescents. Many providers noted for example that:

*Can you please tell me about the existing government policies on reproductive health care in Kenya?*

Provider 3, ‘...in family planning, that is where we have a policy...we are told that, “if you see an adolescent coming to the clinic, don’t tell her that she is in the wrong place”. And that is why we came from the word FP to reproductive health. We welcome the girls, give her a sit, ask her what is your name, where do you come from and what can I do for you? You ask this kind of an open question. No other policies. Even if they come here with an STD we treat them like any other patient.’

Ambivalence and lack of clear understanding of reproductive health terminology, as well as about adolescent sexuality limit efforts to institute adolescent-friendly services. The ambivalence could be related to the training of the health providers. However, some of the health providers indicated that there was a shift from the old



*family planning services* concept, to the *reproductive health* concept. These findings affirm the need for regular training and updating of the health care providers on adolescent reproductive health issues.

#### 6.1.2 Knowledge of Adolescent *Reproductive Health and Development Policy*

This study specifically sought the views of the health providers and key informants regarding the '*Adolescent Reproductive Health and Development Policy*' (RoK, 2003a). The policy recognises the need to access information and services to adolescents (Section 2.1.4). The findings showed lack of awareness among the health providers and key informants about the policy. For example, only one out of the 24 health providers interviewed indicated having heard about it. The policy was published in May 2003 and launched in October 2003 by the National Council for Population and Development (NCPD). Still, a year after the publishing of the policy (during data collection), the health providers demonstrated ignorance to its existence. Also, none of the key informants had knowledge about it.

When asked whether they were aware about the policy, many health providers and key informants reported that; '*I am not aware of it*'. Others would ask 'was there one?' or '*saying what...?*' Others noted that '*you are telling us about it now*' or that '*the policies do not reach here*'. One provider observed that '*may be there is one but I am not aware. May be the DPHN office know about it.*' However, the district MoH and MoE representatives also indicated lack of knowledge about the policy. They also indicated that they had not seen the *written* policy. Surprisingly, even at the provincial level, at the Nyeri Youth clinic, the response was the same '*...I have no knowledge about this. I have not even heard about it.*' The provider who had heard about the policy had learnt about it through the media, but was also not aware about the contents of the policy. Several of the providers also indicated lack of awareness about the *youth-friendly* services concept.

The findings imply the lack of involvement of key stakeholders in the policy making and development process. They also suggest the lack of appropriate channels for disseminating information about existing reproductive health policies. Also, they point to a communication gap between policy and decision makers at the national level, and implementers at the lower levels (province, district and local). Many of those interviewed indicated that their departments were not involved in policy making. The health providers blamed the bureaucratic structure of the healthcare system, and failure by the government to involve key players at the various levels, for poor communication and awareness regarding adolescent reproductive health policies. The health providers and key informants expressed desire to be informed about adolescents' reproductive health services and concepts, and to be provided with the policy to know whether they operated within the policy guidelines. They further noted the need for stakeholder participation in formulating adolescent health policies. This would facilitate acceptance of the policies by the implementers, as well as give them direction in questionable areas.

*Interviewer: Are you aware about the adolescent reproductive health policy that was launched in October 2003?*

Provider 7, 'I have no knowledge about the ARH policy. This has to do with systems design and involvement of the people. For example, from Afya House [MoH Headquarters]. The process of designing policy should have involved stakeholders in different ways and different levels. This way it would have reached the right people. But when they involve consultants, this way they do not reach the people. This is a leadership question.'

Key Informant 6, 'Major concern is if the government is to make policies, it should also involve the people at the grassroots level who are concerned about adolescents so that they can also be in a position to reach them effectively. If the government gives policies only to the Ministry of Health, how does the ministry implement the policies?'

Whilst the health providers and key informants showed lack of awareness about the policy, during the same period, a newspaper supplement containing information

about the policy appeared in a local media<sup>7</sup>. The role of the media as an important tool and channel for reaching a wide audience and informing the public about public health issues is indisputable. However, the media should not replace continuous communication between the top and the bottom, or used to enhance a top bottom approach. The findings affirm the need for continuous communication and sharing of information between the policy makers, the health providers and stakeholders. This would enhance flow of information at all levels, foster teamwork, and enhance partnership and stakeholders involvement in policymaking and implementation process.

### 6.1.3 Nature of existing adolescent reproductive health policies and guidelines

There were no clear and specific policies and guidelines for adolescent reproductive health. The findings show lack of systematically developed reproductive health guidelines to assist the health providers in making decisions about provision of adolescent reproductive health services. The findings also show that adolescent reproductive health policies in Kenya are contained within the context of other reproductive health policies, primarily within policies regarding MCH/FP and HIV/AIDS prevention. The health providers and key informants generally indicated lack of awareness and understanding about the government position and policy regarding adolescent reproductive health. They felt that existing reproductive health policies do not target adolescents directly. Instead, the policies target adults and the married. The health providers cited examples of FGM and HIV/AIDS policies. They noted that the policies failed to address reproductive health issues of adolescents. They argued that the FGM policy targeted all women merely because FGM is ‘a bad vice’ which tampers with women’s health. They also argued that the HIV policy merely responds to ‘a national disaster’ but does not specifically target adolescents.

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<sup>7</sup> ‘Adolescent Reproductive Health and Development Policy: Policy Highlights’. Sunday Nation, April 25, 2004.

The findings also showed that the health providers' interpretation of adolescent behaviour and the perceived reproductive health risks guided their actions and decisions on what services to offer to adolescents. They used personal judgement to determine appropriate services for adolescents, even if this meant defying the policy. For instance, some of the health providers interpreted the seeking of PRHS by adolescents as an indication that adolescents were sexually active or about to start being sexually active. Accordingly, they considered that it would be imprudent to deny adolescents services because this could lead to unintended pregnancies, related complications and death. Thus, the health providers would have missed an opportunity to prevent sexual health risks.

Provider 12, '...It does not matter whether it is an adolescent or an adult. Basically when an adolescent is seeking reproductive health, between the lines, the client is already telling you that they are sexually active or are about to start. Even if you do not assist this client you will see them with a complication that you could actually have prevented and you have missed the chance and an opportunity to prevent a pregnancy that will later end up being aborted or complicated or losing lives or vital organs. The policy is that, services are for all.'

However, although the policy allows adolescents access to family planning services, not all services were considered suitable and appropriate for them. Although the findings reveal the existence of official adolescent reproductive health and development policy (Section 2.1.4), they also show the existence of restrictive policies that limit adolescents access to services and information (Section 6.1.2).

Provider 12, '...The policy is that services are for all. The only thing with FP is if one has not started menarche, you may not give hormonal. But if someone comes here and feel that they opt to use the method, you can counsel the client and you may be able to give the patient condoms. So prevent because sex is not just about pregnancy but also infections.'

The findings also showed contradiction in the views of the health providers regarding existing reproductive health policies. Although the health providers indicated that there were no policy restrictions barring them from offering preventive reproductive health services to adolescents, they also noted the lack of policy guidelines. The findings further showed lack of commitment to review and develop the policies. Despite the lack of clear adolescent-targeted reproductive health policies and guidelines, some providers alluded that the guidelines would be established once plans to set-up adolescent-friendly services were underway. They attributed the lack of clear guidelines and policies to resistance from religious groups on government efforts to introduce school-based sex education, to the moralization of sexuality matters in favour of "abstinence-only" sex education, and to lack of consensus between the government and stakeholders on the contents of adolescent sexual health services and education pack. The lack of consensus between the various ministries and organisations serving adolescents lead to disjointed efforts in provision of preventive reproductive health services for adolescents.

*Interviewer: Are there any policy guidelines on adolescent health services?*

Provider 1, ‘...No specific guidelines for adolescents. In 2000 there was a programme that was to be initiated but because of the controversy from the churches, it was shelved. I think that idea died a slow death. I have not seen anything even in the detailed work plans and the strategic work plan. It is very silent about the adolescent youth.’

Provider 3, ‘...we [MoH] do not have guidelines for teaching adolescents in schools in our office, but in the schools there is a HIV/AIDS curriculum. For class 1 up to university. This is what the teachers can follow but from the ministry [MoH] there is no laid down criterion that we can follow, unless we look at the Ministry of Education syllabus to see what we can teach in different classes. But this is the challenge now. What is the limit given that some in the same class know much and some do not?’

The above findings imply the need for the government to review and re-think its stand on the reproductive health policies for adolescents. Clear adolescent reproductive health policies are important and central in the development and implementation of effective adolescent reproductive health programmes. The findings also imply the need to foster institutional collaboration in harmonising and developing adolescent-specific reproductive health policies and guidelines, and for attitude change among parents, professionals serving adolescents and social institutions like religious groups regarding adolescent sexuality. The findings that there is need for clear policy on adolescent reproductive health services provision concur with that of Elster and Kuznets (1994). Elster and Kuznets noted that although some physicians provide preventive services, comprehensive clinical preventive services are not always a central component of adolescent health care. Factors which contribute to preventive care and service gap include uncertainty relating to how frequent adolescents should be seen, uncertainty about the content of preventive care visits, and questions about importance and efficacy of preventive services in changing behaviour.

#### 6.1.4 Summary

The above findings have shown general lack of awareness about existing ‘adolescent Reproductive Health and Development Policy’ among health providers and key informants. This is partly because of lack of stakeholders’ participation in the policymaking and development process, and lack of appropriate disseminating channels. The findings imply the need for stakeholder participation and bridging the communication gap between policy makers and implementers. The findings have also shown the lack of clear guidelines for adolescent reproductive health. They also show lack clear differentiation of the

*reproductive health* and *family planning* concepts among some health providers. The findings further show that the health providers had been verbally sensitised about the need to offer reproductive health services to adolescents. However, not all services were considered appropriate for adolescents. Also existing reproductive health policies do not target adolescents. Instead, adolescents are reached in the fight against harmful cultural practices or national disasters. The findings indicated the need to regularly inform and update health providers about adolescent health services policies and concepts.

## **6.2 Policy Influence on Adolescents Access and Utilisation of PRHS**

The above findings highlight that lack of clear adolescent sexual and reproductive health policies affect adolescents access and utilisation of PRHS. This study has identified key policy barriers that hamper access, utilisation and provision of adolescents PRHS. Lack of clearly-stated policies to guide adolescent health programmes, lack of adequate awareness by health providers about adolescents' reproductive health policies, restrictive policies and legal requirements, for parental consent, and inconsistency between policy and practice create further obstacles. Further policy barriers to access and utilisation of reproductive health care services are discussed below.

### **6.2.1 Restrictive policies and legal requirements**

This study has established that adolescents experience ethical and legal barriers while accessing and utilising PRHS. Ethical and eligibility requirements based on attainment of 'reproductive health age' or the 'legal age of consent' (18 years and above- Section 2.2.3) affect adolescents access and utilisation of PRHS. Despite efforts

by the government to address sexual and reproductive health of adolescents, legal and ethical restrictions create barriers to full access to reproductive health care by all adolescents. Restriction of services to specific age leaves most adolescents without access to preventive reproductive health services. For instance, VCTs services are restricted to persons aged 18 years and above, or the ‘mature minors’ (RoK-MoH, 2001c). This implies that many adolescents, defined by WHO as persons aged 13 – 19 years (Section 2.2.2), are ineligible to access and utilise VCT services. They thus fall through the net and get forgotten. This creates a challenge for many adolescents, especially given the assumption among many adolescents that VCT centres offer preventive reproductive health services (Sections 4.5 & 4.7.1).

*Interviewer probing on the fact that the nurse is wearing a badge written “Just ask for VCT services from me”.*

Provider 13, ‘I trained recently and even have not started the services although we are going to start soon. But a VCT service or centre is for people who are 18 years and over. And they come voluntarily... If someone younger than 18 years comes, we counsel them to make them understand that the service we are giving, one has to give consent and this can only be done by someone who is 18 years and above. But if it is very necessary that that person get it, then the person is brought by the parent or guardian who will give the consent.

The findings suggest that policy barriers may result in exclusion of adolescents from PRHS. They also imply that adolescents aged below 18 years are ineligible for confidential and anonymous preventive reproductive health services because of policy restrictions. They may, however, access PRHS if they satisfy the ‘mature minors’ criteria – meaning that an STI or a pregnancy has occurred. This finding implies that existing sexual and reproductive health services address the post-exposure preventive reproductive health needs of adolescents, as opposed to pre-exposure needs. The ‘non-exposed’ under 18 adolescents depicted by lack of pregnancy, early marriage, or presence of STDs or HIV are considered ineligible to consent to services.



*Interviewer: Can you please tell me about the existing government policies on reproductive health care in Kenya?*

Provider 4, 'for a client to be taken in for VCT one must be 18 years and above so that they may give their consent. We also have the mature minors, 15 – 18 years. These could be ladies who have delivered very early, these are considered to be able to give consent and they can be tested. With the children, the consent of the parent or guardian is needed. Without it, one can be sued.'

The lack of clear reproductive health policies and guidelines provides an avenue for the health providers to deny adolescents access to PRHS services, especially the adolescent minors. Thus, even though adolescents are informed about available PRHS, this does not guarantee their access to the services as implied below.

*Interviewer probing: does that mean that adolescents without children...would not benefit from VCTs without parental consent?*

Provider 4, 'We...inform the young people what they need to know, what is a VCT so that they may make up their mind when they come to age...and how to behave before they reach this age. Currently nothing more can be done for the under 18 adolescent... If under age, we require someone to give the consent for you because the law does not cover you. Even though we do social mobilisation in schools for adolescents to know about the services [VCT], we would like them to go and give the information to their parents or relatives who are mature, and when they ...attain the age of maturity, they can come and we give them the services.'

These findings concur with previous studies which show that restrictive policies on age and/or marital status may present challenges for adolescents' access and use of PRHS. Dehne and Riedner (2005) observed that in many countries, laws and policies restrict adolescents access to certain health services and commodities according to age, marital status or both. They further observed that African and Asian sexual health programmes mainly serve older and married young people. They observed that in Kenya, parental consent is required for all reproductive health services, and for incomplete abortion treatment for the 15-18 year age group. This is also similar to other developing countries. Kolencherry (2004) in a study conducted in India observed that

certain legal statutes regarding the capacity of minors and policies followed by clinics seemed to restrict young people's access to health care services. Kolencherry observed that in India, a minor cannot seek health services without the presence of a parent or guardian. Elster and Kuznets (1994) also noted that ensuring confidentiality of information exchanged during a preventive service visit is relatively straightforward for adults. However, for adolescents the issues of whether they can legally provide consent complicate it. As such, adolescents do not always get the services they want since the health providers view them as minors.

The findings of this study confirm that policy restrictions may impact negatively on access and utilisation of preventive reproductive health services by adolescents. There is need to address the policy barriers to improve adolescents access to the services. The findings imply the need to tailor adolescent reproductive health policies to their diverse and age-specific needs, and to make the services appropriate to the developmental levels and cultural background of adolescents. The services should strive to bridge the reproductive health services gap, and to enhance a continuum of care across the lifespan.

#### 6.2.2 Challenges resulting from lack of clear definition of 'adolescent'

This study has established that there is no clear definition of adolescent. The lack of universal, clear and distinct definition of 'adolescent' presents potential barriers for adolescents in accessing and utilising PRHS. The health providers highlighted the challenges faced because of lack of clear definition of 'adolescent' and the mix-up of terminologies. They noted that the terms 'youth', 'young people' and 'adolescents' are often used to refer to adolescents. Further, they indicated that this creates confusion, especially in determining what services to provide to adolescents of different ages. One provider noted, for example that, 'the HIV/AIDS language is sometimes very confusing. We talk about youth, confusing youth and adolescents'. This feeling is understandable

given the wide age range often included in the definitions of adolescents. The WHO and UNFPA refers to adolescent as persons aged 10 – 19 years, and classify young adults aged 15 – 24 in the “youth” category. UNICEF, however, considers persons aged up to 18 years as children (Section 2.2.2). Green and Davey (1995) described adolescence in developmental terms and noted that adolescence is a period of transition from childhood to adulthood that takes place between the ages of 10 – 19 year. This lack of clear universal definition of adolescent poses challenges for service providers as indicated below.

*Interviewer probing: You have mentioned that dispensaries are undertakings of the communities, do you know whether they have any specific programmes for adolescents?*

Key Informant 12, ‘you consider adolescents to be what age?...definition of youth again is of concern; I believe some of the youngsters grow up earlier and maybe can be counted as adolescents. But someone going age-wise may think they are not youth...most of our population we call them youth...’

This finding implies the need to review reproductive health policies and to reconcile age classifications. There is need for a clear and comprehensive reproductive health care policy for adolescents in Kenya. Kenya needs to develop a clear working definition of adolescent. The definition should ensure that adolescents under 18 years old are included and have adequate access to PRHS. The working definition could borrow and reconcile the WHO, UNFPA, Green and Davey (1995) descriptions that define adolescent within the age bracket 10 – 21 years.

### 6.2.3 Bureaucratic procedures and rigid policies

This study has established that there existed bureaucracy that affected access and utilisation of preventive reproductive health services by adolescents. The health providers and the key informants blamed the lengthy bureaucratic procedures, administrative red tape, and rigid government policies relating to adolescent health for

lack of comprehensive PRHS for adolescents. The hierarchical system of the Ministry of Health creates obstacles especially for the health providers at the dispensary level.

*Interviewer (probing): Do you think there is something that can be done to improve adolescent reproductive health services?*

Provider 12, "...At the grassroots here we may not be able to change so much because we are also guided by the policies which come from above. So what we may do from the ground is to recommend to our supervisor that we feel that issues of adolescents are not adequately tackled in our set-up and possibly they may allow us to open a facility... For the time being we hope that those who come to seek services will get the services they need..."

The CBOs representatives noted the obstacles in reaching in-school adolescents. They observed the rigid administrative and bureaucratic procedures. To provide guidance and counselling to the in-school adolescents, CBOs are required to obtain clearance from the Ministry of Education. They also must seek permission and make prior arrangement with the school authorities. The process is not only lengthy but also entails vetting of the contents and information given to the adolescents. Restrictions and vetting inhibit CBOs capacity to provide adolescents with comprehensive and complete sexuality information. This rigidity is attributed to lack of policy consensus between the government, religious and civic organisations that co-sponsor schools and participate in designing the school curriculum. These findings highlight the need for the government to relax reproductive health policies on adolescents, and to consistently build consensus among all stakeholders on the nature and content of sexual and reproductive health services for adolescents.

*Interviewer: How can some of the challenges which you have mentioned be addressed?*

Key Informant 1, 'The government should relax some of the policies. E.g. we cannot go to a school and talk about condoms and contraceptives to someone below 18 years. The government policy restricts this. When we go to schools to talk about HIV/AIDS we are given guidelines from the Ministry of Education not to talk anything about condoms. This came about because some of the major stakeholders and sponsors e.g. churches who are also involved in drawing of the school curriculum are against this and

the government does not want to offend them...Some of these policies are restrictive to our work...We are not able to tell them [adolescents] full information despite the fact that most of the adolescents are very inquisitive...’

The findings also show lack of open sharing, collaboration and networking between the government departments, CBOs and FBOs. Although the CBOs are required to follow the MoE guidelines, the findings showed that the CBOs had no access to the stipulated policy. Consequently, they relied on word-of-mouth and verbal clearance from the MoE officials. The findings depict the relationship between the government departments and CBOs as one of rival competitors with competing interests. On the one hand, the CBO representatives felt that they were denied access to the adolescents, and to government policies relating to PRHS for in-school adolescents. They questioned the government’s capability to reach all adolescents, and to effectively offer them the needed PRHS.

Key Informants 2, “...the office of the DEO has been giving partial support [to CBOs] because they feel that only teachers should teach the children...It is becoming a big problem because one cannot reach the kids when one wants to reach them”...“there is a policy. We tried to get that policy but we could not get it because they [education office] say that they have trained their own counsellors. But when we go to the schools, we find whatever we are doing is very different from what they are teaching. There they are teaching on infusion and integration of the counselling skills within the curriculum. We are dealing with the person not for an exam. For the teachers they are preparing the person for examination not moulding the person.”

On the other hand, some government representatives felt that the CBOs lacked knowledge, expertise and technical competency to deal with HIV/AIDS issues and to offer guidance and counselling. They doubted the motive of the CBOs and perceived them as being money-driven. This suspicion and lack of trust could have contributed to the vetting of the CBOs. Accordingly, some of the government representatives felt that adolescent reproductive health matters ought to be handled by the relevant ministries –

that is, the Ministry of Health and the Ministry of Education. Presumably, these would have the needed expertise, trained staff, and technical competency to deal with adolescent health issues unlike the CBOs and individual counsellors.

*Interviewer probing: Supposing an organisation wants to give such services to adolescents in schools. Do you have specific guidelines?*

Key informant 10, “Yes because when the government started guidance and counselling in schools, we got very many people who started coming to our schools saying that they are trained counsellors and they would like to go and teach. So the government put some kind of control such that if you want to go to our schools you would have to get clearance first from the headquarters or the director...Once you have got that clearance, then you come to us and we give you a letter introducing you to the schools. So there are those rules just trying to control...We have done a lot of in-servicing on basic counselling and empowering the teachers with the knowledge of the topics...”

These findings imply the need to harmonise and coordinate adolescents health programmes in Kenya. So long as the efforts are disjointed, and so long as information and the mandate of organisations offering adolescent health services remain unknown, suspicion will persist. Although concerns about the mushrooming of CBOs might be genuine, the findings imply the need to enhance coordination and partnership between the government, religious institutions, NGOs, CBOs, and other stakeholders to effectively reach adolescents at the grassroots level.

#### 6.2.4 Contradiction between policy and practice

The findings showed contradictions between existing adolescent reproductive health policies and practice. The findings suggests that there were no restrictions on age, marital status or parity barring health providers from providing reproductive health services to adolescents so long as they had attained ‘the reproductive age bracket’ (Section 6.2.1). The findings however highlight the dilemma experienced by the health

providers. Despite being aware of the need to offer reproductive health services to adolescents, some health providers were reluctant to offer them family planning services. They felt that contraceptives including condoms, do not offer complete protection for adolescents. They observed that preventing pregnancy would not prevent STIs and HIV/AIDS, but would instead expose adolescents to other risks such as infertility. Some providers also noted that some contraceptives like sterilisation, were inappropriate for adolescents. The health providers favoured 'adolescent-gearred counselling'. They felt that this was a better approach for educating adolescents on the need to protect themselves from not just pregnancy, but also from STIs and HIV. The providers observed the need to encourage adolescents to abstain or use condoms if they have stable partners.

*Interviewer: Can you please tell me about the existing government policies on reproductive health care in Kenya?*

Provider 3, '...these days we tell them about STIs and pregnancy. You will avoid pregnancy if you swallow pills, but will these protect you from HIV/AIDS? We do not deny them the services but we tell her about all the other consequences. E.g. if she gets pregnant she may go for back-street abortion which may end up in death, infection or loss of uterus.'

The findings that health staff and other providers may establish their own policies which prevent access to services to adolescents are however not new. Previous studies identified judgemental attitude and unsympathetic service providers as key barriers to adolescents access to sexual health information and services. Dehne and Riedner (2005) in a review of literature documenting existing experience with provision of STIs services to adolescents, cited the example of Kenya. They observed that 'although the Kenya Ministry of Health policy does not specifically prohibit reproductive health services for adolescents, in general – the younger you look, the less likely you are to be attended to'. They further observed that in Kenya and Nicaragua, young people were usually left to the end of the queue, whereas boys attending STI

clinics were usually given disciplinary talks and the few pregnant girls who attend antenatal care were often punished and told off for getting pregnant at an early age.

The findings of this study also collaborate with that of Hocklong et al. (2003) who observed the need to harmonise reproductive health policies for adolescents. According to these authors, improvement of access to reproductive health services by adolescents requires existence of Public Health Service Act. In their view, the Act should contain regulations and guidelines designed to reduce barriers to access, particularly for adolescents who may have financial challenges and difficulties in discussing their sexual and reproductive health needs with their parents and/or guardians. Hocklong et al. (2003), further observed that the guidelines should be supported by law so that they are not conflicting. They noted that a “*patchwork of laws*” leads to many adolescents, parents and providers lacking accurate or enough information regarding the delivery and availability of confidential services. Thus, policies may need to be clarified before appropriate use of law can be determined.

#### 6.2.5 Provider-parent role conflict

The ‘provider-parent’ role conflict affects the health providers willingness to offer preventive reproductive health services to adolescents. Several of the health providers and the key informants indicated being torn between giving adolescents information about available services, and playing the parental role of guiding adolescents who are like their children. Some felt that offering preventive reproductive services to adolescents negated their parental responsibility. One provider noted for example that, ‘I normally ask myself as a mother, would I want my child to be given a method and then she gets HIV/AIDS.’ This finding concurs with that of Dehne and Riedner (2005). Dehne and Riedner observed that ‘many health workers are themselves parents and may bring a parental perspective to their work. They treat the STIs, but fail to promote or supply condoms, encouraging future abstinence instead’.



## 6.2.6 Conflicting and inconsistent information regarding available services

The findings further suggest that the information provided to adolescents about available PRHS could be conflicting and inconsistent. This creates confusion among adolescents about available services. The adolescents, for example, indicated having inadequate and conflicting information about condoms efficacy. Another example was where information promoting the use of VCT services was provided yet the services were lacking. Most of the health facilities had VCT services promotion materials (posters and pamphlets) but lacked the services. Despite the health promotion messages, the facilities instead offered ‘referral’ VCT services. This was partly because of lack of equipment as suggested below.



Poster courtesy of UNICEF & MoH

*Interviewer...I see that you have put on the wall a poster about VCT. Do you provide the services here?*

Provider 24, ‘we do not provide them. We refer to Othaya health centre [sub-district health facility]. But we are trained and we can also do the counselling. But we do not do the testing because we do not have the machine [testing equipment].’

Figure 6.1 Poster promoting use of VCT services.

This finding suggests the need to ensure that the information availed to the public is complemented by availability of the services. For, instance, although the findings indicated that adolescents are encouraged to seek VCT services, and that adolescents cited VCTs among the preferred sources of information, the findings also showed lack of VCTs in Murang'a District. Thus an inconsistency between the availed information and the available services.

#### 6.2.7 Summary

The findings have shown that existing adolescent reproductive health policies influence access and utilisation of PRHS by adolescents. The policies for adolescents are unclear and undeveloped. At the same time, there is no clear comprehensive or clear working definition of adolescent. The challenges create loopholes that can be exploited to deny adolescents preventive reproductive health services. In addition, requirements based on *reproductive or legal age of consent*, lengthy and rigid bureaucratic procedures, provider-parent role conflicts, and conflicting and inconsistent information about available services hamper access, use and provision of comprehensive adolescent PRHS. They also deny adolescents access to confidential and anonymous preventive reproductive health services. Existing reproductive health policies and services address post-exposure preventive reproductive health needs, as opposed to pre-exposure needs of adolescents. The findings imply the need to develop clear and comprehensive adolescent reproductive health policies, and to come up with a clear working definition of adolescent. They also suggest the need to harmonise adolescent health programmes in Murang'a District, and to enhance stakeholder partnership and collaboration.

### **6.3 Suggestions for addressing Policy Barriers**

Several suggestions were offered for addressing policy barriers. Among these is the need to adopt multisectoral approach, to strengthen stakeholders' participation, and to establish a national coordinating body or network for adolescents health. Other suggestions include regular review of existing reproductive health policies, adolescent reproductive health guidelines and curriculum, and to establish systems to constantly monitor and evaluate adolescents' sexual and reproductive health. These suggestions are discussed further.

#### **6.3.1 Review existing adolescent health policies, guidelines and curriculum**

There is need to review the existing reproductive health policies, guidelines and curriculum on adolescent reproductive health. The Ministry of Health and the Ministry of Education in collaboration with key stakeholders should develop and design adolescent reproductive health policies and guidelines. The relevance and usefulness of the policies, guidelines and curriculum in addressing comprehensive reproductive health needs of adolescents should also be assessed. Once developed, the policies and guidelines should be disseminated to relevant stakeholders. The health providers and the key informants noted the need for consensus building on the components and contents of an adolescent-focused training curriculum and service package. They emphasised that the policy should be clear on what the services should include. That is, whether reproductive health, clinical or preventive care services. Further, the findings imply the need for enhanced dissemination of adolescent reproductive health policies, so that these are well understood by the health providers and caregivers.

*Interviewer: Do you think it is important to train or sensitise students during training about the need to see adolescents as a special category?*

Provider 7, 'Yes. It would be more effective, finally to set up special services for them...What is not clear is in the arrangement of service delivery at the facilities. When we talk about services for youth and adolescents, what components are we talking about? Is it actual services - reproductive health services, clinical services or preventive care? The latter two are not different from those of the adults. In this case then, do these translate into special physical delivery, special clinics or special personnel? Is it certain drugs or special procedures for youth? If these can be looked at, then one can begin to think about the nature of adolescent services that need to be provided. One has also to take into account the issue of finance.'

### 6.3.2 Multisectoral approach and strengthening stakeholders' participation

There is need for greater collaboration and partnership in designing appropriate reproductive health policies for adolescents. The respondents observed the need for collaboration between the ministries of health and education in designing the health education curriculum for schools, and in dealing with challenges that hinder effective implementation of adolescent health outreach programmes.

*Interviewer probing: If we are saying that most people are getting HIV/AIDS by age 20, then we need to think of prevention. But when do we start prevention?*

Provider 16, '...I see that because this is a joint effort even the Ministry of Education should chip in. We can be trained together because we are all workers of the government. So that where the health question arises, I can answer, and where the education question arises, the teacher can answer. If we had the health worker plus the teacher, I think we can do a wonderful job for our children.'

Stakeholders participation is vital in designing appropriate and acceptable adolescent reproductive health policies. Thus, partnership between the government departments like the Ministry of Health, Ministry of Education, department of Culture and Social services, Children's department and the Ministry of Planning and National Development needs to be enhanced. Partnership should also be started with community-based organisations, non-governmental organisations and religious institutions that are

working with adolescents in the district. These should include health workers, parents, teachers and researchers concerned about adolescents health. This would ensure that the policies are widely acceptable, and have the backing of the opinion leaders like the religious institutions.

### 6.3.3 Need for national coordinating body for adolescent health

There is need for establishment of a national coordinating body/network to coordinate adolescent health programmes in Kenya. As much as possible, the coordinating body/network should have national representation. The body/network should be multidisciplinary and comprise representatives from government departments, NGOs, FBOs and other stakeholders, and should have representation at the provincial, district and local level. The body/network should bring together organisations dealing with adolescents health issues and enhance stakeholders participation in development and implementation of adolescent reproductive health programmes at the grassroots level. The roles, responsibilities and expectations of the collaborating partners should be clearly defined to enhance sustainability of the collaboration process. Efforts should be made to ensure that activities of different ministries and organisations are not conflicting and that they complement each other.

Further, the coordinating body/network, together with the stakeholders, should develop and harmonise adolescent reproductive health policies and guidelines, and undertake regular review of the policies and guidelines to ensure that they are relevant and up-to-date. It should also ensure that the policies and guidelines are accessible and disseminated to relevant ministries and organisations dealing with adolescent health issues. The body/network should also facilitate resource mobilisation, assess training needs of health professionals serving adolescents, and capacity building needs of the departments serving adolescents. It should also monitor and constantly evaluate implementation of adolescent health programmes in Kenya.

#### 6.3.4 Need to monitor and evaluate adolescent PRH policies and services.

There is need to constantly evaluate reproductive health policies for adolescents, and to monitor sexual and reproductive health needs of adolescents. The respondents observed the need to develop a checklist for monitoring implementation of adolescent health programmes. This would help to bridge the access and utilisation gap, and ensure that the response efforts are targeted to the real needs of adolescents. Further, monitoring and evaluation should be broadened to include services provided through public and private health facilities, religious institutions like the youth seminars, NGOs, and CBOs including community youth groups. The various stakeholders should liaise and jointly develop a checklist of what to teach the adolescents.

Provider 4, ‘There is no checklist of what they are doing with the adolescents unless we prepare that now because we are seeing the challenge. Now that we have talked I notice that there is a gap, which we need to look at. During the microteachings the nurses should know exactly the areas, [*we can guide them*] they should go and teach the adolescents... We can liaise with them to come up with a kind of a checklist of what to teach the adolescents. Even with the treatment of STIs we can try to do that...’

#### 6.3.5 Summary

Adolescent reproductive health is a health issue and policy issue. Existing policy barriers that restrict adolescents access and use of PRHS need to be addressed through:

- Development of clear policies and guidelines which clearly stipulate the nature of PRHS that should be provided to adolescents.
- Dissemination of policies to key stakeholders to raise their awareness about existing adolescent reproductive health policies.
- Address and harmonise the inconsistency between policy and practice.
- Ensure that legal requirements for parental consent do not create additional barriers to access and utilisation of services by adolescents.

## CHAPTER 7

### **BARRIERS TO ACCESS AND UTILISATION OF PREVENTIVE REPRODUCTIVE HEALTH SERVICES BY ADOLESCENTS**

#### **7.1 Overview**

Another purpose of this study was to find out about the barriers and challenges that adolescents face in accessing and utilising preventive reproductive health services. This study was based on the premise that effective access and utilisation of preventive reproductive health services by adolescents should ensure that (a) health information and services are available, accessible, acceptable and affordable (RoK, 2003c), (b) privacy and confidentiality is enhanced, (c) staff are sympathetic to the needs and circumstances of adolescents, have knowledge and experience in serving adolescents, and the willingness to offer correct and complete information about existing services to adolescents, and to provide them with needed services, and (d) that services should demonstrate acceptance and respect of adolescents (Heaven, 1996).

This section presents the study findings on the perspectives of the adolescents, the health providers and the key informants about the barriers and challenges faced by adolescents in accessing and utilising preventive reproductive services. The identified barriers include lack of adolescent health services, adolescents lack of awareness about available services, psychosocial barriers, ethical, institutional and structural barriers. The implications for improving access and utilisation of preventive reproductive health services by adolescents are discussed and proposals for tackling the identified barriers made.

## 7.2 Lack of Adolescent-specific Services

Adolescents lacked access to adolescent-friendly services. Those who needed preventive reproductive health services used the same services as those provided for adults, for example, MCH/FP services and curative services. Adolescents also felt that the lack of VCT centres in Murang'a District denied them access to sexual health information (Section 4.7.1). Adolescents expressed feelings of being neglected and marginalized from health services. They felt that, unlike the adults and children, they were neglected, uncared for, and excluded from services. Many adolescents felt that efforts by the government, NGOs and CBOs to address their health concerns were inadequate. They expressed the need to be offered separate services from adults and parents.

*Interviewer: As far as you know, is anything being done to address these concerns?*

Adolescent 4:99, 'The government is not doing anything. The NGOs they deal with adults and children and leave us aside. We feel like we are just left behind...I have never seen anything for adolescents but may be there is.'

*Interviewer: Is there any additional information that you would like to share with me...?*

Adolescent 5:48, 'Adolescents should be provided regular guidance and counselling by NGOs. These provide free education and they are good...they should come specifically to the youth...We should be taught alone without the parents. If I am taught in the presence of my parents I would feel uncomfortable...'

The health providers and key informants concurred with the adolescents. Similarly, their views denoted the continued social exclusion of adolescents from preventive reproductive health services. For example, the health providers noted that public forums (*barazaas* in Swahili) targeted at adults, like the HIV/AIDS awareness campaigns including education through schools and churches, do not effectively reach adolescents. Consequently, adolescents are less likely to access and utilise services that



do not provide adolescent-gear information and services. They continue to face sexual health risks with their needs remaining largely unmet. The findings of this study indicate the existence of a reproductive health service gap within the Kenya health care system that hinders adolescents access and utilisation of PRHS. Accordingly, adolescents are not guaranteed access to comprehensive reproductive health services across their lifespan.

The findings correspond with previous studies that highlight the importance of adolescent-specific and friendly services. Dehne and Riedner (2005) noted the lack of adolescent friendly services in Africa. They observed that efforts to establish adolescent friendly reproductive health services in Africa are recent. These findings imply the need to establish adolescent-friendly services in Kenya, to wholesomely address preventive reproductive health needs of adolescents, and to offer adolescent-focused services.

### **7.3 Adolescents ignorance about Available Services**

Adolescents lacked adequate awareness about existing preventive reproductive health services. Lack of adequate awareness, compounded with lack of adolescent-specific services pose a big challenge to adolescents when accessing and utilising PRHS. This also implies that adolescents have no appropriate forum for sharing their sexual and reproductive health concerns. Although access to services and information is not a privilege but a right (UNDP, 2003), the findings of this study suggest that adolescents do not enjoy this right and are not accorded their right to access sexual and reproductive health information and services. Further study findings show that adolescents were unlikely to access PRHS from the mainstream reproductive health services because of lack of adequate awareness about available services. They also lacked the necessary knowledge about service provision procedures and processes. The key informants made similar observations.

Key informant12, ‘...even as the communities are claiming not to move out of the traditional way, there is no forum where adolescents can sit and discuss sexuality matters. In the end the child discovers and gets information from the wrong people.’

Most of the adolescents in this study felt that they received inadequate information regarding available preventive reproductive health services. This finding corresponds with the finding that showed unwillingness among the health providers to inform adolescents about existing PRHS. This was due to the feeling that adolescents are too young to use such services. Some providers offered selective information regarding existing services for adolescents, despite being aware of the need to provide adolescents with full-range of information and services. Selective provision of information heightened adolescents ignorance about available PRHS. Consequently, they failed to access and use the services.

*Interviewer: Can you please tell me about the existing government policies on reproductive health care in Kenya?*

Provider 11, ‘Presently there are no restrictions. We give them FP services...But we tell them the contraceptives are not good because they may interfere with their hormones and this can make them fail to get pregnant when they want... adolescents are not told that the services are provided in public. But we are told when we go for seminars that we should give them services if they come seeking the services.’

The adolescents expressed the need for more and up-to-date information on available adolescent health services and to be informed about what to expect during service provision. The findings of this study concur with that of Hocklong et al. (2003). Hocklong et al. (2003) observed that the barriers impeding adolescents access to sexual and reproductive health services could be addressed by a common set of strategies falling under the rubric of “youth-friendly environments”. They further argued that youth may delay seeking services if they have inadequate or incorrect information regarding the location of services and their eligibility for care, if they are not planning

to have intercourse, or if they have easy access to condoms. Naré, Katz and Tolley (1997) in a study conducted in Senegal also identified lack of information about the location of family planning services as one of the factors inhibiting adolescents access to reproductive health and family planning services. They observed that, some of the adolescents did not know how to find the services and they were uncomfortable and embarrassed to ask for directions.

The findings of this study also correspond with previous studies supporting the view that adolescents have to know about services to use them. The UNFPA (2003b) observed that despite the increased awareness of adolescents sexual and reproductive health needs, adolescents lack information about available services. Leslie et al. (2002) in an Action research conducted in Burkina Faso and Senegal (West Africa) on adolescent sexuality and reproductive health made similar observations. They found that adolescents lacked adequate awareness about facilities in their communities that offered medical care and counselling specifically for adolescents. Despite the observations, there are striking differences between the findings in this study and that of Leslie et al. Whereas the West African study showed that adolescents considered traditional healers as an alternative to formal healthcare system, adolescents in this study showed greater preference to access services in the formal healthcare system, including the VCT services. When asked what they would do if they had a sexual health need, a higher proportion of the adolescents (39.5%) indicated that they would seek help from health professionals (Section 4.8.9).

The varying preferences among the adolescents reflect the prevailing socio-cultural differences in healthcare seeking patterns in different regions and communities. Nonetheless, the findings indicate that adolescents are eager to interact with health care providers and to be offered services. The findings contrast the notion that adolescents are arrogant and not keen on being advised by the adults and the health care providers (Section 7.5.4). On the contrary, adolescents demonstrated desire for health professionals, school authorities, parents, counsellors, PLWAs and older peers like

university students to offer them preventive reproductive health information and services. They however expressed the need for confidentiality and to be served by health care providers who did not know them.

The lack of awareness among adolescents about available services is also due to non-involvement in their sexual health matters. The respondents noted the need to effectively engage adolescents and their peers in their health matters and to inform them about available services. They further noted the need to engage adolescents in giving health talks and in planning for their health services. This would help them to learn positive aspects from their peers, learn from their peers' mistakes and therefore make right decisions.

*Interviewer: In your opinion, how best can these challenges be resolved?*

Provider 3, 'the fellow youths should be involved so much. Those who have been taking drugs, those who have been infected. These ones should be invited to talk to the youth. When a youth tells them, "I am already positive and I know what it is, so my fellow youths please do 1, 2, and 3". This time they even fear because it is their colleague who has stood there and told them I am already infected. But if the old one's like me stand there and tell them, they will say, "huyo tu, wameenjoy sasa sisi ndiyo wanatwambia – these people have enjoyed life, now they are telling us not to enjoy life". For example...when our students [*nursing students*] talk to the adolescents, we normally see that they listen. And they ask questions, but if I stand, there is a difference. They are also role models to the adolescents. We should have other youths who are trained to go and talk to the adolescents. A fellow youth will have a lot of impact than someone like myself.'

Effective provision of adolescent reproductive services requires involvement of not only the providers but also of the users of the services. Adolescents are partners and stakeholders in their own health and should be informed about available PRHS. They should also be involved in deciding and planning their services. Understanding the needs of adolescents calls for working with them and not in isolation. The health providers noted that adolescents rebel and engage in risky behaviour because they are

often left on their own and are not involved in planning for their health. The findings imply the need to give adolescents right information at the right time to help them make right decisions, know their rights, and become aware about available services and where to seek them. The government needs to continuously engage adolescents in decision-making regarding their sexual health matters. Consequently, adolescents would seek PRHS and open up about their health concerns.

*Interviewer: Is there any additional information that you would like to share with me?*

Provider 4, 'It is time we went to everybody, that is, the professionals, the administration and all the stakeholders to realise that we are in a new world and that adolescents need to get the information they need and the right information at the right time so that they make the right decisions. Adolescents need to be involved more so that they know their rights, where they can get information. This is a challenge to us all...because we are not giving a lot of emphasis to adolescent activities... people sometimes think that they [adolescents] are rebelling to what we are trying to tell them...'

The lack of institutionalisation of adolescent reproductive health implies that the concept of adolescent sexual and reproductive health is not common knowledge in the communities. Information regarding adolescent-friendly services is foreign at the community level and it is unlikely that adolescents, particularly those living in the rural areas, would be aware about such services. The bureaucratic red tape that regulates and vets CBOs activities restricts adolescents access to information about available PRHS (Section 6.2.3). The findings of this study suggest the need to adopt a multisectoral approach to create awareness about adolescent-friendly services. The findings also imply the need for community education to create awareness about available health services. One health provider observed that, "there is actually a gap between what we have and what the community knows that we have". The findings imply the need to educate adolescents, parents, health care providers, CBOs, and religious based organisations about the need for adolescents to access and use PRHS. Different forums

can be used to inform communities about available PRHS for adolescents. For instance, the provincial administration and the schools could play an important role in disseminating information through the community and parents-teachers meetings respectively. Community education is also needed to correct the perception that health facilities are only centres for treating diseases.

#### **7.4 Psycho-social and Interpersonal Barriers**

This study has identified psychosocial barriers that affected the level of access and utilisation of preventive reproductive health services by adolescents. The adolescents exhibited interpersonal fears of sharing sexual health problems with their parents, sharing services with adults, and fear of being served by familiar health providers. The adolescents were ashamed and embarrassed to use PRHS. They exhibited lack of trust of the healthcare givers and fear of breach of confidentiality. This hindered their access and utilisation of PRHS. These barriers and their implications are discussed further in the following sections.

##### **7.4.1 Fear of suspicion and sharing problems with parents**

This study has established that communication problems experienced at the family level affects adolescents ability to openly access and utilise PRHS. The adolescents generally preferred to remain with their unmet sexual health needs rather than inform or involve their parents because of fear of being suspected as sexually active. The adolescents preferred to share their sexual health concerns with unfamiliar persons. They observed that ‘most adolescents fear telling their parents information about sex’. They also observed that ‘one cannot share with parents, but with someone else who does not know you’. The lack of openness about sexuality matters between adolescents and their parents deepens adolescents fear of accessing and utilizing PRHS

(Section 7.4.2). The adolescents felt that informing their parents, and even health providers, teachers and caregivers, about their need to access and utilise PRHS would lead to suspicion that they were sexually active. Consequently, they feared to express their need to access and utilise PRHS.

*Interviewer: ...is there any time that you had a sexual health need but you did not know where to get information, advice or service?*

Adolescent 7:6, ‘...itching when I have periods. I have not told anyone. If I tell my friends they may start backbiting me that I have had sex. If I go to the school nurse she may tell the teachers who are her friends. If I tell my mother she may think that I have had sex. I am afraid that the doctor may also tell me that I have had sex, they start asking me many questions to arrive at this. Because of this, I have not gone to see a doctor. It has remained a problem to me. We sometimes talk among friends and they say one should apply Vaseline and powder. But this does not work with me. I also find it difficult to talk to the guidance and counselling teacher because even them they may think...that I have had sex and ask my parents.’

The findings suggest that the lack of close interaction between parents and adolescents creates obstacles for adolescents in sharing their sexual health concerns. Adolescents expressed the need for parents to be open with them and to discuss sexuality issues with them. The findings imply the need to bridge communication gap between adolescents and parents regarding sexuality matters.

#### 7.4.2 Fear of sharing services with adults

The adolescents feared sharing reproductive health services with adults. This study has established that there were no separate reproductive health services for adults and adolescents. Sharing of services with the adults hinder adolescents access and use of PRHS. Adolescents were likely to avoid services if they felt that the services were not meant for them. The adolescents indicated that they disliked waiting and queuing for services with adults and avoided services in facilities where they were likely to meet

their parents and relatives. They feared that being seen at the health facilities might raise suspicion and questioning about their reasons for seeking services, and were anxious that their parents might know that they had sought services.

*Interviewer: Can you tell me what are some of the services that you feel should be provided for adolescent boys?*

Adolescent 3:88, ‘...its good to have services for different ages. If an older person finds you at the VCT, they will wonder what you are doing there and he will bring the information home. Adolescents do not want to be seen by other parents because they may tell your parent. They will also wonder what you are doing there because it is thought that someone goes to VCT to be tested only for HIV but that is not the case. Someone can also go to a VCT to be counselled and guided on how to live.’

The findings of this study correspond with that of Moya (2002). Moya observed that young people do not want to run into family members and neighbours when entering, utilizing or leaving sexual health facilities. This study has established that the fear among the adolescents of suspicion, and uneasiness in mixing and sharing services with the adults emanate from their feelings that they may be seeking “wrong” services which their parents might not approve. It also emerges because of the invisibility of adolescent health problems. Often, adolescently may lack outward physical signs and symptoms depicting their nature of illness or health problems. This gives rise to suspicion and questioning from the adults and also their peers about their reasons for seeking services. However, even if adolescents have outward physical signs like pregnancy, which suggests the type of needed services, they may encounter discomfort in using same services with adults as Figure 7.1 depicts. Being young and unmarried compounds the problem because reproductive health services are seen as solely for women and the old. Accordingly, adolescents are not expected to seek reproductive health services. Adolescents felt that provision of separate PRHS would counter this problem and enhance privacy, anonymity and confidentiality in seeking care.



*Interviewer: If you have never used the services, why is this so?*

Adolescent 1:127, 'If you go to hospital to seek information, someone might think that you have a disease [STD] then they will start to gossip. People may say that I am a bit too small [young] to visit these organisations. Some people associate these medical clinics as being for married women and elders. Here also in school it is difficult to seek this information because if people see me, they will think that I am pregnant and begin to gossip.'



Figure 7.1 Poster containing education message on teenage pregnancy  
“Poster courtesy of FPPS, JSI and NCPD”

The findings of this study point to the lack of understanding about adolescent sexual and reproductive health and about the role of PRHS. They demonstrate that ambivalence and misconception about adolescent reproductive health needs lead to stigmatisation of services and social exclusion of adolescents from services. The findings entrench the behavioural theorists perception of ‘healthy adolescents’ (Perry, 2000; Section 2.3.3). They also imply the need to have separate reproductive health services for adolescents to curtail the psychosocial and interpersonal barriers barring adolescents from accessing and utilising available PRHS. Adolescents need to be provided with services they can identify with to enhance their access and utilisation of preventive reproductive health services. This would create a conducive environment that encourages adolescents to openly share their sexual and reproductive health concerns.

The findings further show a service gap in the lifespan where services are planned and availed to the adults and children, leaving out the adolescents. This situation needs to be corrected to ensure completeness of access and utilisation of services throughout individuals’ lifespan. This requires first an understanding that sexual and other health needs differ across the lifespan. Second an appreciation of the need to provide services to adolescents to meet their unique sexual and reproductive health needs, and third the provision of appropriate services for them. This should be supported with public awareness and sensitisation on the need to integrate adolescents in health care delivery system.

#### 7.4.3 Fear to be served by familiar health providers

The adolescents feared being served by health providers and health professionals known to them. They feared that the health providers might perceive them negatively or tell their parents that they had sought preventive reproductive health services. On the contrary, the adolescents showed confidence in sharing with people who did not know

them their sexual health concerns. This could be because sexual matters are private. Adolescents seemed comfortable to share their sexual health concerns with strangers who they were likely to have little interaction with in future; and who might not remember them even if they met. This phenomenon highlights the complexities of dealing with adolescents sexuality matters. This study terms this phenomenon as *stranger confidence versus familiarity anxiety*. The health providers made similar observations. They noted that adolescents avoided going to them if they knew their parents, or if they had served in the same facility for long and therefore had known the adolescents since childhood. The providers associated adolescents preference for private clinics as opposed to government health facilities, if they had sexual health needs, with shame and familiarity anxiety.

Provider 18, 'the youths do not feel free to come and tell us their problems. They feel ashamed to present their problems. May be it is because we have been here for a long time and they would not want us to know their problems. Not many come to present reproductive health problems like seeking family planning services and information, or even when they get raped, they do not come to report. We don't know why they do not come.'

Despite the above observations, the health providers were opposed to the view that they should not serve in communities where they are known or in the same facility for too long. Instead, they stressed the need for providers to have the right skills to enable them serve adolescents effectively. Some of the health providers felt that someone who is known would serve and understand the community better than an outsider. The findings imply the need for adolescents to understand that they can obtain health information and advice, and that they can ask questions about their sexual health concerns from the mainstream health facilities.

#### 7.4.4 Fear of parental involvement and of breach of confidentiality

The findings of this study show that adolescents lack of trust, fear of parental involvement and of breach confidentiality deterred them from accessing and utilising PRHS. These fears made adolescents to withhold information regarding their sexual health problems. These fears aggravated if the health providers knew the parents of adolescents, took contact details of parents when serving adolescents, or if the adolescents were accompanied to health facilities by their parents. These findings suggest that adolescents may fail to openly share their sexual health problems with health providers who are acquainted or familiar with their parents. They are also likely to avoid health facilities where their parents are known.

Adolescent 7:24, ‘...I always felt a bit uncomfortable...that it was my father who takes me. I sometimes fear that he may go later and ask what I said. This sometimes makes me to withhold information, unless he [doctor] first of all promises not to tell my father. I find it difficult to tell him [doctor] about my relationships with girls and my sex experience. If they did not know my father and I am the one who took myself, and they have no way of knowing my parents, or even ask me for my parents address, I think I would feel more comfortable to open up. When you give such information, you are suspicious why the person wants to know information about your parents...’

The key informants echoed similar views.

Key Informant 2, ‘...this should be the goal, to have a place where adolescents can go to freely and have confidence that they can confide in the person to pour their hearts out and be sure that whatever they give will not leave the door. The greatest fear that adolescents have is to share their problems and hear whatever they have talked outside. This really kills their morale...’

The findings of this study concur with that of Dehne and Riedner (2005). Dehne and Riedner observed that fears that services may be unable to guarantee confidentiality make adolescents not to seek STI services. They further observed that ‘even when there are assurances that clinic information will stay confidential, anxiety often remains that

parents or other adults will find out about their STIs'. The fear of parental involvement and the need to break this barrier has been noted in other studies. The American Academy of Family Physicians (AAFP, 2006) recommends that when caring for an adolescent patient, the physician should offer the adolescent an opportunity for examination and counselling separate from parents/guardians, and that adolescents privacy should be respected. Further, they suggest that physicians should make reasonable effort to encourage adolescents to involve parents or guardians in healthcare decisions. They also note that physicians should educate parents to encourage their adolescents about personal responsibility in health care, and enhance communication regarding appointments and payments in a manner supportive of the adolescents rights to confidentiality. The American Academy of Family Physicians observes further that:

...Legal requirements and interpretation of laws that impede the provider/patient relationship are detrimental to adolescents. The medical community has a long-standing commitment to ensure appropriate protection of confidentiality for their adolescent patients...Ultimately, the health risks to adolescents are so compelling that legal barriers should not stand in the way of needed health care. (AAFP, 2006).

## **7.5 Communication Barriers**

This study has identified communication barriers that affected the level of access and utilisation of preventive reproductive health services by adolescents. Poor communication and lack of openness between the health providers lead to lack of access and utilisation of PRHS by adolescents. The findings showed that poor communication was perpetuated by lack of trust, negative attitude between adolescents and the health providers, and intergenerational conflicts between adolescents and the adults including their parents. The findings also indicated that socio-cultural factors create communication barriers and adolescents failure to access and utilise PRHS. These

factors include the socialisation process that uphold gender-based myths about sexuality, moralisation of sexuality matters where discussing sexuality matters is perceived as naughty, lack of appropriate language to discuss sexuality matters, and provider-parent role conflict. Other interpersonal challenges that hampered open communication between the health providers and the adolescents included variations in age and awareness levels among adolescents, as well as age and gender of the health providers. The factors contributing to communication barriers are discussed further below.

#### 7.5.1 Embarrassment, cultural inhibitions and lack of openness about sexuality

The adolescents were shy and embarrassed about seeking sexual health services. They identified sensitivity and discomfort about discussing sexuality matters as an obstacle to their access and utilisation of preventive reproductive health services. Amuyunzu et al. (2005) made similar observations in a study conducted with in-and out-of-school adolescents in Burkina Faso, Ghana, Malawi and Uganda. They observed that adolescents shy and are ashamed to obtain sexual and reproductive health services. The health providers and key informants corroborated these findings. They noted that adolescents especially boys seek health services in groups, go to distant health facilities, opt for self-medication, or consult their peers for advice if they have sexual health problems. This study has shown that adolescents are embarrassed and reluctant to discuss sexual health problems with health providers.

Adolescent 4:90, ‘...fearing I might go there [*to the health facility*] and they [*health providers/caregivers*] start asking me some questions which I cannot answer, or which I can feel shy to answer.’

Adolescent 2:109, ‘...may be sick but may fear of going to hospital if one has an STD or itching in the private parts because of fear of telling the doctor your problem because of feeling shy.’

This study has further established that there existed social-cultural factors that influenced the level of access and utilisation of PRHS by adolescents. Socio-cultural practices that perpetuate gender-sexuality myths contributed to adolescents shyness and failure to openly share their sexual health concerns. Although the health providers indicated that girls use reproductive health services more than boys, they were quick to note that boys open up more than girls when they have sexual health needs. They observed that boys were more open to obtain condoms and to seek STI services.

The health providers associated the lack of openness among girls to the socialisation process which encourages boys' sexual prowess and restricts the same among girls. Sexuality matters are traditionally perceived as male's domain. The socio-cultural expectation that girls should not show sexual prowess makes them to shy away and not open up even when they need services. Ahlberg (1996) and Mziray (1998) made similar observations. Ahlberg (1996) in a study conducted in Central Kenya noted that the pressure to remain chaste is put on young women while little pressure is put on the boys. Ahlberg further noted that boys have traditionally been socialised especially during circumcision, that sexual activity is part of becoming a man. Mziray (1998) in a study conducted among boys in Kilimanjaro and Morogoro regions in Tanzania observed that the community does not easily dismiss boys as promiscuous because they do not fall pregnant and because their sexual behaviour is not publicly evident. In this study, girls feared being perceived negatively if sexually active. There is need therefore to engender adolescents reproductive health services taking into account the socio-cultural confinements that adolescents have to deal with.

The above findings imply the need to educate adolescents and their peers to understand the dangers of self-medication and of not seeking care. Pharmacists and other health professionals who dispense over-the-counter (OTC) medicine should also be sensitised on the sexual health needs of adolescents and the need to encourage adolescents to seek professional medical care. The findings also imply the need to sensitise health providers, caregivers and other professionals serving adolescents about

adolescents sensitivity to sexual health matters, and their health care seeking behaviour. It is important to understand the needs and situations of boys and girls and their sensitivity towards sexual health matters to encourage openness, and removal of culture-based sexuality myths as observed below.

*Interviewer: Why do you think the boys are more open than the girls?*

Provider 16, 'I think naturally girls are not very free in giving their problems. They shy off. But boys are more open...even when the girl-child is coming here, she has that thing at the back of her mind...The set up of our community is that, the girl should not have a boyfriend but the boy is allowed to have a girlfriend and there is no problem. So, the girl will automatically shy off and will see I am being considered immoral but if the boy says he has a girlfriend, he will not be considered immoral.'

#### 7.5.2 Lack of culturally-appropriate language

This study has established the lack of culturally appropriate language to enhance communication and openness about sexuality matters. Lack of appropriate language made communication and openness about sexuality matters between adolescents, health providers, parents, teachers and other caregivers difficult. Culture was blamed for language and communication barriers and the perpetual lack of open sharing about sexual health matters across generations. Many providers and key informants noted that 'in our African culture, people do not like talking so much about sex and sexuality.' Consequently, the health providers, teachers, parents and other health professionals shy away and lack courage to discuss sexuality issues with adolescents.



*Interviewer: Is there any additional information that you would like to share with me?*

Provider 4, ‘...our cultures, our minds, our bringing up are playing a very big role in sidelining the adolescents with the kind of services and information we give to them... It is a challenge to us all in the society... some are like my sons and daughters, and they may shy off. It is time we start involving them, “don’t see them for tomorrow but for today”. This will help to change their behaviour. Some are reacting because we are not involving them.’

In schools, teachers are expected to talk openly (talk straight) to adolescents about sexuality matters. Despite the directive from the Ministry of Education, teachers shy off. Although the topic on reproductive system is taught in school subjects like biology and home science, these do not address the sexual and reproductive health needs and challenges of adolescents. The health providers and the key informants observed that adolescents may perceive talking openly about sexuality matters as “naughty” and may shy off. To escape this dilemma, teachers may use difficult and scientific language thus widening the communication gap on sexuality matters. As a result, adolescents are left with no one to inform them and share their sexual health problems with.

Key Informant 11, ‘...culturally we are not free to discuss those internal issues... Even myself I may not be able to talk to my children directly to tell them what is happening...Even the church people, when they go to talk about these issues, they do not hit the nail on the head. They start giving long stories to explain something...I witnessed a teacher teaching class 5 about the reproductive system and she used very complicated words such that the pupils could not understand what she was saying...’

The respondents observed that the traditional ways of informing and educating adolescents about sexuality matters were gone. They noted the need to engage adolescents, to identify new ways of educating them and to train health professionals serving adolescents to effectively and openly inform and educate adolescents.

Key informant11, ‘...we need further training...to give us the confidence and courage to discuss those things which may be seen to be naughty...But now we have a problem. The teacher when they start talking about these things the students start laughing and the teacher withdraws. We need to look for another approach.’

These findings imply that cultural sensitivity is crucial in enhancing adolescents ability to access and utilise PRHS, and to open up to the health care providers. These findings concur with that of Wyn et al. (1999) who observed the effects of language barriers on health care utilisation. They argued that ‘linguistic barriers are difficult under any circumstances, but when dealing with the critical issues faced in health care, lack of information or misinformation because of language barriers can be devastating and can impede appropriate care. The findings imply the need for culturally appropriate language and to adopt different approaches to communicate with adolescents. There is also need to enhance communication skills of health care professionals and teachers to improve their capacity to effectively communicate with adolescents.

### 7.5.3 Negative attitude between adolescents and caregivers: Generation gap

This study has identified the existence of negative attitudes and suspicion between adolescents and health care providers which affected the level of access and utilisation of PRHS by adolescents. Adolescent-provider relationship is crucial in determining adolescents access and utilisation of PRHS. According to Wyn et al. (1999) ‘a good relationship with a trusted provider can ameliorate other perceived problems with the health care plan’. In this study, the health providers perceived adolescents as uncooperative, arrogant, difficult to deal with, unwilling to be guided, uncompromising, secretive, and opposed to guidance and advice from adults. The negative attitude and behaviour of adolescents were associated with the generation gap and inter-generational differences.

*Interviewer: Do you or your institution/ organisation face any specific challenges when offering reproductive health services to adolescents?*

Provider 3, 'the youths nowadays are calling themselves "dot coms". So somebody like me who is not of their age, when I stand and start telling them there is AIDS, some of them will just say "she is an old folk, what does she know"...You can imagine with this kind of an attitude they will miss this important seminars. They say, "they are always telling us, they think we don't know" and yet they do not know. There still get pregnant and get infected with HIV...The youths are going out of their way and they say that...we should not bring them up the way they we were brought up with strictness.'

Likewise, the adolescents had negative attitude towards the health providers and caregivers. They perceived them as uncaring, suspicious and untrustworthy. They demonstrated lack of trust and having poor relations with the caregivers. The adolescents cited qualities of their preferred health providers and caregivers. Among the most frequently cited qualities were: welcoming, friendly, caring and informative. The adolescents expressed desire to be served by understanding and sympathetic health providers who handled them as 'adolescents' and were willing to openly discuss sexual health matters with them. The adolescents also wished that the providers would be social and show interest in their health concerns.

Adolescent 2:107, '...young people may have a problem and may not know who to go to because they are shy since they do not know how the person will react. If we can have a hospital for the youth and we have people who understand the youth, we can like her or him. Someone who talks to me in a good language, who asks me about my problems and encourages me to be open. But if someone does not ask many questions, I would find it difficult to open to him or her. If they do not ask questions, you may just keep quiet. And they may give you medicine, but that may not be the real treatment that you need.'

The findings also show that the health providers' ability to negotiate inter-generational gap is crucial in provision of preventive reproductive health services to

adolescents. It is essential that health providers are able to enhance and sustain interaction and communication with adolescents. Some of the health providers observed that age may not be an issue but how one interacts with adolescents. Thus a young but gloomy health provider is unlikely to appeal to adolescents. Health care providers should therefore have appropriate skills, accept adolescents and be non-judgemental. They need effective communication skills to enable them cut across generation differences so that adolescents can trust them with information as noted below.

*Interviewer: probing on whether age is an issue when providing services to adolescents.*

Provider 4, ‘...age plays a big role and also the individual, how one handles and interacts with the adolescents. Whether one accepts them, is one commanding them or accepting their ideas. Age may contribute but when they come here we laugh and chat and talk their language because I know that if I try to bring my age bracket to them, they are likely to go...May be we need new blood but even these ones need to learn that adolescents need to be handled with a lot of care because they are very tender...’

The findings of this study point to the need to understand the effect of the generation gap on adolescents access and utilisation of PRHS. The findings also correspond with previous studies. Neckermann (2002) observed that public health facilities have typically been avoided by young people for their lack of friendliness, especially provider attitudes and concerns of confidentiality. Further, young people are often concerned that the staff would be hostile or judgmental, and that they would rather pay for contraception or treatment than run the risk of the nurse’s delivering moralistic lectures or telling their parents why they have come to the clinic. Naré, Katz and Tolley (1997) in a study conducted in Senegal among mystery clients made similar observations. They observed that some of the clients who sought family planning services were sent away by health care providers and were simply referred to the pharmacies. They further reported that the health care providers told the mystery clients to focus on their studies, and that they were too young to engage in sex, even when all

they wanted was information about contraceptives. Naré, Katz and Tolley further observed that the clients were advised to keep their virginity until marriage, that girls should watch out because boys are dangerous and not sincere; and that the providers who were willing to provide information did not take a lot of time with the young people. Instead, they simply gave them documents to read. The Senegal example is not unique but a characteristic of the situation in most African countries, including Kenya. The findings imply the need to enhance interaction between adolescents and health providers, and to change the negative perceptions between them.

#### 7.5.4 Providers' bias and poor communication with adolescents

This study has established that there existed significant bias and judgmental attitude among the health providers which affected access and utilisation of PRHS by adolescents. The judgmental attitude and bias held by health providers deterred them from providing PRHS and information about available services to adolescents (Section 7.3). Although the health providers indicated being aware and sensitised about the need to offer PRHS to adolescents indiscriminately, the practice showed the contrary. This study has established that health providers continued to deny adolescents PRHS. Several health providers expressed reluctance to offer preventive reproductive health services to adolescents like contraceptives because of personal beliefs and values.

The findings of this study suggest that poor communication between adolescents and health providers aggravate adolescents failure to access and utilise PRHS. This study has established that the health providers were unwilling and not ready to offer PRHS to adolescents without questioning them why they wanted to use the services. The findings portrayed a picture where adolescents were not ready to answer questions about their reasons for seeking services. This questioning created communication barriers between health providers and adolescents. It also deterred adolescents from accessing and utilising preventive reproductive health services.

Provider 16, ‘...it’s like us health workers we feel that we should not give adolescents family planning methods. And when they come here, you see they normally shy off to ask for the services and even when they ask for the services, I might not be in a position because of what I believe in. I will not give the services without asking questions. And the girl does not want to be asked questions. She wants the service without questions. But the first question I will ask her is, "why do you want a method at this age?" And you see this is the question she did not want. So she opts not to come. So automatically I will have put her off. And if one is courageous enough to come and ask the question, even if I give the method, she will pass the word that “I went there and the health worker asked me so many questions - *Ile maswali mengi ya clinic (the many questions from the clinic)*”. As it is being said, the questions we ask. So these girls are not ready to answer our questions neither are we ready to give them the services without the questions. So you see now that one creates a barrier.’

The findings further showed that adolescents disliked being questioned about their reasons for seeking services. Instead, they desired to be provided with services with as little questioning as possible. The questioning of adolescents by the health providers created obstacles and fear among adolescents to access and utilise PRHS, and to openly share their sexual health concerns. This study further shows that adolescents worried about approaching health providers.

*Interviewer: If you have never used the services, why is this so?*

Adolescent 4:90, ‘Fearing that I might go there and they start asking me...some questions which I cannot answer or which I can feel shy to answer. Like whether I have ever had sex and whether or how many boyfriends I have. Also may be the one who you are talking to looks stone face...not...smiling...’

Adolescent 2:107, ‘With discharge, its private and one cannot tell anyone...The doctor was asking many questions. He created fear in me and I just told him that I was coughing and that I had a headache.

Figure 7.2 below depicts the effects of communication barriers on the utilisation of preventive reproductive health services by adolescents.

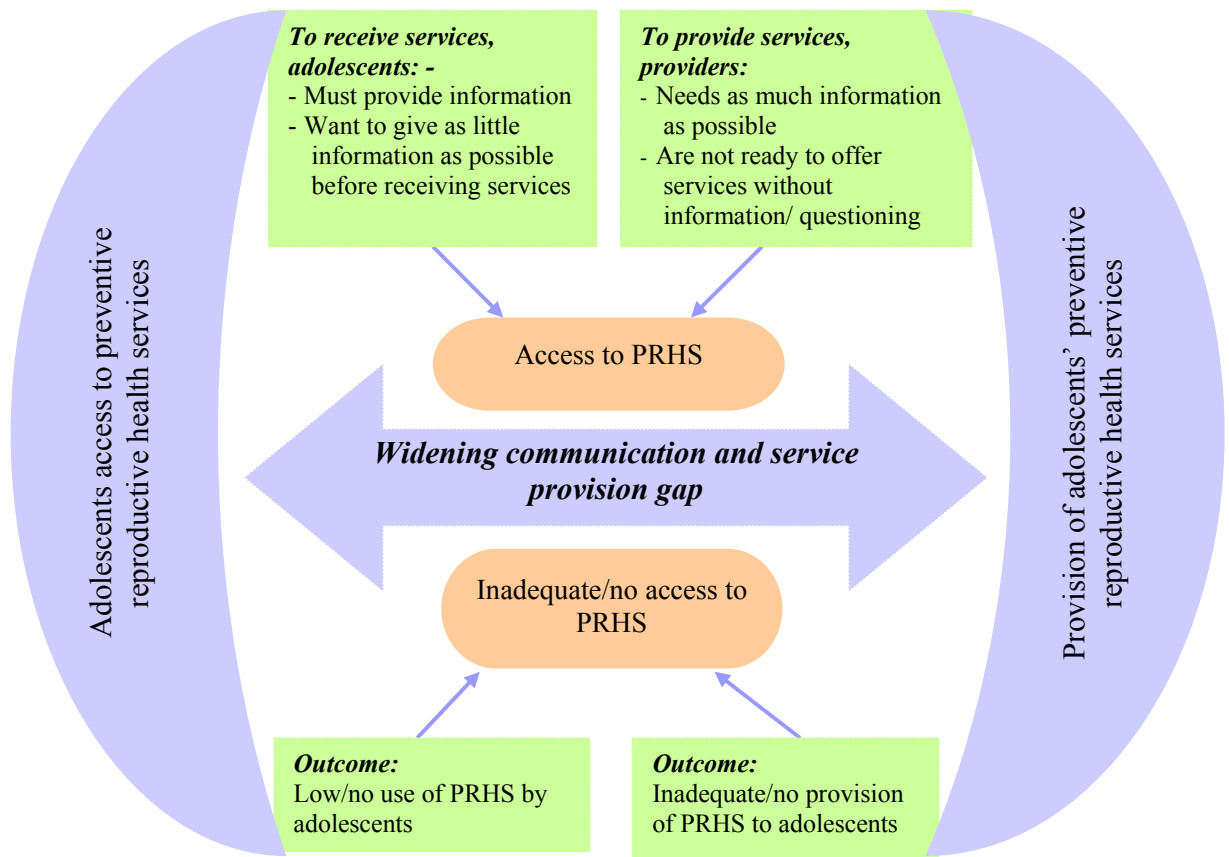


Figure 7.2 Effect of communication barriers on access and provision of PRHS

The findings of this study correspond with that of Amuyunzu et al. (2005). Amuyunzu et al. observed that adolescents in Burkina Faso, Ghana, Malawi and Uganda preferred traditional healers to health workers because the traditional healers, unlike the health workers, did/do not collect as much personal information as clinics and hospitals. The findings of this study imply the need for interventions to narrow the communication gap between adolescents and health care providers. The negative

perception held by adolescents towards the health providers and vice versa could gradually change if there is increased interaction between the two. This would also remove the fear among adolescents to approach health providers. The findings have highlighted the professional dilemma experienced by health providers. Further, they have highlighted the contradictions between existing reproductive health policies and the practice. These contradictions need to be recognised and resolved so that adolescents do not continue to be denied access and use of preventive reproductive health services.

The above findings imply the need to enhance interaction and positive attitude between adolescents and health providers. They also imply the need to change the negative perceptions between adolescents and health providers. It is through this that adolescents can learn about their reproductive health and fill knowledge gaps and reduce dependency on peers who might mislead them. Interviews with adolescents showed that adolescents were ignorant about health matters and their body changes (Sections 4.3 & 4.7.1). Elster and Kuznets (1994) emphasised the importance of close adolescent-provider interactions. They noted that health guidance is most effective when it is interactive, that is, when the adolescent and the physician have an opportunity to listen to each other, express concerns about particular issues, and jointly develop a plan of action to address those concerns. The findings of this study imply the need for health providers together with adolescents to develop plan of action to ensure adequate follow-up and enhance interaction. The health providers could enhance communication with adolescents by showing interest when interacting with them. Adolescents reproductive health issues are intricate and require adequate attention and time to enable adolescents to comfortably share their problems and ask questions as suggested below.



Provider 12, ‘...So what I think it is just a matter of attitude. That when an adolescent comes, we give them time. Let the adolescents feel that what brought them has actually been addressed. Some of the times,...we have not given them treatment because the issues that brought them here did not need treatment. They did not need to go with drugs. We only needed to sit down and talk over the issues most of which may be just social.’

Enhancing positive attitude between the health providers and the adolescents could be achieved through sensitisation and training of the health professionals serving adolescents. In this study, the health providers identified their training needs in the following areas: counselling and communicating skills, adolescent psychology and behaviour including lifestyle and dressing, and ethical issues especially on enhancing privacy and confidentiality. The health providers emphasised the need for regular and refresher courses to keep them abreast with current reproductive health issues. They also felt that the trainings should be multidisciplinary and be extended to other professionals serving adolescents including medical social workers.

Provider 4, ‘...There are very many disciplines specifically dealing with adolescents...There should be quite a number of people trained to handle the adolescents specifically. That is, understand what the adolescents are saying, what they are doing, how they are dressing up, how they are behaving and why they are reacting the way they are doing, for example, medical social workers.

Further, the health providers noted that training and sensitisation should be extended to adolescents to educate them about the need to use preventive reproductive health services, and to encourage them to interact with health providers without fear. Sensitisation of adolescents could be done through use of posters, and incorporation of adolescent health issues in the school curriculum.

## **7.6 Ethical Barriers**

Ethical barriers create obstacles for adolescents in accessing and utilising PRHS. The barriers result from a number of factors. These include lack of confidential services for adolescents due to lack of adolescent-friendly and integrated services, lack of cultural and professional sensitivity regarding sexuality issues among health providers, judgemental attitude of health providers, and ethical requirements for parental involvement. The identified ethical barriers and their effect on adolescents access and utilisation of PRHS are discussed further.

### **7.6.1 An all-inclusive service framework versus privacy and confidentiality**

This study has found that there were no separate preventive reproductive health services for adolescents. The findings of this study suggest that adolescents have not been adequately planned for and that existing services do not effectively reach them. The lack of adolescent-friendly services failed to guarantee privacy and confidentiality of adolescents. The findings indicated that marginal efforts made by the government to tackle adolescent health issues had not translated into concrete changes in the organisation of health facilities. Rather, there were no separate services for adolescents and health institutions continued to operate on the old all-inclusive model. Adolescents queued and shared services with the adults. This created discomfort for adolescents because they dislike being known that they are seeking services (Sections 7.4.2 & 7.6.2).

This study has further established that the environment for providing PRHS for adolescents was not conducive. Waiting at the MCH/FP clinic denied adolescents privacy and also seemed to imply that adolescents were pregnant or seeking family planning services. An all-inclusive health services framework is unattractive for adolescents and makes them to avoid services. The findings imply the need to

reorganise reproductive health services and to have separate clinics for adolescents to accommodate their unique sexual and reproductive health needs.

*Interviewer: Are the services offered in the same setting as those of the adults?*

Provider 12, ‘what I know is that they [adolescents] will not be comfortable sitting at the same place with their mothers and aunties. This may be a hindrance and that is why there is need for a special adolescent service or facility. Even if I was in their shoes, I would not be comfortable in such a situation. E.g. waiting for MCH if I do not have a child, everybody will know that either I am pregnant or I am going for FP. For sure adolescents...may not even want anyone to know that they are using the FP services.’

The findings of this study collaborate previous studies which identified the service environment as an important factor in determining adolescents access to sexual and reproductive health services. For example, research conducted in the United States and Britain pointed to a relationship between “youth-friendly” environments and service utilisation. Adolescent preventive reproductive health services should not only be available but also user-friendly. Hocklong et al. (2003) argued that gaps between first sex and first reproductive health visits should be expected if adolescents do not find services to be youth-friendly. Stone and Ingham (2003) noted that:

For young people’s sexual health services to be effective, they must be user-friendly, non-judgemental, accessible, approachable and confidential. They also must provide a range of services for both men and women, and above all, they should be deemed appropriate and acceptable by young people in the locality.

This study established overwhelming desire among adolescents, health providers and key informants for the establishment of adolescent-specific services. The health providers noted that adolescents need to be handled well to transit effectively into adulthood. They however noted that adolescents are not guided. Instead, they are ‘somehow forgotten’ and left on their own. The health providers felt that available

services do not adequately serve the needs of adolescents. This has implications for adolescents' sexual and reproductive health care. Many health providers also felt that adolescents would be effectively served if there were specific services for them. Moreover, adolescents would have increased awareness about available services and would feel motivated to use them. The findings imply the need to bridge the service gap through establishment of comprehensive, integrated and gender sensitive adolescents services. The findings of this study suggest that in places where there were adolescents clinics, like the neighbouring Nyeri and Thika Districts, adolescents sought PRHS services.

Provider 7, 'It would be more effective finally to set up special services for them [adolescents]...What is not clear is in the arrangement of service delivery at the facilities. When we talk about services for youth and adolescents, what components are we talking about? Is it actual services, reproductive health services, clinical services or preventive care? The latter two are not different from those of the adults. In this case then, do these translate into special physical delivery, special clinics or special personnel? Is it certain drugs or special procedures for youth? If these can be looked at, then one can begin to think about the nature of adolescent services that need to be provided. One has also to take into account the issue of finance.'

The findings also suggest the need for consensus building on the nature, contents and depth of adolescents-specific services. Whereas most health providers and key informants agreed on the need for adolescent-friendly services, a few thought that adolescents encountered no difficulties in accessing available services. They suggested that adolescents need education but not sexual health services. A few of the health providers and the key informants also expressed anxiety that providing separate services for adolescents would not offer solutions and that this would encourage sexual activity among adolescents. The assumption that offering adolescents sexual health services would increase their sexual engagement is not new. However, scholars, policy makers and public health experts have previously refuted this view. For example, Hocklong et

al. (2003) observed that effective behavioural approaches do not increase young people's sexual risk-taking or promiscuity. Instead, they increase the knowledge and skills that adolescents need to make informed sexual and reproductive health decisions, and to engage in responsible sexual behaviour. Evidence also suggests that adolescents lack of sexual health knowledge and information can lead to serious health consequences and sometimes death, and not the opposite.

The above findings nonetheless introduce a new dimension to this study. One could ask for instance whether there is a difference between *adolescent health education* and *adolescent health services*. Many scholars, as well as this study, have argued in favour of adolescent-friendly services. However, given the financial and infrastructural limitations of setting up adolescents-specific/friendly services in rural areas like in Murang'a District, there is need for flexibility and assessment of alternatives. Adolescents should be provided with sexual health information, preventive reproductive health services and education irrespective of their social-economic background or residence. The lack of physical structures should not act as barriers to provision of PRHS to adolescents. Heaven (1996) similarly observed that health education for adolescents can occur in many different settings. The findings of this study imply the need for comprehensive adolescent health services. These should include provision of sexuality information, provision of condoms, counselling and adolescent-specific VCT services. The findings also imply the need to equip adolescent health centres with a range of IEC materials to enhance adolescents awareness about varying reproductive health issues. Consequently, this would help to destigmatise adolescents health services.

Provider 6, 'we need more IEC materials, books and cassettes for education. Now we have few books and magazines, which we have been borrowing. Even the pictures we have here are mainly on HIV/AIDS. Adolescents may feel this is an AIDS centre. We need to have more materials on youth.'

## 7.6.2 Labelling of services versus lack of integration

The labelling of health services compounds the challenges adolescents have in accessing all-inclusive reproductive health services. Although adolescents could access preventive reproductive health services from the MCH/FP clinics, the services were considered inappropriate for adolescents. MCH/FP services are traditionally meant for mothers and their children and therefore do not favour adolescents. This situation is compounded by lack of integration of curative and MCH/FP services. The WHO recommends the effective integration of sexual and reproductive health services, where services are provided in one room in a single visit (Dehne and Snow, 1999). This study has established that reproductive health services were offered in separate rooms which were labelled accordingly. The health providers cited staff shortages, heavy workload, time constraints and lack of adequate space as reasons for not offering integrated services. This study further established that the health providers divided their tasks to cope with these challenges. Such division of services runs contrary to the goals of comprehensive and integrated services which are an important dimension of quality of care. It also compromises health providers ability to offer confidential services.

*Interviewer: Are services offered in the same setting as those of the adults?*

Provider 24, 'we provide our services in separate rooms. For example we have two rooms for MCH/FP services. We have other three rooms for curative and preventive. So we have the labels outside there. So if you want to go to the clinic [MCH/FP] you just go to third door and wait there. If you want to go to the curative you wait somewhere else...This can create a problem [for adolescents]...but sometimes we do not have any way out...we have shortage of staff. Generally you are supposed to give everything from the same table but its not possible being one...'

Labelling of the services implied non-inclusiveness and adolescents were less likely to use services that were labelled as MCH/FP. Likewise, the health providers

considered the terms *Family Planning*, and *Maternal and Child Health* inappropriate when used to refer to services for adolescents since adolescents ‘have no families to plan’. They noted that the labelling of services leads to stigmatisation of the services and fear among adolescents to access and utilise services that are not meant for them. The stigma associated with services and the perception that those seeking services have problems make adolescents to avoid services. Similar views were noted about the school health services. Whereas many adolescents indicated the need for schools to have separate guidance and counselling office to enhance their privacy and confidentiality (Section 5.4), the need to adopt appropriate labelling of the services was noted. This would avoid stigmatisation of guidance and counselling services and the assumption that the services are meant for adolescents with problems. These findings imply the need to destigmatize adolescents PRHS and to remove the ‘problem-based’ perceptions. There is need to adopt appropriate labelling of services. Some of the health providers suggested the need to change from “MCH/FP” to “reproductive health and adolescent services”.

*Interviewer Probing: Do you think that labelling of MCH/FP services would make this easy to be identified by adolescents?*

Provider 24, “Ja., we have thought about that ourselves. And even the ministry knows that...that term of MCH/FP we need to call it “reproductive health services”. When it comes to “family planning” we change to “reproductive health” but with MCH we still leave it because it deals with maternal health. If it is put in a way that adolescents know that there is a service it is better, for example add “and adolescents”...’

*Interviewer: Do you or your institution face any specific challenges when offering reproductive health services to adolescents?*

Key Informant 10, ‘...that is the same problem the teacher counsellors are facing in schools. They will just have an office, they will welcome people [adolescents] who have problems, but so long as its called guidance and counselling office, they [adolescents] will withdrawal because people have the impression that once you go there you have a problem, and they do not want to be known that they have problems.’

### 7.6.3 Professional sensitivity versus ASRH needs

The findings of this study showed high sensitisation among the providers on the need to offer confidential services and to ensure the privacy of adolescents. However, observations during the field study showed lack of professional sensitivity among some providers. In two facilities, the providers were observed asking patients about their problems at the waiting area. This creates additional barriers for adolescents especially if they share services with adults. The health providers generally noted the need to attend to clients individually, to ensure confidentiality when handling clients records and not to ask about their problems publicly. These findings point to the need to create continuous awareness among health providers and caregivers on professional work ethics and norms, and the need to enhance confidentiality and empathy in service delivery. Further, the findings imply the need to enhance privacy and confidentiality in the entire service provision path including at the entry point, during the intake process and during consultation. The findings also imply the need to organize services in a way that they enhance the privacy of adolescents. The health providers made similar observations.

Provider 12, ‘...he may come with a headache which you treat. But the root cause of the headache may have been something else that may be troubling him/her that can only be addressed in an environment that is tailored to address adolescent issues. Adolescents have unique needs and they want them addressed in their own unique way.’

Elster and Kuznets (1994) similarly observed the need for sensitivity when dealing with adolescents. They noted that communicating with adolescents requires a special sensitivity to their stage of development and their cognitive abilities.



#### 7.6.4 Parental involvement versus adolescent right to confidentiality

This study has established that many parents exert significant influence on adolescents to seek PRHS. The study has also established that parental involvement could lead to coercion of adolescents by their parents to access and utilize PRHS. The findings further suggest that parental involvement could lead to breach of adolescents' right to confidentiality and that the 'minors' in particular, could be coerced to use services. The findings further show that breach of confidentiality occurred if adolescents were accompanied by their parents/guardians to the health centres and to the doctor's room during consultation. The findings also showed that some of the adolescents were forced by their parents to seek services from providers they were uncomfortable with. This denied them their right to confidentiality and decision-making about their health matters. Of the 36 adolescents who had used services, nine indicated having been prompted by their parents to use the services. In one case, a thirteen-year boy reported of having been forced by his parents to undergo 'voluntary' counselling and testing (VCT). A 17 year old girl also indicated being asked by her parents to see their preferred doctor, whereas a 17 year old boy indicated having used services because he was required to do so by his parents.

*Interviewer: What are some of the things that you felt could have been done better?*

Adolescent 6:38, "Adolescents feel uncomfortable going to health facilities. For example, I went to a VCT...I did not like it...my parents forced me to go for it...I was very sick. One day they told me we are going to Nairobi as usual. I saw a VCT advertisement, and we went in...I was 13 years then. I feel it was good for me to know my status because I will avoid those behaviours...but I did not like the fact that I was not told what I was going to do, and also the fact that the results were not given to me. I was just told to go out. I was very frightened...I just asked myself, if I am positive what could I do. When I think of this...I hate my parents..."

The breach of confidentiality could arise due to policy and legal requirements for parental consent and the dependency of adolescents on their parents for support. This is despite the fact that reproductive health is a basic human right (DFID, 2004). The WHO states that “life, survival, maximum development and access to health services are not just basic needs of children and adolescents but are also fundamental human rights.” The 1994 International Conference on Population and Development (ICPD) stressed “the importance of taking ASRH needs seriously, and emphasised that these should be seen as basic human rights. In the ICPD Program of Action, governments in collaboration with nongovernmental organisations (NGOs) are urged to meet the special needs of adolescents while safeguarding their rights to privacy, confidentiality, respect and informed consent” (WHO, 2004a). Despite this recognition, financial barriers, lack of free services for adolescents and dependence on parents/guardians compromise adolescents right to confidentiality and to health services. Consequently, adolescents may have little bargaining power even when their right to reproductive health is denied or violated. This leads to resentment among adolescents towards preventive reproductive services. The findings imply the need to safeguard adolescents (particularly the ‘minors’) right to confidentiality and to decision-making about whether and when to seek PRHS.

#### 7.6.5 Providers’ authority & identity versus adolescents access to PRHS

The findings of this study imply the need for health providers to identify with adolescents. Social distance resulting from unequal social status of the adolescents and the health providers/caregivers could threaten adolescents ability to freely share sexuality matters. Identifying and creating a friendly and comfortable environment for adolescents could take different forms. Views obtained during the interviews showed that health providers could identify with adolescents through language, service identification, and dressing by not wearing doctors’/nurses’ uniform. In one health

centre, the VCT nurse/counsellor wore a budget written *'Just ask for VCT services from me'*. At the Nyeri youth clinic, the provider observed the effect of nurses' uniform on adolescents health seeking behaviour. This is captured in the following excerpt. See also Figure 7.3.

*Interviewer: What challenges do you face when providing services to adolescents?*

Provider 6, '...adolescents fear the hospital set up. When they see you in uniform, they do not open up. To deal with this challenge, I opted to wear civilian clothes other than the nurse uniform. This way, I found that they feel more free with me and open up more. The other thing is that the health worker has to be friendly to them. This way they open up.'



Figure 7.3 Photos showing nurse at a youth clinic in civilian clothes

(Note: The youth clinic is not in Murang'a District but in the neighbouring Nyeri District).

The finding suggests that social and power imbalances between adolescents and the health providers create communication barriers. Providers uniform symbolises the power and authority bestowed on health providers to determine patients well-being, such as authority to make decisions on the services to offer adolescents. However, this creates a social gap and fear among adolescents to approach health providers. A senior health expert observed that:

Provider 7, ‘The idea is to look at the old perception of uniform. It classifies people and seems to endorse power on the wearer. In a hospital situation, it shows the person is powerful and in-charge. If you are in no uniform, it may show that sharing is more like the owner-receiver situation. When the uniform is removed, part of the classification is removed and one comes closer to the recipient.’

Heller, McCoy and Cunningham (2004) similarly emphasised the authority and role of health care providers in shaping and determining health outcomes. He noted that:

...Physician authority is thought of as *the* legitimate medical experience, expertise, and knowledge...in essence the provider seeks to impose parameters and regimens on the user by telling the user what to do...Individual providers may find ways to incorporate user-centred practices in their delivery of care and to advocate changes to medical systems that broaden their reach and scope for the user.

The findings of this study point to the need to understand the effect of identification and providers’ dressing on adolescents access and utilisation of PRHS. Further research is needed to understand the extent to which providers’ uniform and service identification badges affect adolescents access and utilisation of health services, and their ability to open up to health providers. The findings nonetheless suggest the need for provider flexibility when serving adolescents. They also demonstrate that health providers can use their position positively to influence and motivate adolescents to access and use PRHS.

#### 7.6.6 Social aspects – age and gender of health providers

This study has further established that the age and gender of the health providers posed significant barriers in access and utilisation of preventive reproductive health services by adolescents. The adolescents generally preferred to be served by younger health providers as opposed to older providers. They thought that the young providers understood their sexual health issues and were non-judgemental. However, a few adolescent preferred being served by older providers. They considered older providers as more experienced and knowledgeable in dealing with sexual health issues. Others were neutral on their choice of health providers. They thought that what was important was the health providers' ability to identify with and understand adolescents. The preference among the adolescents for male or female health providers may also be influenced by past experience.

Adolescent 7:11 (Girl) - '...Male or female doctor? According to experience, I had a headache and I was attended by a female doctor, she was very rude. When I was in form two, I had a problem and was attended by a male doctor, it was an operation. He was very understanding. So I would prefer a male doctor. Men usually understand...Age? Old or young. I would prefer a young doctor may be from 30 – 45 because they are young and will understand us better. For example if you are going there for treatment, they understand better. He or she is young, one will have confidence when talking to her, but the old ones you have to give respect and you are shy.'

Apart from the age consideration, the adolescents showed gender inclinations in their choice of providers. Girls preferred to seek services from female health providers as opposed to seeking services from male health providers. Girls generally showed reluctance to share their sexual and personal health concerns with male health providers. They assumed that female providers would be more understanding as they may have

experienced similar problems like them. On the contrary, some boys favoured female health providers to male health providers.

Adolescent 2:113 (Girl), ‘...If I had a sexual health problem, may be I would feel shy and would feel that I do not want to see a doctor especially if it’s a man. Especially if my parents have to be told what the problem is.’

The preference of health providers on gender basis is not unusual or confined to adolescents alone. Wyn et al. (1999) in a report on barriers and benefits of managed care for low-income women in California made similar observations. They observed that Latinas and Asian-American women were reluctant to discuss personal health problems or issues with male providers, and that many assumed that female physicians would be more understanding due to their own personal experiences as women rather than their professionally derived expertise. The findings of this study show that adolescents preference for age and gender of the health provider is rooted in the socio-cultural, inter-generational and inter-gender relations. In the cultural context, sexuality issues are confined within age-sets and gender boundaries (Magicalkenya, ca. 2006). Adolescents might feel culturally bound to respect the older health providers and thus fail to openly share their sexual health concerns with them.

The health providers concurred that adolescents experience discomfort being served by health providers they perceived as old or of the opposite sex. The preference for male or female providers was based on adolescents judgement on such factors as these: - whether the provider is polite, understanding and able to handle adolescents well, whether the provider is sensitive to adolescent health problems, whether the provider is open and willing to discuss sexual health issues with adolescents, and whether the adolescents can confide and identify with him/her. The findings imply the need for health facilities to have both male and female providers to effectively cater for the needs of boys and girls. However, staff shortages especially in rural health facilities

create barriers (Section 7.7.4). Despite this, it is important to educate adolescents to be free and create trust in health providers without gender bias.

*Interviewer probing: Based on your experience, would you recommend that health workers serving adolescents should not be in uniform?*

Provider 16, ‘What I know is that when adolescents come here, they look for someone who they can identify with. For example, they even look for someone in trousers. Adolescents identify with people who can dress like them, and people who are not so old. Someone who is just slightly above their age... [about the gender]...it matters a lot depending on the problem one has. For example, some boys with STIs are sensitive and want to be seen by a man. Some want to be seen by a lady counsellor but some do not mind. In the event that we do not have a sitting male clinician, we call the doctor to serve the male adolescents. This way we enhance confidentiality.’

The findings of this study point to the need to address the social aspects of service provision. Further research is needed to understand how social factors such as age and gender of health providers affect adolescents access and utilisation of PRHS.

## **7.7 Structural and Institutional Barriers**

Another purpose of this study was to find out about the barriers that health providers faced when providing reproductive health services to adolescents. The study also sought the views of the health providers on how the identified barriers could be addressed. This study has established that there existed significant structural and institutional barriers that affected access, utilisation and provision of PRHS to adolescents. The cited structural and institutional barriers included the following: poor set-up and organisation of health facilities, lack of adequate space and consulting rooms, lack of confidential outlets for dispensing condoms, staff shortage and heavy workload, lack of adequate transport means, and lack of funds for establishing and equipping adolescent health centres. These barriers are further discussed below.

### 7.7.1 Poor structural set-up of health facilities and inadequate space.

This study has established that poor structural set-up of health facilities affected adolescents' ability to access and utilise PRHS. The findings suggest that adolescents may fail to use services if the structural set-up of the health facilities impedes their privacy and confidentiality. The health providers observed that adolescents shied from public health facilities because they did not like to be seen seeking care. They noted that adolescents preferred to use health services that were frequented by other adolescents and not by adults, as well as services which were far to safeguard their privacy, and to be served in health facilities they identified with.

Provider 10, '... the set-up may affect adolescents ability to open up. Because an adolescent as you know, you have to understand them and the stage in life they are in. So the hospital set-up or the room where they are or the place where services are offered should be set up in such a way that an adolescent feels that is where he/she belongs...where they will meet...people of their age and may be they will share when they are on the queue... This one creates a room or an environment of openness even when they go to see the clinician. They will be able to open up and say their problem because this is their clinic and where they belong.'

The health providers associated poor communication between them and adolescents, as well as lack of privacy and confidentiality to poor structural set-up of health facilities. The providers noted that structural barriers resulting from poor architectural designs and set-up of the health facilities affected their ability to promote and enhance privacy. The health providers also observed that health facilities are public places, and that poor organisation of health facilities made it difficult for them to ensure adolescents' privacy and confidentiality.



*Provider probing: Why do you think they are uncomfortable to come here for condoms, yet here they can get more advice?*

Provider 18, "...the youths also avoid publicity. They know that a hospital is a public institution and anybody will come here. And when they come to ask for condoms, they may feel like it's not the right thing..."

Provider 19, '...there is nothing I can do since the dispensary is already constructed. If I was to decide, I can tell them to create private rooms. Before any dispensary is put up, it is important to get a design so that they know what to put where. It should be in a way that it enhances confidentiality and privacy. They should get a design from the Ministry of Health, not just putting up a building to help the community...'

This study has further established that the lack of adequate space and consulting rooms affected the health providers' ability to protect adolescents privacy. The health providers observed that most public health facilities were congested and that privacy could not be ensured at the waiting areas and sometimes during consultation.

Provider 1, 'Adolescents being who they are, we do not have appropriate infrastructure, resources and capacity to handle them. We need to cater for them in a more friendly and gentle way so that we encourage them to come and seek our services. As you realise our MCH is usually very congested, their mothers and uncles are still coming. We need to have a place specifically for them so that we can have a new way of approaching issues so that we encourage them to use the services without getting stigmatised. Even our staff attitude should change sometimes the way we handle them can discourage them from seeking the services.'

The findings of this study imply the need to improve architectural designs and structural set-up of health facilities. The findings also imply the need to organise and improve the structural set-up of the health services (from entrance to consulting rooms) in a way that they enhance the privacy and confidentiality of adolescents. Further, the findings affirm the need for adolescent-friendly services. This would make adolescents feel that they are in their place and consequently enhance open sharing. Heaven (1996) made similar observations and stressed the need for confidentiality:

To be effective, the delivery of health services should occur in those places most likely to be frequented by adolescents. The service should use materials (e.g. videos, pamphlets etc.) that are appropriate for the teenager and that respect the anonymity and confidentiality of the client. Finally, staff should be sympathetic to the needs of the adolescents, while no financial barriers should be placed on those who decide to make use of a service... In other words, it is important that adolescents feel at ease in these settings and believe that they are accepted and respected. If not, educational strategies are not likely to succeed.

#### 7.7.2 Lack of appropriate confidential outlets for dispensing condoms

Promoting condom use is widely accepted as a strategy for reducing the spread of HIV (RoK, 2001b). For condoms to be used, they must be available, accessible, affordable and comfortable (Skinner, 2001). Despite the observations by health providers that adolescents (especially boys) sought condoms (Section 5.5), this study has established that there existed structural and institutional barriers that hindered access to condoms by adolescents. The findings showed that the existing condom outlets were not ideal for adolescents. The health providers cited the available outlets as: outpatient curative services, MCH/FP clinics, and condom dispensers available at public health facilities and public places like bars and loadings. Despite the evidence that free condoms were available and could be accessed through the health facilities, this study found that adolescents experienced barriers in accessing condoms. Although adolescents could get condoms from health facilities without queuing, the findings showed that they instead preferred to join queues to protect their privacy.

Provider 11, ‘...If one is coming for only condoms, one does not have to pay anything, not even the registration. Those with information come direct to ask for the condoms but some fear and join the queue because they do not want to be known.

We also see some coming from far areas for family planning and when we ask them why they do not go to the nearby health centre they say that they do not want to be known in their area that they use FP methods...'

This study has established that inappropriate placement of condom dispensers created access barriers for adolescents. Observations made in this study showed that condom dispensers were placed in open places, like the outpatient services waiting areas (Figure 7.4). In one facility, the dispenser was placed in a public toilet. The reasons cited for placing dispensers in open places included: - fears that children would misuse condoms or that groups opposed to condom promotion would damage them. This study has further established that adolescents faced significant barriers in accessing and picking condoms publicly from condom dispensers. The health providers observed that adolescents, especially the boys, picked condoms from the dispensers secretly in the evening or early morning to avoid being seen, or that they sought condoms in groups.

Provider 12, 'adolescents...who look healthy...come for condoms especially the boys. We have a dispenser and in the evening when we close they pick...It is the issue of shyness. During the working hours when the facilities are open, they would feel that...somebody from their place will see them ...Coming to pick condoms is a sexual issue and most people are not comfortable talking about sexuality...So these people will shy off coming during the day. But when they find that the clinic is closed at 5.00pm, they find most of the people are gone...so you find they come to pick the condoms and walk out.'

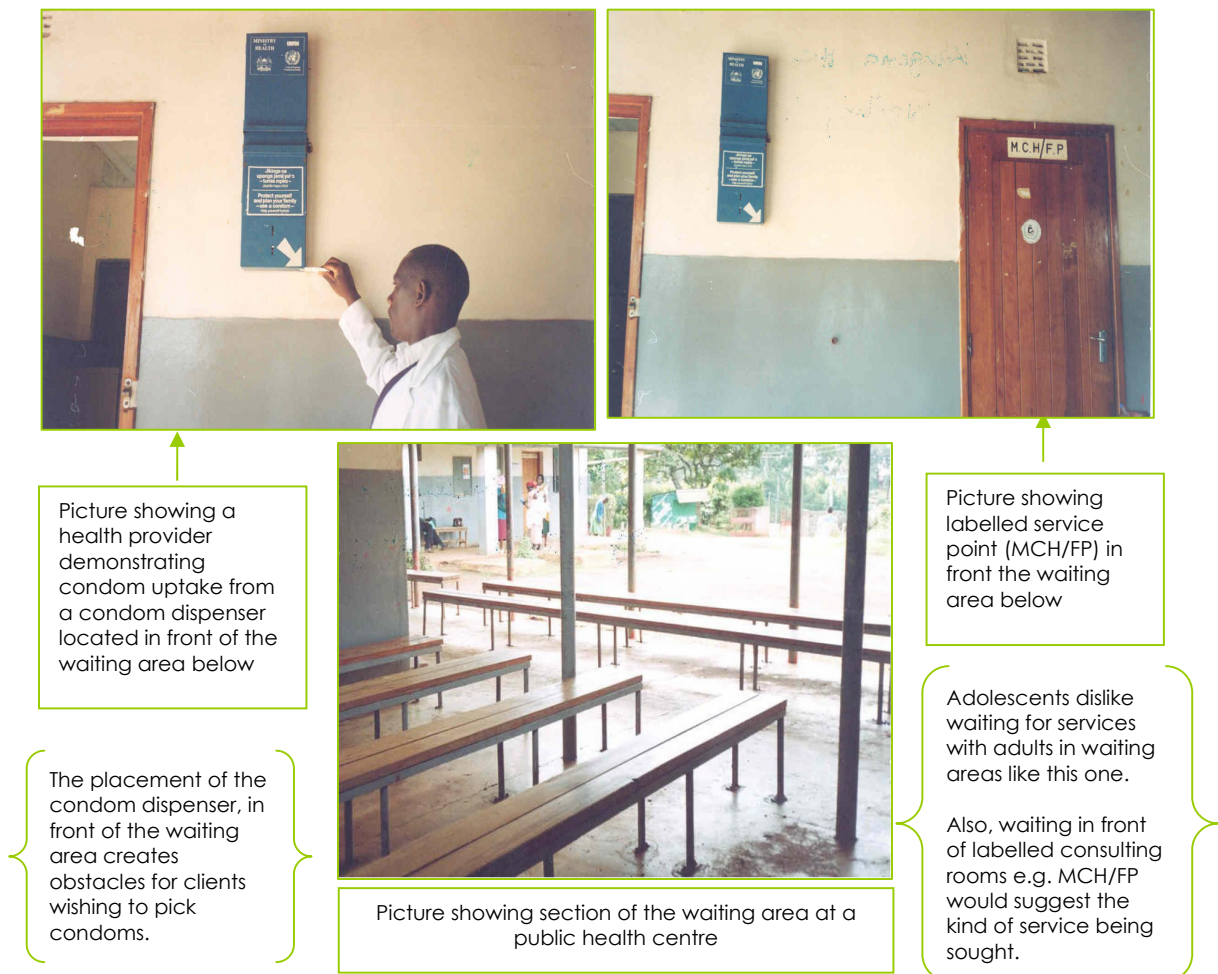


Figure 7.4 Photographs showing waiting area, placement of condom dispenser and labelled MCH/FP services.

The findings of this study show that there existed other institutional barriers that created obstacles to condoms access by adolescents. These included occasional condoms stock-outs. In addition, not all the health facilities had condom dispensers. Only three out of the 12 covered health facilities had condom dispensers. The findings of this study show evidence of stock-piling of condoms in some health facilities (Figure

7.5). The health providers associated stock-outs and stock-piling of condoms with logistical problems and ineffective distribution systems.

Provider 2, ‘...the only problem now is in the distribution because it is only the family planning clinics (through the office of the DPHN) where they are being dispensed. It is now being reorganised so that the department of public health will take over the role of distributing condoms and ensure that all the public health technicians ensure that dispensers have condoms.’



Figure 7.5 Photograph showing piled condom stocks

The above findings imply that the lack of condoms dispensers and lack of privacy hampered adolescents access and utilisation of PRHS. The findings also show that despite condoms availability, adolescents did not access them. This was attributed to the prevailing cultural practices that treat sexuality matters as taboo. The secrecy associated with sexuality matters created further challenges for adolescents, especially

girls, in accessing condoms from public places. Adolescents experienced discomfort in accessing condoms publicly and feared being perceived as promiscuous.

*Interviewer probing: Why do you think they are uncomfortable to come here for condoms, yet here they can get more advice?*

Provider 18, 'They may fear to come here because they probably imagine that we will think that, that is the only thing they do {engaging in sex}...If seen, by others using it, the people might start warning each other "you be careful about someone who is using condoms so much". Some people might start avoiding the person especially the girls... Also if they come for condoms, we talk to them and advise them. They do not feel comfortable about this...'

The findings of this study correspond with that of Skinner (2001) in a study on decision-making about condom usage among youths in Cape Town. Skinner found most youths being aware that condoms could be obtained from clinics. He further observed that the youths encountered barriers in collecting condoms from clinics because of the high visibility of the building, and that many youths encountered difficulties in going to the clinic because they were scared that nurses would ask them questions and mock them. Skinner further noted that adolescents had difficulties in talking openly to older people about sex, as well as being identified by elders as sexually active. The findings of this study, while they correspond with that of Skinner, also differ. Whereas the nursing staff in the study by Skinner denied poor relations with the youth, the findings of this study showed awareness among the health providers of the fears that adolescents have in accessing and utilising services from public sector health facilities.

### 7.7.3 Lengthy hospital procedures and increased contacts

The findings of this study suggest that lengthy hospital procedures and increased number of contact persons could heighten adolescents fear of breach of confidentiality. The health providers observed that adolescents preferred being seen by the same health provider. Accordingly, they would decline or delay seeking care if their preferred health

provider was absent. The findings suggest the need to integrate adolescent reproductive health services to shorten the service provision path and reduce the number of contact persons serving adolescents. This would reduce adolescents fear of breach of confidentiality and encourage them to access and utilise services.

*You have mentioned that sometimes the young boys prefer coming to you than going to the female nurses...*

Provider 12, ‘...what I have seen is that sometimes I may not have time. And I may tell the boys to go to the lady nurse and I assure them that they will get the information. Some of them opt to go away and come back another time to see me because they feel that - I have identified you and I have confided with you and do not want to confide in somebody else...’

#### 7.7.4 Staff shortage and heavy workload.

Staff shortage and lack of adequate space hampered the health providers ability to enhance confidentiality. Despite being sensitised on the need to offer individualised services in one room, during a single visit and under an environment that provides privacy and confidentiality of clients, the health providers indicated that they sometimes attended to patients together in one room to save time. Health providers in-charge of MCH/FP clinics noted, for example that they sometimes served clients together in one room because of staff shortages, heavy workload and inadequate consulting rooms (see Figure 7.6).

*What challenges do you face when providing services to adolescents?*

Provider 5, ‘...privacy at the clinic is still not optimum. Due to the large number of patients who come to the clinic, we are forced to take two patients in one room at the same time...if there was enough room and personnel, one would be seen alone in a room. This way the patient or the adolescent would tell you more...This becomes a challenge particularly to the adolescents who may fear that someone may follow them. The queue is not the best...It would be best if one would come in a way that nobody knows what one is doing.’



Figure 7.6 Photograph showing setting inside an MCH/FP clinic  
(MCH/FP clients sit on the benches and wait together in one room)

Staff shortages were more acute in the rural areas compared with the urban areas. The health providers noted that some facilities had only one or two nurses who dealt with many patients. The providers noted that in addition to providing health services, they performed additional administrative duties like stock taking of medicines and preparation of monthly medical reports. The providers noted that reproductive health issues are sensitive and require adequate time to be handled effectively. They however noted that persistent staff shortages and heavy workload affected their ability to effectively serve adolescents.

Provider 1, 'we have very acute shortage of nurses and these are the people who are supposed to give these services. In 13 of our dispensaries we only have one nurse...it is difficult because this is the nurse who is doing the cleaning, the curative, the MCH and doubles to be the head, meaning that she is also dealing with other administrative issues of the facility. If the staffing situation does not improve, even if adolescents programmes were introduced it might not be feasible to have them on the ground.'



The inadequate time allocated for provision of PRHS implied that adolescents did not get comprehensive sexual health information in continuous and lengthy sessions. The adolescents similarly noted that staff shortages and long queues discouraged them from seeking services.

*Interviewer: What are some of the things that you felt could have been done better?*

Adolescent 2:113, 'When you go there (health facility) if you have different problems you have to wait. Those giving services are two or three and the queue is normally very long and some people go back home and some may not come back. So staffing is a problem.'

Although staff shortages could be addressed through training of more staff, training without institutional support would not necessarily lead to desired outcomes. High staff turnover, unequal distribution of staffs, and interdepartmental transfers affect provision and implementation of adolescent health programmes. The findings of this study showed high levels of staff turnover. During the dissemination phase, eleven of the health experts who had been interviewed in the data collection phase had transferred or could not be reached. These included senior staff of the Ministry of Health (MoH), Ministry of Education (MoE), and the Gender, Sports, Culture and Social services department. In the MoH alone, those transferred included the District Medical Officer of Health (DMOH), the District Public Health Nurse (DPHN) and two senior nurses. Those transferred in other departments included the District Social Development Officer (DSDO), and the Deputy District Education officer (D-DEO). The District Aids and STIs coordinator (DASCO) was on leave and could not be reached. Three CBOs could also not be reached either because they had closed down or the contact persons had moved to other location. Although the transfers were described as normal government processes, constant staff turnover would affect sustainability of adolescent health programmes. It also affects adolescents access and utilisation of PRHS especially because they dislike being served by different health providers (Section 7.7.3). The

findings imply the need to institutionalise adolescent health services within the health care system to ensure that unavoidable transfers and shifts of health staff do not affect provision of PRHS to adolescents. A department dealing exclusively with adolescents health issues should be set up, as has been done with the under 5's and MCH/FP services. The government should also designate specific staff to handle adolescent health issues as suggested below.

Provider 6, '...There is need to have a permanent clinician at the clinic. This would enhance confidentiality and continuity so that the youths do not feel mishandled when the clinical officers are changed all the time.'

#### 7.7.5 Inadequate PRHS and outreach programmes

This study has established the lack of effective outreach PRHS for adolescents. The health providers noted the importance of outreach services in reaching adolescents effectively. They observed that outreach services were needed especially in early identification and diagnosis of health needs of adolescents. The findings of this study however show that outreach programmes were lacking, few or irregular. The health providers were concerned about the lack of preventive outreach services. They attributed the problem to staff shortages, lack of transport means, and lack of field health workers to deal with preventive care. The health providers noted that the health care system gives greater preference to curative and other urgent cases and little attention to adolescent outreach programmes. These findings suggest that the health providers did not adequately and aggressively prevent sexual health problems among adolescents. Instead, they waited for adolescents to get sick to go for treatment. Further, the findings implied that existing reproductive health services offered post-exposure and not pre-exposure reproductive health services. The findings also imply the need to

intercept early and to provide adolescents with sexual health information to prevent infections and sexual health problems facing them.

Provider 16, 'most of the health field workers were retrenched...our preventive programme is very weak. We do not have personnel who are dealing with preventive. We are waiting for people to get sick so that they can come here and we treat them. This is very dangerous. And as we used to say that prevention is better than cure. Now it seems that cure is better than prevention [*laughs*]...We are not preventing any more.

#### 7.7.6 Transportation problems

The findings showed great willingness among health providers to offer outreach services to the in-and-out of schools adolescents. This desire was however hampered by lack of reliable transport means. The findings revealed that only three out of the 12 facilities covered in Murang'a District had vehicles. These were used for distribution of drugs and contraceptives to the health facilities, and for other health programmes including emergency services. This study has established that the lack of reliable transport means created barriers for the health providers in providing outreach services for adolescents.

The findings imply the need for the government to address transportation barriers facing health facilities. The health providers emphasised the need for inter-ministerial, inter-departmental and institutional collaboration in dealing with transportation problems. The providers noted that financial constraints and lengthy government procurement procedures made it difficult for each facility to have a vehicle. They observed the need for joint efforts between schools, ministries and departments serving adolescents. The providers suggested that the various institutions serving adolescent could address transportation problems by: - pooling financial resources, planning activities together to maximise use of available vehicles, and sharing available vehicles on rotational basis.

Provider 19, 'It is my wish in future that we can get a vehicle for the location. So today if I use it, tomorrow the Kagumo-ini people can use it, then Kairo. This way it would be easy to reach adolescents and we can go to all the schools. The Kairo person can go up to the forest. Sometimes in Kenya, it is difficult to get a vehicle for every dispensary. And like here in these areas, the dispensaries are very near. We cannot get a vehicle in every dispensary. The way to simplify things is to get a vehicle for the whole location. Then we liaise together, the health workers, to know who is going where and when.'

## **7.8 Summary**

This study has identified barriers that affect adolescents access and use of preventive PRHS. They included: - lack of adolescent-specific/ friendly services, lack of adequate awareness among adolescents about available PRHS, psychosocial barriers including fear of mixing and sharing services with adults, and fear of seeking services from familiar health providers, embarrassment among adolescents to use services, fear of being suspected as being sexually active or having a sexual health problem. This study has concluded that adolescents showed 'familiarity anxiety' but had 'stranger confidence'. Other barriers included poor communication between adolescents, the health providers and caregivers; fear of parental involvement and of breach of confidentiality, lengthy hospital procedures including increased contacts with different health providers, cultural inhibitions, biased socialisation of boys and girls regarding sexuality matters, and lack of culturally appropriate language. Other were lack of confidentiality and privacy, failure to integrate reproductive health services, inappropriate labelling of health services, judgemental attitude among providers when dealing with adolescents, and breach of adolescents right to confidentiality. This study also identified structural and institutional barriers that hampered health providers ability to offer confidential services. These include inadequate consulting rooms, inadequate and inappropriate condoms outlets, staff shortages and heavy workload, weak preventive reproductive health outreach programmes, and transport problems. The above barriers need to be amicably addressed to enhance adolescents access and utilisation of PRHS. This would enhance open communication between adolescents and health care providers. It would also ensure that adolescents have access to confidential PRHS, and that their preventive reproductive health needs are met.

## **CHAPTER 8**

### **CONCLUSIONS, POLICY IMPLICATIONS AND WAY FORWARD**

This section presents the overall study conclusions and the implications of the study findings. It provides concrete proposals on what needs to be done to address identified barriers that hinder effective access, utilisation and provision of preventive reproductive health services (PRHS) for adolescents. It further presents proposals for improving access and utilisation of PRHS by adolescents and for informing policy.

#### **8.1 Study Conclusions**

This study sought to establish the factors influencing access and utilisation of preventive reproductive health services by adolescents in Kenya. The study expected to gain an understanding of the challenges facing adolescents in their pursuit to access and utilize PRHS in Murang'a, Kenya. The study further aimed at establishing the existing reproductive health policies, and to find out how the policies affected access and utilisation of PRHS by adolescents. In addition, it aimed at identifying the barriers that adolescents face in accessing and utilising PRHS, and to provide proposals for addressing these barriers. The study was carried out in Murang'a District, Kenya among 114 in-school adolescents from six secondary schools, 25 health providers from 14 health care facilities, and 18 key informants representing government departments, non-governmental organisations (NGOs), community based organisations (CBOs) and religious/faith based organisations (FBOs).

The study findings show that adolescents had sexual and reproductive health concerns that required them to access and utilise PRHS. The adolescents expressed behavioural, psychosocial, maturation and developmental, and societal related concerns. The main sexual health concerns of adolescents included fear of contracting STIs

including HIV/AIDS, concerns about early pregnancies and about early exposure to sexual debut. The findings also show that adolescents lacked adequate knowledge about maturation and body changes. There existed gender differences in the concerns of boys and girls. Whereas boys showed greater concern about increased sexual desires, girls worried about unintended pregnancies and menarche related problems. The findings further show that adolescents had psychosocial and societal related concerns.

Despite the notable concerns, adolescents feared to share their concerns with parents, health providers and caregivers. They feared being suspected as sexually active and to consult health providers they perceived as judgemental and unsympathetic. They also lacked awareness about available services and the service provision procedures. The findings show that efforts by the government, schools, NGOs, CBOs and FBOs to address sexual and reproductive health concerns of adolescents were inadequate and incomprehensive. Adolescents are socially excluded from reproductive health services and are left with no one to advise them. As a result, their needs remain unmet. Many adolescents turn to their peers for advice who might also be inadequately or incorrectly informed.

This study has established that there were no adolescent-friendly services in Murang'a District. Although adolescents considered health facilities and VCT centres as invaluable sources of preventive reproductive health services, the findings show lack of specific health care services for adolescents. Consequently, adolescents shared services with adults. VCT centres were also lacking, few or far between. The lack of adolescent-friendly/ specific services failed to guarantee adolescents privacy and confidentiality. The all-inclusive environment in public health facilities was not conducive for adolescents seeking PRHS. Consequently, adolescents avoided services where they were likely to meet their parents and relatives. They feared that the invisibility of their health problems might raise suspicion that they were sexually active or had sexual health problems. They also feared breach of confidentiality. Adolescents feared that adults or health providers might inform their parents that they had sought PRHS.

The study shows the need to increase and strengthen PRHS for adolescents in the rural areas. The respondents associated the lack of adolescent health services in Murang'a District to lack of planning for adolescent services, failure to prioritise adolescent health, lack of adequate and reliable data on adolescent sexual and reproductive health (SRH) to guide policies and planning for adolescent health services, and marginalisation of the rural areas. The health providers and the key informants were concerned that Murang'a District lags behind not only in developing viable adolescent health and outreach services, but also infrastructurally, and in implementation of other health programmes. The lag was attributed to lack of adequate government support and lack of stable NGOs and CBOs in the district focusing on adolescent health. This study affirms the need for the government to move beyond rhetoric, to taking more pro-active role in increasing availability and accessibility of adolescent health services. This would enhance efforts to meet the ICPD goals that the government committed itself to.

This study shows that schools had made efforts to respond to sexual health needs of adolescents. Notable efforts included provision of guidance and counselling services, establishment of Family/Growth groups, Academic families and HIV/AIDS clubs, integration/infusion of HIV/AIDS education in the school curriculum, as well as provision of curative and referral services. Despite these efforts, adolescents encountered difficulties in accessing and utilising school health services. Effectiveness of school health services was hampered by the following factors: lack of confidential or individualized services; lack of consistent, regular, standard and programmed guidance and counselling sessions, lack of guidelines to direct the guidance and counselling sessions, and lack of trust among adolescents of teachers and school caregivers. The findings further show lack of comprehensive school health services for adolescents. This was compounded by lack of effective coordination between schools and health care facilities, restrictive school timetables, rigid and lengthy referral procedures because of the 'gatekeeper approach' applied by school authorities.

Further study findings show that adolescents did not use preventive reproductive health services even when they had sexual health needs. Although the findings of this study seemingly aligns conceptually with the developmental theorists' notion of *healthy adolescents* that perceives adolescence as the healthiest stage in the lifespan with no major health threats, they also show specific differences. Contrary to the healthy adolescents notion, the findings of this study show that many adolescents had unmet sexual and reproductive health needs, and had overwhelming desire to access and utilise preventive reproductive health services. This study provides ample evidence to support the *contemporary theorists' notion* that adolescents face sexual health risks that justify their need to access and utilise sexual and reproductive health services. Despite this, the level of use of PRHS by adolescents was low. The health providers could not effectively reach and serve adolescents because adolescents did not go to health facilities and did not want to be served by familiar health providers. The study shows prevailing gender differences in access and use of PRHS. The health providers revealed that more girls than boys sought reproductive health services. However, adolescents generally sought post-exposure as opposed to pre-exposure PRHS. This study has highlighted the need to engender adolescent reproductive health services taking into account the social confinements of adolescents.

This study has further established the lack of clear policies and guidelines on adolescents' sexual and reproductive health. The establishment of the *Adolescent Reproductive Health and Development Policy* could provide policy directions and guidelines for health providers in their efforts to offer PRHS to adolescents. However, this study shows some amount of ignorance and lack of awareness among health providers and key informants about the existence of the policy or its contents. In addition, the study has revealed that policy restrictions led to exclusion of adolescents from accessing and utilising preventive reproductive health services. Legal and ethical requirements defined according to 'reproductive health age' or 'legal age of consent'



rendered most adolescents ineligible for confidential and anonymous preventive reproductive health services.

This study has revealed that lack of clear policies created obstacles for health providers/caregivers in providing PRHS to adolescents. Existing reproductive health policies are not adolescent-geared, neither do they address the service needs of adolescents. Instead, the policies address post-exposure preventive reproductive health needs as opposed to the pre-exposure needs of adolescents. The study shows the health providers/caregivers' decision on whether to offer PRHS to adolescents, and the appropriateness of the services, was shaped by their interpretation of adolescent behaviour and the perceived health risks. This provided an avenue for them to deny adolescents PRHS. Further, adolescents might have little bargaining power even when their right to confidential services is denied or violated. This study, as well as previous studies, shows that health providers and caregivers may establish their own policies which prevent access to services by adolescents. Additionally, conflicting and inconsistent information about available services, lack of universal or working definition of adolescent, rigid policies create policy-related barriers that hamper adequate provision of comprehensive PRHS to adolescents. This study proposes the need for the government in collaboration with stakeholders, to review existing reproductive health policies, to come up with a clear, realistic and acceptable working definition of adolescent, and to provide age-specific adolescent PRHS.

The lack of clear adolescent preventive reproductive health policies is evident in practice and perceptions of health providers. Evidence in this study shows conflict between policy and practice. Many providers expressed reluctance to offer PRHS to adolescents, or to give them information about available services. The health providers blamed unclear policies and guidelines, culture, negative attitude by adolescents and provider-parent role conflict, for their inaction and failure to offer adolescents PRHS. The lack of professional sensitivity among some providers and constant questioning about the appropriateness of PRHS for adolescents led to their denial of services to

adolescents. The judgmental attitude portrayed by health providers contributed to the negative perception among adolescents that reproductive health services are for adults and the married. Consequently, adolescents failed to seek services and feared to approach health providers. Even when they did, the fear of being perceived as sexually active and of breach of confidentiality made adolescents not to effectively open up to the health providers.

The lengthy and rigid bureaucratic procedures, censorship and vetting of the contents of school-based sexuality education pack made it difficult especially for CBOs to effectively reach adolescents. It also limited their ability to provide comprehensive sexual and reproductive health information to adolescents. As a result, adolescents received inadequate and sometimes contradictory information. Evidence from this study showed lack of inter-ministerial and institutional collaboration and consultation on adolescent health matters. The government departments, NGOs, CBOs and FBOs did not adequately consult or share information about their activities. Instead these actors seemed to treat each other with suspicion and as rival competitors.

This study has established additional barriers that significantly hampered adolescents access and utilisation of preventive reproductive health services. These are summarised as follows: -

1. Lack of adolescents awareness about PRHS and lack of confidential adolescent-friendly services. Although the findings show that adolescents could access PRHS through mainstream formal health services, they also show that adolescents lacked awareness about available services and how to access them. The lack of awareness was partly because of lack of adolescent-friendly and specific services, and failure to inform adolescents about existing reproductive health services. This combined with lack of effective preventive reproductive health and outreach programmes meant that adolescents had no access to affordable, acceptable and confidential preventive reproductive health services. Thus, existing reproductive health

services dealt with post-exposure needs as opposed to pre-exposure sexual health needs of adolescents.

2. Psychosocial barriers. Adolescents experienced psychosocial barriers that hampered their access and utilisation of services. The adolescents feared parental involvement and breach of confidentiality. They feared accessing PRHS in the same facilities with adults. They felt embarrassed and shy to use reproductive health services and feared parental involvement. They also feared to be served by familiar health providers, a condition which this study terms as '*familiarity anxiety versus stranger confidence*'.
3. Interpersonal barriers and poor communication between adolescents, health providers and caregivers. The findings show that there existed negative attitude and perceptions between health providers and adolescents. This study has shown widening communication gap between adolescents and health providers/caregivers, which created further challenges for adolescents in accessing and utilising PRHS. On the one hand, the health providers perceived adolescents as arrogant, uncompromising, secretive and opposed to guidance from adults. Contrary to these perceptions, adolescents demonstrated willingness and desire to access and utilise services and to be informed and advised about sexuality matters. On the other hand, adolescents perceived health providers/caregivers as uncaring, judgemental, suspicious and untrustworthy. They expressed desire to be served by welcoming, friendly, caring, informative, non-judgemental and trustworthy health providers/caregivers who would identify with them, and treat them as adolescents. Interestingly, despite the perception by adolescents, the study shows desire among health providers to offer PRHS if policy restrictions, staffing shortages and transportation problems were addressed. The providers noted the need for training to enable them to effectively handle adolescents, and to understand their sexual health needs and behaviour.

In addition to the above, other communication barriers arose from authority and social distance depicted by wearing of uniforms by health providers/caregivers. This created fear and lack of freeness among adolescents to communicate with health providers. The age and gender of the health providers also affected communication between them and the adolescents. Adolescents wished to be served by young health providers and the girls especially, by female providers.

4. Structural and institutional barriers included the following: - inadequate space and consulting rooms, staff shortages and heavy workload hindered health providers' ability to offer confidential services and to enhance adolescents privacy. These barriers made the health providers to separate services and sometimes to offer services to patients together in the same room. The division of services and failure to guarantee clients privacy violates the goals of comprehensive integrated services. They also affect adolescents level of access and utilisation of services, and enhanced their fear of breach of confidentiality. Inappropriate and non-confidential condoms outlets were other noted barriers. Condoms use promotion is a key global health strategy used to prevent the spread of STIs including HIV, and to prevent unintended pregnancies. However, inappropriate placement of condom dispensers and non-confidential condoms sources made it difficult for adolescents to access free condoms in public health facilities. Further, inappropriate labelling of reproductive health services compounded adolescents challenges of accessing and utilising PRHS in an-all-inclusive health service model. Waiting at service points that were labelled, for example as MCH/FP, suggests the kind of services being sought. Consequently this enhances suspicion.
5. Ethical and practice related barriers included the following: - lack of privacy and confidentiality, breach of adolescents right to confidentiality, professional dilemma and judgemental attitude among some providers when dealing with

adolescents, lengthy hospital procedures, and increased contacts with health providers that compromised adolescents privacy and confidentiality.

6. Social-cultural barriers. These include the following: - cultural inhibitions and lack of openness towards sexuality matters, lack of culturally appropriate language to discuss sexual health matters across generations, biased socialisation of boys and girls that perpetuated gender-based sexuality myths about sexuality matters.

In summary, this study has shown the existence of a service gap in the lifespan where services are planned and provided for adults and children leaving out adolescents. The study underscores the need to bridge this gap to ensure completeness, availability and accessibility of sexual and reproductive health services across the lifespan. The gap can be bridged through establishment of comprehensive, integrated and gender sensitive adolescent health services. This study concludes that the lack access and utilisation of sexual health services and information by adolescents leads to their exposure to sexual health risks and not the opposite. Thus, adolescents just like adults and children should be accorded their basic right to health, which includes access to affordable and confidential preventive reproductive health services. The above mentioned barriers need to be aggressively and amicably addressed to improve access and utilisation of PRHS by adolescents.

This study highlights the need to reorganise public health services and to have separate services for adolescents to accommodate unique SRH needs of adolescents. The study proposes the need for harmonisation and coordination of adolescent health services and programmes in Kenya. It also proposes the need to strengthen stakeholders networking, partnership and participation; and to establish a national coordination body/organisation or departments, to exclusively deal with adolescent health matters,

and to coordinate adolescent health programmes. Further, the study proposes the need for baseline data on adolescent reproductive health, and for constant monitoring and evaluation of effectiveness of adolescent health services, as well as their reproductive health indicators and outcomes. It also proposes the need to adopt appropriate labelling that reflects inclusiveness and not marginalisation and exclusion of adolescents. The concrete proposals and recommendations for addressing identified barriers, and other factors that hinder or influence adolescents access and utilisation of PRHS are presented in Section 8.4.

## **8.2 Data Validity and Reliability**

The concept of reliability implies that two or more scholars conducting similar studies and using similar study designs would yield similar results. Potential sources of error in qualitative data stem from the process of data collection, categorisation and analysis. Although the priority in grounded theory is data analysis as opposed to data gathering, it is critical that the quality of the data gathered is reliable and valid. Validity and reliability begins with the data collection phase and not just data analysis. In this regard, I adopted selection procedures that were capable of producing reliable data. For example, I did pre-testing to identify and bring out possible constraints and weaknesses in the research process and took quick intervention strategies to deal with identified constraints. I carefully selected the study subjects and closely monitored and supervised the data collection and recording exercises to ensure that the quality of information generated was high. I transcribed all the interviews to guard against potential linguistic errors and omissions. I also adopted careful data analysis procedures while at the same time identifying gaps in the data.

A second fieldwork phase was undertaken to share preliminary findings with the study subjects, validate the data and fill identified gaps. Validation is an act that confirms that the research meets the goals and objectives for which it was intended.

This is an integral phase in research guided by grounded theory because it allows the subjects to raise questions and the researcher to confirm the results.

### **8.3 Limitations of the Study**

This study has addressed important public health issues and provided useful policy recommendations. The study however has several limitations that need to be highlighted. First because the study focused on only the in-school adolescents makes it difficult for the data to be generalisable as representing the views of all adolescents outside the school bracket. The sexual and reproductive health needs and challenges of the out-of-school and the married adolescents are likely to be different from those of in-school adolescents. The findings and the recommendations should thus be adapted for in-school adolescents. Further empirical and baseline data would be needed before designing reproductive health programmes for out-of-school and married adolescents.

This study has methodological limitations. The study covered one district in the Central province of Kenya. Although two health facilities in the neighbouring Nyeri District were covered, the number was too small to claim representativeness. However, the qualitative study was useful in providing the realities of a rural district and the challenges faced by adolescents in accessing and utilising PRHS. Again, this might not reflect the situation in the entire country. Some rural districts could have other cultural related challenges, since Kenya is highly multi-ethnic and multi-cultural. This challenge could be eliminated if a broader study is undertaken, representing different regions and communities of Kenya.

Despite the above limitations, the findings of this study are useful in highlighting the status of preventive reproductive health services for adolescents within a developing country context. The findings, to a large extent, corroborate previous studies conducted worldwide. The study is therefore useful and applicable within a Panafrican and even global context.

## **8.4 Policy Recommendations and Way Forward**

Adolescent reproductive health is not only a public health concern but also a policy issue. This study has vital policy implications for enhancing adolescents access and use of preventive reproductive health services (PRHS). This study has demonstrated that policy, ethical, structural, institutional, interpersonal, communication, cultural and societal barriers need to be effectively and aggressively addressed to enhance adolescents access and utilisation of PRHS; and to address the causes of sexual and reproductive health problems facing adolescents. This study has specific policy and programme recommendations that need to be considered. They include the following.

### **8.4.1 Intensify efforts to provide adolescent-friendly and gender-specific PRHS**

The findings that there were no adolescents-friendly/specific services in Murang'a District imply the need for the government to intensify efforts to establish adolescent centres in Kenya. The aim should be to ensure adolescents equal access to information and services. Although this study restricted itself to one district, the findings reflect the general situation in most districts of Kenya. As a first step, the government, schools, NGOs, CBOs, and FBOs need to formally acknowledge that adolescents have sexual and reproductive health (SRH) needs and concerns, and that they need to access and utilise PRHS. This should be followed with provision of the services to adolescents.

Further, there is need to engender adolescents' sexual and reproductive health services. This should ensure that adolescent health programmes and interventions target the unique and individual needs of boys and girls. Efforts to respond to adolescents health concerns should consider the socio-cultural confinements of boys and girls regarding sexual health matters. The services should address diverse SRH needs of adolescent boys and girls that encompass prevention, protection, health promotion, and care. They should also enhance adolescents access to factual SRH information and



education, to confidential guidance and counselling services, and to curative and referral services. To accomplish this, the government needs to do the following: -

1. The government (through the MoH) needs to establish comprehensive freestanding or integrated adolescent friendly-services in Murang'a District, and in the country at large. It should ensure that adolescents are provided with accessible, acceptable, confidential, flexible and friendly health services that they can identify with.
2. Allocate a budget and provide enough funds for establishment of adolescent clinics countrywide and for equipping them with videos and IEC materials that are suitable for adolescents.
3. Establish voluntary counselling and testing (VCT) centres in Murang'a District and other rural areas. As much as possible, VCT services should be integrated into adolescent-friendly and PRHS. The aim should be to ensure that VCT services are available for adolescents who need to access and use them.
4. Provide information, advice, education and counselling to adolescents about maturation, growth and development across the lifespan, relating with peers, parents and adults, personal hygiene and cleanliness and dealing with rape.
5. Provide promotive and preventive reproductive health services. These should include preventive care such as counselling and testing services for pregnancy and STDs; provision of contraceptives (including condoms); intervention, treatment and referral services; provision of delivery services including pre- and post-natal care, pre- and post-abortion care, and rehabilitation services to address drug use related problems, as well as services promoting abstinence.

#### 8.4.2 Standardising adolescents' PRHS and programmes

This study has shown lack of uniform adolescent health services. The government in partnership with policy makers, programme planners and health providers need to harmonise and standardise adolescent health programmes in Kenya. There is need for stakeholders' consensus about the content, depth and quality of adolescent PRHS package. The aim should be to ensure adolescents have access to reasonable, comprehensive, and uncensored sexual and reproductive health information and services; and to ensure uniformity and accuracy of information provided to adolescents. Although the study findings show overwhelming need for adolescent PRHS, they also show lack of consensus on the type of services that should be provided to adolescents. Divergent views persisted among health providers and key informants on whether to offer PRHS to adolescents, especially contraceptives. The NGOs and CBOs need to be actively engaged in developing an adolescent PRHS package. This would reduce the need to censor and vet school-based sexuality services.

Further, there is need to develop a checklist for periodic monitoring and evaluation of adolescent PRHS. The checklist should form the starting point for monitoring the reproductive health status and outcomes of adolescents. It should also be enforced and used as reference documents for ensuring that all adolescents, irrespective of gender, age, marital status or locality, have access to full range of PRHS. Also the content and quality of services offered to adolescents need to be continuously monitored and evaluated.

#### 8.4.3 Prioritising pre-exposure PRHS and enhancing outreach programs

This study has established that existing PRHS and policies largely address post-exposure reproductive health needs. Accordingly, adolescents seek post-exposure services like ANC, post-abortion care or treatment for STIs, as opposed to pre-exposure

services. The government, in collaboration with strategic stakeholders like the MoH, MoE, NGOs, CBOs and FBOs need to strengthen and boost availability of pre-exposure PRHS for adolescents. To achieve this, the government needs to do the following: -

1. Encourage adolescents to seek pre-exposure PRHS and not just post-exposure services. This can be achieved by educating adolescents about available PRHS for them, and by addressing barriers that hinder their access and use of the services.
2. The government should adopt and enforce policies that promote provision of PRHS to adolescents. Adolescents access to PRHS should be enhanced and provided through the public and private health facilities, schools, NGOs, CBOs, FBOs and appropriate community forums. The government should also intensify community awareness about the benefits of early access and utilisation of PRHS by adolescents. This would help to destigmatize PRHS.
3. Strengthen and scale-up PRHS and outreach programmes for adolescents. The government should support health providers/caregivers to provide PRHS to adolescents within and outside the health care facilities, in communities and places most frequented by adolescents. The government needs to designate specific staff to coordinate and oversee implementation of PRHS and outreach programmes for adolescents. It should also provide health providers with adequate and reliable transport means to enable them to effectively reach adolescents.
4. There is need to assess and improve health institutions' capacity (human and technical) to provide comprehensive and confidential PRHS. Further, there is need to address staff shortages and enhance equitable distribution of staff in all regions. The government needs to train more staff to specifically serve adolescents and reduce or limit staff transfers. Further, it should continuously assess and evaluate the training needs of health professionals serving adolescents, and constantly update them on global reproductive health issues of adolescents.

#### 8.4.4 Improving school-based adolescent PRHS

There is need to improve and strengthen school health services to make them adolescent-friendly, comprehensive and responsive to sexual and reproductive health needs of adolescents. This is particularly important because most adolescents spend their adolescence period in school. To achieve this, the following is needed: -

1. Schools should strengthen guidance and counselling services. They should ensure availability of regular, intensive and programmed guidance and counselling. Schools that do not have guidance and counselling should initiate them.
2. The Ministry of Education and the schools need to carefully assess and evaluate the relevance, usefulness, and effectiveness of family/growth and academic families, HIV/AIDS integrated curriculum. The quality of school health services should be regularly reviewed and strengthened accordingly.
3. The Ministry of Education (MoE) in collaboration with the Ministry of Health (MoH), and relevant stakeholders, need to develop a school-based sexual health services guidance and counselling curriculum. The curriculum should be used and followed by the guidance and counselling teachers and counsellors to ensure complete and comprehensive coverage of ASRH issues, and avoid repetitiveness of topics. The guidelines should be constantly reviewed to ensure their applicability in provision of school-health services. Further, the MoE in partnership with the schools and counsellors should source and provide adolescents with IEC materials covering a range of ASRH issues i.e. books, pamphlets, handouts.
4. School authorities should strive to build the trust and confidence of adolescents in school health services. Adolescents privacy and confidentiality should be enhanced at all times during service provision. To do this, schools should have

separate guidance and counselling office to ensure availability of confidential and individualised services. They should also ensure that the services are provided by friendly and non-judgemental caregivers/counsellors, and that treatment and referral services ensure adolescents confidentiality. Although testing for pregnancy may be necessary, it should not be punitive or used as an opportunity to provide crisis guidance and counselling. Further, school caregivers and counselling teachers serving adolescents should be sensitised about ASRH needs. They should also be trained and equipped with necessary communication skills to help them effectively serve adolescents.

5. There is need to strengthen school health treatment and referral services. School should adopt less restrictive regulations, integrate referral services with school learning programmes, and shorten and enhance the referral process. Schools should liaise with healthcare providers to design appropriate school health referral services. This may include allocating specific consulting hours or rooms for in-school adolescents. This would minimise the need to accompany adolescents to health facilities, reduce delays among adolescents in seeking services, enhance communication between adolescents and health providers, and ensure adolescents access to confidential reproductive health services.

#### 8.4.5 Establishing clear policy framework on adolescents PRHS

Effective PRHS provision to adolescents is tenable if there exists clear and comprehensive policies and guidelines for provision of adolescent health services. The government needs to develop clear and standard adolescent health policies and guidelines to be followed in the delivery of adolescent PRHS. The policies and guidelines should be adolescent-friendly and emphasise promotion of PRHS. Further, the government needs to ensure that the policies and guidelines are available and accessible to relevant stakeholders, and are used to guide provision of PRHS service to

adolescents. To achieve this, the government needs to intensify dissemination of information regarding existing adolescent reproductive health policies. It should also sensitise health providers on the need to implement the policies. Further, adolescents should be informed about existing reproductive health policies that give them the right to access and use PRHS.

Once developed, the policies and guidelines need to be regularly reviewed, revised and updated accordingly. The government in collaboration with relevant stakeholders need to constantly ensure the relevance and effectiveness of the policies and guidelines in addressing diverse reproductive health needs of adolescents, and in meeting the challenges and realities of the 21<sup>st</sup> Century as stipulated in ICPD Program of Action.

#### 8.4.6 Formulation of appropriate working definition of ‘adolescent’

In chapter two and six (Sections 2.2 & 6.2.2), we have established that there is no universal definition of adolescent. A universal definition of adolescent is vital. The government in collaboration with relevant stakeholders needs to develop a clear and acceptable working definition of ‘adolescent’. The definition should clearly stipulate the age and gender-specific services that should be offered to adolescents. The government needs to adapt, or borrow and appropriately modify the WHO definition, which defines adolescents as persons aged 10 – 19 years.

#### 8.4.7 Addressing ethical, structural and institutional barriers.

Evidence in this study suggests that adolescents have no adequate access to confidential PRHS. There is need to reconcile and streamline policy, practice and ethical issues to ensure that a safe and supportive environment is provided for adolescents seeking PRHS. Adolescents need to be guaranteed and accessed their right

to confidential services. Legal requirements for parental consent, and restrictive and rigid school regulations that result in breach of adolescents right to confidentiality need to be assessed and reviewed. Further, the government should improve the structural set-up of health facilities and ensure that the service environment promotes adolescents privacy and confidentiality. The aim should be to reduce suspicion and fear of breach of confidentiality among adolescents. To achieve this, the following needs to be done: -

1. The government needs to provide regular and appropriate in-service training for health providers/caregivers to continuously remind them of the need to uphold adolescents right to confidentiality and privacy when serving adolescents.
2. Health providers should seek parental involvement when absolutely necessary, taking into consideration the need to protect and safeguard the rights of ‘minors’ to privacy and confidentiality. They should also promote parental awareness (*Parents Guidance and Counselling*) about the need to provide confidential services to adolescents.
3. The Ministry of Health needs to adopt appropriate labelling of health care services that reflects inclusiveness of adolescents. The Program for Appropriate Technology in Health (PATH), 2003 recommends that ‘an attractive board with a “Youth-Friendly” logo should be put in front of the youth centre’. Further, promotion boards should indicate that services are “free for charge”.
4. There is need to institutionalise and ensure privacy and confidentiality in the entire service provision path. This includes the intake process, at the waiting area, and during service provision. Health providers need to ensure adolescents access to confidential services that are provided in a friendly environment at all times.
5. Ensure availability of adequate space and consulting rooms. As much as possible, health facilities should have separate and specific consulting rooms and hours for adolescents to avoid mixing adolescents with adults; and to ensure that maximum

privacy and confidentiality is accorded during service provision to all clients/patients, and not only to the adolescents.

6. The health facilities should ensure availability of condoms at the health facilities and other outlets that are accessible to adolescents. There is need to ensure that condom dispensers are placed in private and appropriate places that promote privacy and confidentiality of adolescents. As much as possible, condom distribution should be integrated in adolescent PRHS.

#### 8.4.8 Enhancing awareness about available PRHS for adolescents

The government needs to intensify efforts to inform awareness and educate adolescents about PRHS that are available for them. Brochures containing information about ASRH services need to be developed, published and disseminated to adolescents and strategic stakeholders including parents, schools, health providers/ caregivers, FBOs, CBOs and communities at large. The aims should be to: ensure availability of correct and complete information about available PRHS for adolescents; enhance adolescents awareness about the need to access and utilise the services; and to reverse the perception that sexual and reproductive health services are for adults, women and the married. This would also help to reduce the stigma associated with the services.

#### 8.4.9 Enhancing adolescents-health providers/caregivers communication

There is need to foster greater adolescent-provider interaction and to eliminate communication barriers between adolescents and health care providers. Socio-cultural factors that impede open communication between adolescents and health providers should be addressed. The aim should be to enhance open sharing and communication. To do this, the following needs to be done: -



1. The government needs to encourage and sensitise health providers/caregivers and professionals serving adolescents to demonstrate some amount of cultural and professional sensitivity when serving adolescents. Health providers should be flexible and create a friendly environment to encourage adolescents to approach them and share their sexual health concerns with them.
2. The government should enhance training and sensitisation of health providers and professionals about the need to be non-judgmental and to spearhead open sharing and discussion on sexuality issues with adolescents (*straight talk*). It is imperative that health professionals serving adolescents are impartial, non-judgemental, understanding, caring, sensitive and empathetic to the needs of adolescents. Consequently, adolescents would feel respected and cared for. They would be motivated to access and utilise PRHS and to open up to the health providers/caregivers.
3. The health providers/caregivers should recognise and address interpersonal factors that enhance communication between them and adolescents. Aspects that foster increased communication should be recognised and promoted. These may include age and gender of health providers, and provider's uniform and identification.
4. The government needs to initiate and support training of adolescents to equip them with basic negotiation and communication skills. The aim should be to help adolescents relate and communicate effectively with both the peers and adults about sexual health matters.

#### 8.4.10 Establishing parent guidance and counselling programmes

The government needs to start parent guidance and counselling, and support services. The aim should be to sensitise parents about issues related to adolescent sexual and reproductive health. Adolescents in this study stressed the need for parents'

guidance and counselling to improve parents understanding of ASRH needs and behaviour. Adolescents wished that their parents could openly discuss sexual health matters with them, and be less suspicious of their behaviours. This study has shown that good and open communication with trusted and non-judgemental adults especially parents can significantly influence adolescents ability to openly access and utilise PRHS, and to freely open up to the health providers. To achieve this, the following needs to be done:

1. Health providers and other caregivers need to carefully assess and recognise adolescents who experience problems in communicating with parents (adults), and devise appropriate strategies for addressing the problems.
2. The government should enhance sensitisation of parents who include teachers, health providers and caregivers, on the need to be open to adolescents. The parents should be informed about the need to enhance open sharing and communication about sexual health matters with adolescents, and the need to encourage adolescents to access and utilise PRHS. This study shows that parents, teachers and health providers/caregivers significantly influence adolescents level of access to information and services. The government should devise programmes aimed at equipping parents with skills and knowledge to understand adolescent development, to discuss sensitive issues without embarrassment, and to provide a supportive environment for adolescents. The programmes should be continuously and rigorously evaluated. Strategies that prove effective in enhancing adolescents access and utilisation of PRHS should be adopted as ‘best practices’ for expanding provision of adolescent PRHS in Kenya.

#### 8.4.11 Enhancing coordination of adolescent PRHS and stakeholders' participation

There is need to harmonise and effectively coordinate adolescents health programmes and interventions in Kenya. Departments dealing exclusively with adolescents health issues need to be established at the national, provincial and district level. The aim should be to ensure continuity of adolescent health programmes, availability of staff, and provision of logistical support to the departments dealing with ASRH matters. In addition, the government needs to establish a national coordinating council to monitor and coordinate adolescent health programmes in Kenya. The council should help to eliminate unnecessary duplication of efforts, reduce gaps in provision of PRHS to adolescents, and enhance cost effectiveness by mobilising and pooling available resources. The council should have nationwide representation with branches at the provincial and district level to ensure a smooth link between the national and the grassroots levels. It should be multi-sectoral and multidisciplinary, and comprise representatives from the public and private sectors. These should include public health professionals, policy makers, researchers, social workers, counsellors, religious leaders, teachers, parents and community representatives.

Further, there is need for stronger public/private partnership and for greater involvement and participation of the 'third sector' in adolescent health matters. Accordingly the government needs to recognise and strengthen efforts by schools, religious institutions, NGOs, CBOs and FBOs to provide adolescent health services. Joint partnership and stakeholders participation is needed to effectively provide adolescent health services, and to confront the challenges facing adolescents in accessing and using PRHS. The Ministry of Health should take overall responsibility for control and regulation of adolescent health programmes.

#### 8.4.12 Enhancing participation and involvement of adolescents

There is need to recognise that adolescents are partners in their own health. The government, policy makers, researchers, teachers and other professionals serving adolescents need to actively involve adolescents in planning and making decisions about their sexual and reproductive health matters. This should include sitting in the HIV/AIDS committees and being provided with appropriate information. As much as possible, adolescents should be incorporated and participate in developing, reviewing and revising adolescent reproductive health policies. Adolescents should also be actively involved in planning of adolescent health programmes, designing and formulation of the contents of the services, and in the implementation of reproductive health interventions targeted to them. This would ensure the relevance, effectiveness and gender-responsiveness of policies, programmes, and services. In doing this, the government and other key actors would be acting in line with the ICPD Programme of Action that recommends greater involvement and participation of adolescents in their health. Thus, ‘the owners of the body’ need to be engaged and involved. If necessary affirmative action should be adopted as noted below.

*Interviewer: Do you have any additional information?*

Key Informant 1, “Appeal to govt, NGOs and community at large to remember adolescents who are a group which has been forgotten, even when we talk about HIV/AIDS. Affirmative action should be advocated for the youth. They should be involved in the HIV/AIDS committee and not the old to represent them. The owners of the bodies are often not involved in reproductive health issues... this is a human rights issue...”

The findings of this study concur with previous studies that underscored the need to involve adolescents. Hurrelmann (1990), for example argued that if interventions targeted at young people are to be accepted by them, and the immense potential for interventions in this age group is to be realised, their own viewpoint must be investigated and incorporated into programmes. Goodburn and Ross (2000) also argued

that despite the resource constraints, planners and policy-makers should invest in young people so that they themselves become a resource for delivering health interventions to their peers. They further noted that programmes for young people should be developed with them and not just for them. They noted that young people often have radically different perceptions and priorities about health and disease, and respond to different messages, from adults. Hocklong et al. (2003) however noted that initiatives rarely take bold steps to reinvent services or adopt educational strategies from a youth perspective. The findings of this study confirm observation by Hocklong et al. and imply the need to effectively engage adolescents in sexual and reproductive health matters. This is key in promoting their health, encouraging health-promoting behaviours, and maximising the benefits of prevention efforts.

#### 8.4.13 Implications for future research

This study has addressed an important public health topic by focusing on adolescent sexual and reproductive health. It has contributed vital information that can help to bridge knowledge gaps about PRHS for adolescents. By focusing on a developing country - Kenya, and a rural district - Murang'a, the study has highlighted the challenges adolescents in developing countries and in rural settings face, and are likely to face, in accessing and utilising PRHS. Despite the contributions, the study has identified knowledge gaps that merit further research. Further qualitative and quantitative research is needed in the following areas:

1. Conducting and collecting baseline data on the sexual and reproductive health situation of adolescents in Kenya, and in Murang'a District.
2. The government needs to explore different strategies to address sexual health concerns of adolescents. One possibility would be to start and implement *Health Promoting Schools* programmes. To do this, a research is needed to explore

applicability and acceptability of a *Health Promoting Schools* concept/ programme in the Kenyan context. The concept modelled along the European Network of Health promoting schools<sup>8</sup>, is used in European settings to improve school health services. However, its suitability needs to be assessed, taking into consideration Kenya's diverse socio-cultural contexts and environment.

3. There is need to undertake studies to investigate role of religious organisations (FBOs) in adolescents sexual and reproductive health, particularly male circumcision. The findings of this study show increased response by FBOs to respond to adolescent health issues. This seems contrary to the wide-held perception that FBOs resist efforts to offer sexual health education and services to adolescents. Further research is needed to understand the paradigm shift.
4. Explore the prevalence of sexual exploitation and coercion of adolescents, for instance, increased rape incidences and the effect on adolescent sexual and reproductive health.
5. Investigate the persistent practice of FGM in Murang'a District. The study learnt that the harmful FGM practice prevails in Murang'a District. Research is needed to understand why the practice persists despite the wide perception that FGM practice has died in the district.

#### 8.4.14 Implications for theory

This study followed a life-course theoretical approach. The theory treats adolescence as part of the lifespan and of human growth and development. The findings of this study have demonstrated the relevance and applicability of the life-course theoretical approach in research focusing on adolescent PRHS. Specifically, the notion of *healthy adolescents* has been demonstrated in this study. This notion asserts that

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<sup>8</sup> [http://www.who.dk/ENHPS/evaluation/20020605\\_1](http://www.who.dk/ENHPS/evaluation/20020605_1)

adolescents experience a relatively troublesome free and healthy transition to adult life, that they are in the physically healthiest developmental period in the life-cycle, and lack major health problems (Green and Davey, 1995; Perry, 2000). This notion is relevant in this study in highlighting the reasons for failure to prioritise adolescent reproductive health issues, and to plan and provide PRHS for adolescents. It also helps to explain the social exclusion and marginalisation of adolescents from provision, access and use of PRHS. The notion of *healthy adolescents* also supports the finding of a few adolescents, who cited lack of felt need as their failure to access and utilise health services.

The contemporary theorists' notion of adolescence provides theoretical and conceptual explanations for the major study findings. First it acknowledges the health threats of the present day adolescents. The diverse reproductive health concerns and challenges raised by adolescents in this study support this view. The maturation and developmental concerns raised by adolescents confirm the contemporary theorists notion, which emphasises the role that biological factors like hormonal changes, somatic changes, or changes in reproductive maturity, play in shaping the adolescence experience. Further, the fact that adolescence period need not inherently be problematic bears evidence in this study. If adolescents are included in health care system, their health issues prioritised, and appropriate PRHS provided for them, the sexual health risks facing them would be minimised. Adolescent focused, sensitive, age and gender specific programmes and strategies, if developed and implemented would curtail the negative effects of biological influences, hormonal changes or changes in reproductive maturity (Kipke, 1999; Steinberg, 2001). Thus adolescents need not incur or experience sexual health risks. Instead, they need to be assisted to transmit smoothly into adulthood.

The findings of this study show increased awareness and recognition of the sexual health risks facing adolescents, and the need to offer PRHS to adolescents. The findings also show efforts being made to address sexual health challenges facing adolescents, albeit inadequate. The findings are in line with international health policies and debates. The need to recognise the unique sexual and reproductive health needs and

vulnerabilities of adolescents is expressed internationally. This has been a topic for policy discussion in international summits and meetings which have made recommendations regarding protection of adolescents health. These include the 1994 ICPD conference, the 1995 Beijing Conference, the 1999 five-year review of ICPD (ICPD+5), the 2004 ICPD+10 Dakar conference, and the Millennium Development goals. This indicates that adolescents' sexual and reproductive health is a global public health issue that calls for global and glocal response.

In response, several countries – particularly developed countries like the United Kingdom and the United States of America - have initiated 'youth information centres' and 'youth-friendly' clinics. In Murang'a District, the concept of adolescent-friendly services is not well understood. Also adolescent/youth-friendly services are largely lacking. Existing services do not adequately and comprehensively address sexual and reproductive health needs of adolescents. Many adolescents have no access to reliable, confidential, affordable and acceptable PRHS. The services, if available, are concentrated in urban areas leaving adolescents in rural areas with no access to services. Adolescents in rural areas continue to be socially excluded from mainstream reproductive health services. Thus commitment by the government to offer comprehensive adolescent-friendly services remains as mere rhetoric. This translates into a gap in the life-course where adolescents are not well equipped to deal with transition challenges. Social exclusion of adolescents from reproductive health services means that they continue to face sexual health risks, which they may well carry into adulthood. To close the missing link, there is need to integrate adolescent period with other development stages in the life-course. The aim should be to move from the problem-based adolescent period to a healthier adolescent period.



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## **APPENDICES**

### **Appendix A: Data Collection Instruments**

## STUDY ON HEALTH SERVICES FOR ADOLESCENTS IN KENYA

Researcher: Anne Kamau, School of Public Health, University of Bielefeld, Germany  
Tel: +49 174 5487116 or +254 722 319359. Email: kamau.anne@gmail.com

### ADOLESCENTS INTERVIEW QUESTIONNAIRE

Tapes labelling format (e.g. 2 1 2)		
Interviewer	School	Respondent
1. A	1. Kamacharia	1. Boy
2. B	2. Kiria-ini	2. Girl
3. C	3. Kiru	
4. D	4. Kiangunyi	
	5. Wahundura	
	6. Kangema	
	7. Njumbi	

#### Bio data:

1. Name.....
2. Can you please tell me your age?
3. Please tell me whether you live with your parents? (both, one, other)
4. What is the occupation of your parents?
5. Can you please tell me your religious affiliation?

Young people like yourself experience body and emotional changes as they grow up. They also have needs and concerns about their health and they sometimes wish that they can get someone to talk to and share these concerns. I would like to ask you some questions about your main health concerns and how you try to cope or deal with them. Please feel free to ask any questions or seek clarifications. The information that you provide will be treated with utmost confidentiality and will not be used for any other purpose other than this study. Participation in this research is voluntary and you are free to withdraw your participation at any time.

#### Reproductive health services:

6. Now X..... what do you think are the major health problems facing adolescents in Kenya today?
7. As far as you know, is anything being done by the government, NGOs or other organisations to address these concerns? Please explain.
8. Please tell me, does your school provide you with information and services that can help you to meet these concerns? Please explain
9. In your opinion, do you think that it is necessary for adolescents like yourself to be provided with sexual health services? Please explain.
10. (For girls, if boy **go to 11**) Can you tell me what are some of the services that you feel should be provided for adolescent girls?
11. (For boys, if girl **go to 12**) Can you tell me what are some of the services that you feel should be provided for adolescent boys?
12. Please tell me about organisations that know of which offer sexual health services.

13. Do these organisations that you have mentioned above, offer sexual health services to adolescents in Murang'a? (*If no **go to** 15*)
14. If yes, please name them and tell me what kind of services they provide.
15. If no, please tell me whether you know of any other organisations in Kenya that offer sexual health services to adolescents? (*If none **go to** 30*)
16. What kind of services do the organisations that you have mentioned in 12 above offer to adolescents?
17. How did you learn about these organisations?

Use of services:

18. Please tell me if you have ever received services from any of the organisations that you have mentioned above? (*If no **go to** 30*)
19. If yes, what kind of services did you received from these organisations?
20. Why did you choose to use services from these particular organisations?
21. Can you tell me whether anyone prompted you to go to these organisations?
22. Can you tell me whether anyone accompanied you to receive these services?
23. Did you have any difficulties in locating the organisations? If yes, please explain
24. Please tell me whether you had to pay to receive the services. (*If no **go to** 26*)
25. If yes, did you find the services affordable? Please explain
26. Please tell me some of the things that you liked about the service that you received?
27. What are some of the things that you felt could have been done better?
28. Please tell me, whether you were satisfied with the services that you received?
29. Did you receive additional information about sexual health matters, for example, how you can protect yourself or someone else from getting sexually related illnesses, pregnancy and HIV/AIDS? Please explain. (***go to** 30*)

Never used service:

30. If you have never used the services, why is this so?
31. Do you know of someone else who has used the services mentioned above? Please explain (*If no **go to** 30*)
32. Please tell me the extent to which they were satisfied with the services that they received.
33. Please tell me, is there any time that you had a sexual health need but you did not know where to get information, advice or service? Please explain
34. Is there any additional information that you would like to share with me about other services or information that are necessary for adolescents?

*Thank you for your time - END*

## STUDY ON HEALTH SERVICES FOR ADOLESCENTS IN KENYA

Researcher: Anne Kamau, School of Public Health, University of Bielefeld, Germany  
Tel: +49 174 5487116 or +254 722 319359. Email: kamau.anne@gmail.com

### HEALTH PROVIDERS' INTERVIEW SCHEDULE

Bio-data:

1. Name of the organisation:.....
2. Name of the expert:.....
3. Position in the organisation:.....

*As the .....at this institution, I am sure that you have a wealth of experience in reproductive health matters. I would like you to share this information with me. At this juncture, I would like to ask you a number of questions. My first question to you is,*

- 4.
5. What do you think are the major health concerns/challenges facing adolescents in Kenya and in the district today?
6. As far as you know, is anything being done by the government, NGOs or other agencies to address these issues or concerns?
7. Please tell me about the reproductive health services that are offered, at this institution/ in the district etc.
8. Among the services that you have mentioned, which ones are offered especially for adolescents?
9. Can you tell me how your institution/ organisation is involved in provision of reproductive health services to adolescents in the district?
10. What are some of the challenges that you or your institution/ organisation face in offering reproductive health services in general?
11. Do you or your institution/ organisation face any specific challenges when offering reproductive health services to adolescents?
12. In your opinion, how best can these challenges be resolved?
13. Can you please tell me about the existing government policies on reproductive health care in Kenya?
14. In your opinion, how do these policies influence provision and utilisation of reproductive health services by adolescents in the district?

15. Can you please tell me what are the major challenges in implementation of these policies.

16. In your opinion, how best can these challenges be addressed?

Additional questions for the service providers (MoH)

17. Can you tell me about the reproductive health services that are most sought by the adolescents at your health centre/ facility?

18. About how many boys/girls seek reproductive health services from your health centre/ facility per day

19. Are the services offered in the same setting as those of the adults?

Additional questions for the District Education Office (DEO)

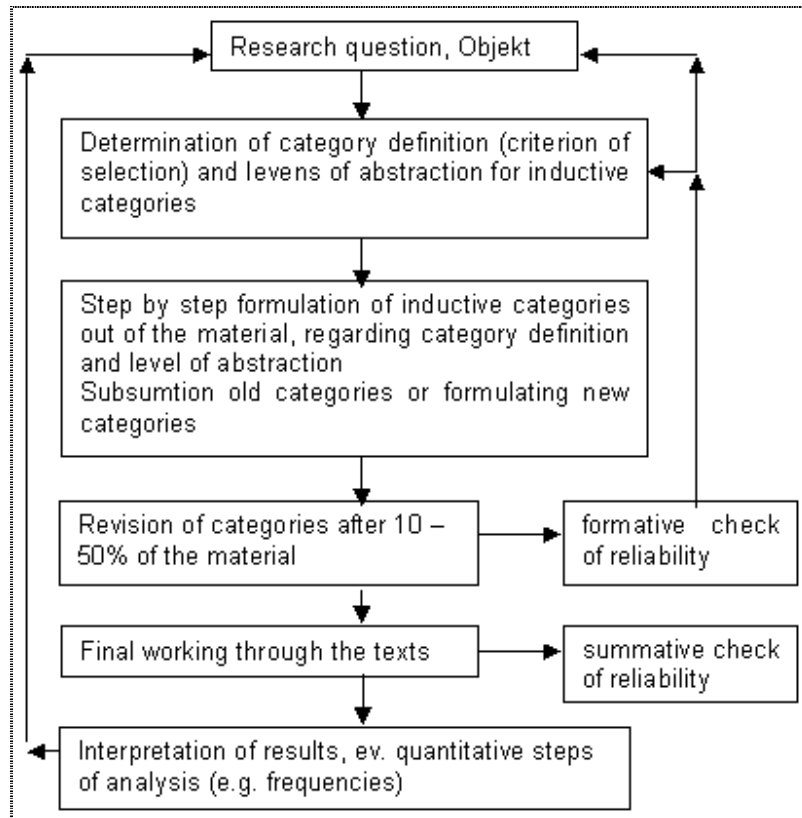
20. I know that there have been plans to implement the family life education (FLE) in schools, to what extent has this been successful in the district?

Closing question for all:

21. Is there any additional information that you would like to share with me?

*Thank you for your time – END*





Source: Mayring, 2000

## Appendix B: Step model of inductive category development

(NB: read '*Objekt*' as '*objective(s)*' and '*levens*' as '*levels*').