SRHR alliance

Exploring the factors that influence access to SRH services for young people in Kenya: A study of three different health service models used by the FHOK

Final Report

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SRHR alliance

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The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.

Contents

Abbreviations

ASK	Access, Services, Knowledge
ASRH	Adolescent Sexual and Reproductive Health
CCC	Comprehensive Care Clinic Alliance
FGDs	Focus Group Discussion
FHOK	Family Health Options Kenya
FGM	Female Genital Mutilation
IDI	In-depth Interviews
IGAs	Income Generating Activities
KIIs	Key Informant Interviews
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, queer or questioning
MYP	Meaningful youth participation
OR	Operational Research
PLHV	Person living with HIV /AIDS
PMTCT	Prevention of mother-to-child transmission
RAs	Research Assistants
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
YFS	Youth Friendly Services
VCT	Voluntary Counselling & Testing

Executive summary

This study was conducted to explore factors affecting access to SRH services for young people in three different health service models implemented by FHOK: stand-alone, integrated, and regular health facility; and factors influencing effective and meaningful youth participation. The study sought to:

- Explore perception of young people aged 15-24 years on the different health service and information models of stand-alone, integrated, and regular health facility in ASK implementing regions
- Investigate factors affecting utilization of information and services (inhibitors and enhancers) in stand-alone, integrated, and regular health facility models by young people aged 15-24 years in ASK implementing regions

The study used a mixed methods (quantitative and qualitative) cross-sectional approach. The qualitative study involved carrying out of KIIs with service providers from the ASK program and FGDs with groups of youth (both boys and girls) between 10 and 24 drawn from the general population and special groups of young people including sex workers, LGBTI, YPLWHIV, disabled, and refugees. A total of 24 KIIs and 27 FGDs were conducted, tape recorded and transcribed verbatim. A quantitative survey using a structured questionnaire was conducted with 619 participants. The questionnaire included both close-ended and open-ended questions.

Three most sought services disaggregated by health facility models were: VCT for HIV services (68.4%, 130); STI counselling and treatment (51.1%, 97) and family planning services (50.0%, 95) in the regular model; SRH Education (82.9%, 175), VCT for HIV (71.1%, 150) and family planning services (42.2%, 89) for integrated model; and, VCT for HIV (81.9%, 167), SRH Education (77.5%, 158) and STI counselling and treatment (59.3%, 121) for stand-alone health facility model. VCT for HIV services was the most commonly sought service across all the three youth friendly. In general, young people in the study were more likely to seek services from the integrated model, followed by the Stand Alone Model and the Regular Models in the last year preceding the survey.

Some of the factors that affected young people's ability to use SRH information and services cited by the respondents included unavailability of services, lack of a friendly environment at the facility; perception of whether they would get confidential services and attitude of the providers. The qualitative study revealed that the young people experienced other barriers when seeking SRH information and services: Perceived high and unaffordable cost of services; self-imposed stigma related to in seeking STI/HIV services and contraception; fear of knowing HIV status; and cultural and religious norms.

Generally, majority (88.3%) of all youth interviewed in the three models reported that they liked the information or service received. Some of the noted strengths of services are: Guaranteed privacy and confidentiality of youth; pocket friendly or free SRH services for youth under 25 years; many SRH services under one roof; trained service providers offering good quality services and LGBTI friendly; clean and comfortable environment; provision of additional SRH information and counselling; non-discriminatory in offering services to all groups of persons including lesbians, gays and bisexuals and sex workers; and young friendly service providers. Among others, this study recommends that FHOK focuses on creating a friendly environment in their facilities and creating awareness about the facility

to generate demand for the SRHR services and information. FHOK can also promote outreach services to reach the hard to reach youth with SRHR information and services. Most importantly, FHOK needs to develop targeted health services for the special groups, train service providers on strategies of serving special groups and increased awareness creation of YFS services among youth should go alongside engagements with parents/communities for support.

1.0 Introduction and background

Family Health Options Kenya (FHOK) is a pioneer in reproductive health programmes in Kenya, which offer a wide range of integrated sexual and reproductive health and HIV/AIDS services targeting young people and the general public. It has presence in all urban areas covered by the Reproductive Health Initiative and has a strong grassroots network of 61 member branches in 49 districts, twelve (12) static medical centres popularly known as "Family Care Medical Centres" and youth centres with strong community outreaches. These are found in Nakuru, Eldoret, Kisumu, Meru, Thika, Bondo, Kakamega, Malindi, Mombasa and Nairobi, which has three facilities. FHOK currently has 150 fulltime staff with part time medical personnel of forty serving in respective medical centres throughout the country. It is considered a centre of excellence providing capacity building in sexual and reproductive health, quality services as well as championing sexual and reproductive health and other rights.

The Access, Knowledge and Services (ASK) programme is a 3-year programme (2013-2015) funded by the Dutch Ministry of Foreign Affairs. The programme aims to enhance uptake of Sexual Reproductive Health (SRH) services among young people aged between 10-24 years, including underserved groups. In Kenya, the programme is implemented by 15 partners comprising of Africa Alive (AA), Adventist Development Service (ADS), Kisumu Medical Education Trust (KMET), Centre for the Study of Adolescence (CSA), Clinton Health Access Initiative (CHAI), Child Line Kenya (CLK), Family Health Options Kenya (FHOK), Great Lakes University of Kisumu (GLUK), Maximizing facts on AIDS (MAXFACTA), Nairobits Trust, Network of Adolescence and Youth of Africa (NAYA), National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK), UNESCO, Women Fighting AIDS in Kenya (WOFAK) and the World Starts With Me Alumni Youth Advocacy Network (WAYAN).

Under ASK programme, FHOK's youth friendly service (YFS) projects aims at improving the SRHR of young people by reaching them with a minimum package of information and high-quality SRH services and commodities. Various activities are being implemented including; (i) mapping of YFS facilities in Nairobi and Eldoret; (ii) developing and monitoring a referral system for YFS in Nairobi and Eldoret; (iii) subsidizing costs of SRH services for young people through the waiver system;

(iv) static and Mobile outreaches for SRH service provision (VCT, PMTCT), community based distributors and condom dispensers; (v) training health care service providers and facility In-Charges on provision of Integrated YFS services; (vi) community awareness on the importance of SRH service provision; (vii) advocacy debates.

To improve the services (supply-side) and increase uptake, FHOK strives to improve the youth-friendliness, quality and accessibility of its health clinics and clinical outreaches (demand-creation), including ensuring access for youth in the age group 10-24 years. The SRHR/YEA Alliance programmes are guided by the theory of change (see figure 1).

1: Theory of change as applied by ASK Alliance programme

The Alliance partners bring complementarity /synergy supplementing government efforts in striving to realise the MDGs 4, 5, 6 and 8. It is the Country representative in HIFA2015 - (Healthcare Information for All in the year 2015) global campaign. The programme is non – discriminatory and currently puts great efforts to reach all including persons with disabilities with SRHR/FP information and services.

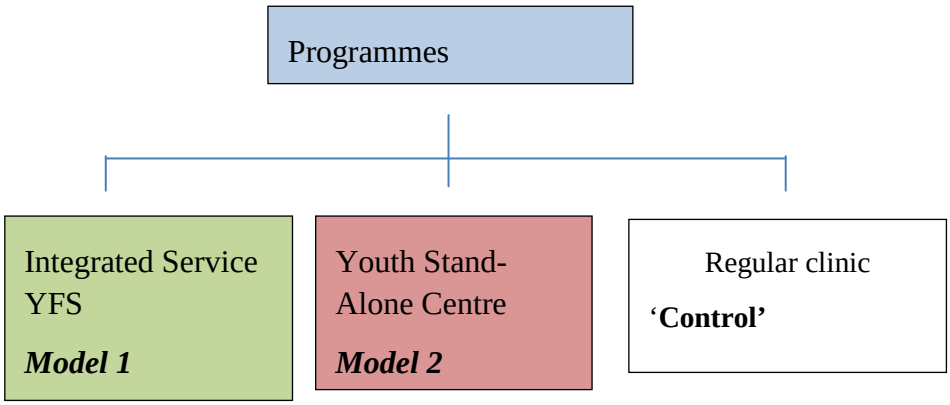
FHOK intervention strategies

To provide a range of supports to young people, FHOK has developed distinct, complementary and specialised projects for the provision of youth friendly services. The projects serve and are organized around 3 health service models:

(a) Integrated service model, i.e. a youth friendly corner within a health facility where young clients' access coordinated youth friendly SRH services and information,

(b) Youth stand-alone facility which are youth spaces providing a holistic response to young people, and

(c) Regular FHOK clinic (general services clinics without special provisions for youth), as illustrated in the following figure.



Model 1: *Integrated service model i.e. a youth friendly corner within a health facility*

Family Health Options Kenya provides Integrated Sexual and Reproductive Health services at the Eldoret Integrated health clinic and Youth centre. The centre started in 2000, has gradually increased its range of services from vertical family planning to Integrated Sexual Reproductive Health such as Maternal and Child Health (MCH), Maternity, Pap smear tests, Laboratory investigations, Pharmacy, Voluntary Counselling and Testing (VCT) for HIV/AIDS, Outpatient treatment and referral.

The Eldoret Youth Centre provides reproductive health information and counselling to the youth aged 10 to 24 years within Eldoret town and its environs. It offers services to young people who are not yet sexually active in order to assist them to delay the onset of sexual activity; to provide reproductive health information and services to the youth aged 10 to 24 years who are sexually active to assist them to prevent and thus reduce the incidence of reproductive health (RH) related problems.

The centre also supports; capacity building for young people to empower and equip them with life skills and knowledge essential to address issues and challenges facing the youth in our society; advocacy for gender equity and equality and eradication of harmful practices, and recognition and prioritization ASRH in policies and programmes; and the improvement of social economic status of young Kenyan men and women. The Eldoret Youth Centre mainly targets the young people within Eldoret town and in Four Divisions namely; Turbo, Kapsabet, Kapsoya and Kesses Divisions.

Youth Centre uses the following strategies to reach young people: lectures & facilitation's, community mobilization, drama/skits, debates, guest speakers/experts, discussions, youth friendly corner, collaboration, Voluntary Counselling and Testing (VCT), peer education activities, library services, recreational activities, entertainment room, information centre among others.

Model 2: *Youth Stand-Alone facility*

The FHOK Youth Centre located in Eastleigh in Nairobi provides an environment that is friendly to young people. The centre begun in 1986 to ensure young people are informed and served with comprehensive reproductive health services. At that time, the prevalence rate of STI amongst the youth was very high and the number of young people who were testing positive for HIV was also on the rise. The access of services by the youth at the clinic was very low and those who sought services did so out of necessity when their situation was in dire need. The service providers at the time realized that most of the young people who came to the facility lacked basic SRH information and engaged in risky behaviours. Moreover, there was a lot of stigmatization of young people who sought RH services at the time and most of them lacked the financial capability to pay for the said services.

The FHOK team felt there was a need to support the access of SRH services by the youth who were in dire need of assistance. In view of this, a youth corner was established within the FHOK Eastleigh Health clinic to attract young people into the facility. The centre uses youth friendly strategies and offers a range of SRH services to young people living in Eastleigh and its environs which include:

- Family planning and other sexual and reproductive health services
- VCT and general counselling on sexuality,
- HIV/AIDS services,
- Girl empowerment sessions,
- Business initiatives and training,
- Knowledge and information services,

- Recreational activities (e.g. gym, arts, theatre, drama, rehearsals and presentations, entertainment) and library.

The centre is run by young people and provides an environment where youths share their life experiences; learn life planning skills, access RH services besides holistic development of other skills. Referral is offered for services not provided at the centre.

***Model 3**: Regular clinic (without special provisions for youth)*

In Kisumu, a Family care Medical Centre was selected, where youth activities are conducted within regular service provision. Although there are no special provisions, young people can still access all available services they may require. The centre offers a range of services aimed at increasing awareness of individual reproductive health as well as the general wellbeing including family planning methods, pap smear for screening cancer of the cervix, safe motherhood services (ANC, Maternity Services, PNC, Post-Partum FP), child health services (Immunization, Growth Monitoring), emergency contraception, unwanted/teenage pregnancies counselling, post abortion care (PAC), management of infertility, STI management, education on adolescent sexuality, general counselling, and other outpatient services such as minor surgery including male circumcision. Other initiatives offered include breast examinations, health talks and other events, family planning updates, linkage and referral for treatment of complicated cases.

Table. 1 Characteristics of the different models

Model type and location	***No. Of Service Providers***	***Range of Cost***	***Operating Hours***
Integrated health facility Eldoret	1 Doctor, 6 Nursing Officers(one directly attached to the youth clinic), I clinical Officer	Curative Consultation varies Kshs 200-500; Family Planning(varies from Kshs 150-2000; Cervical Cancer Screening range 300-800; ANC and PNC – Kshs 200-500; Well Baby Care-200; Comprehensive Abortion Care, Minor Surgical Procedures, Comprehensive HIV-range 100; Laboratory Services - from Kshs 100; Ultra sound Kshs 1800 ; Inpatient: - Maternity services – range from Kshs 35,000-85,000	Outpatient: Mon – Fri - 8.00am to 5.00pm; Sat and Public Holidays 9.00 a.m. to 4.00pm. In-Patient & Maternity: 24 hours, 7 days a week VCT/YOUTH Clinic: Everyday 9.00am to 6.00pm
Stand Alone health facility, Nairobi	Clinical Officer-1 VCT Counselor -1 Lab Technologist-1	Consultation -Kshs100; VCT Kshs 50; Contraceptives range from Kshs 50 – Kshs 800; STI screening and treatment range from Kshs 100- Kshs 1000	Monday – Friday -9:00 am- 6:00 pm Saturday & Public Holidays 9:00 am -3:00 pm
Regular Health facility- Kisumu	Clinical Officer-1 Nursing Officers-2 Pharmaceutical Technologist-1 Lab Technologist-1 VCT Counsellor-1	Consultation- Range Kshs 300-1000; ANC Range- Kshs 100-1000(new clients); Family Planning- Kshs150- 10,000; Male Circumcision Kshs 2,000	Outpatient: Monday – Friday -8.00am to 5.00pm; Saturday and Public Holidays-9.00am to 1.00pm

Study rationale and objectives

Young people are defined as being between the ages of 10-24 years, which is inclusive of the adolescent development age. The term "young people" encompasses a number of different groups such as early adolescents (10-14), late adolescents (15-19), young adults (20-24), urban and rural youth, those in school and out of school, married and unmarried, those who engage in sexual relations and those who do not. All these essentially form the priority target population of the FHOK ASK health service program. These young people are not a homogeneous group and there can be substantial barriers for individuals and cohorts in achieving objective and/or subjective wellbeing.

These barriers exist at various levels, with wellbeing arising out of complex interplay between individual, situational, economic, socio-cultural, institutional and systemic interactions. Those young people whose pathways to wellbeing have been compromised (regardless of the source) are considered to be disadvantaged or vulnerable.

Link to ASK result area and overview of linked program activities

ASK Results focus mainly on: exploring the (factors and actors) that influence access to SRH services for young people [10-24years] in three different health service models: stand-alone, integrated, and regular health facility; and factors influencing effective and meaningful youth participation. The main objective of the OR is to provide FHOK with an accurate estimate of prevailing situation of the different models and how they influence access to SRHR services for young people.

A secondary objective is to provide the program with data on effective ways or strategies to meaningfully involve /engage youth to positively influence on the development, implementation and delivery of SRHR interventions. The assumption embedded in the projects logic is that special provisions for the young people increases the accessibility and suitability of services to young people thereby influencing the uptake of services. This was tested in the study and results proved the assumption right.

Area 1: Reaching the unreached

The ASK program focuses on groups that are highly vulnerable for SRHR problems and that have specific needs. The objective is to better inform Young people, (including LGBTQI, YPLWH, Young adolescents (1-16) and young people in remote areas and disabled young people) with the aim to enable them to make healthier choices regarding their sexuality. The operational research will provide insights into their current SRH needs, knowledge, practices, rights-violations and the target-group specific ‘culture’. This information is used to effectively adjust the program, for example: (1) using effective communication strategies on how to reach these group; (2) tailoring information, including addressing harmful practices; and (3) offering services in a way that are accessible and relevant for the ‘underserved’.

Area 2: Contribution of the public and private health sector to SRH of young people

Public and private, formal and informal, for-profit and not-for-profit health service delivery points can all deliver SRH services to young people. Operational research focuses on identifying and gaining insight into the services currently used by young people, their quality and how specific sectors can be strengthen or collaborations made to improve services and SRH of young people. This research will inform on referral systems for young people, and provide insight in possible ways of collaboration

between the not-for-profit and for-profit health sector and on effective strategies to increase uptake of SRH services by young people.

Study objectives

Whereas standards for provision of youth friendly services have been agreed upon, assessment of different models applying these standards are limited. Therefore, the study hopes to carry out the OR to inform the intervention.

Purpose of the OR

To explore factors affecting access to SRH services for young people in three different health service models: stand-alone, integrated, and regular health facility.

Specific objectives:

- To explore perception of young people aged 15-24 years on the different health service and information models of stand-alone, integrated, and regular health facility in ASK implementing regions
- To investigate factors affecting utilization of information and services (inhibitors and enhancers) in stand-alone, integrated, and regular health facility models by young people aged 15-24 years in ASK implementing regions.

The study reviewed the activities undertaken under the project, results and progress attained with a view to understand the intervention strategies.

Central Research Question

"What are the factors affecting young people's access to SRH information and services in the three FHOK health service provision models; stand-alone, integrated, and regular health centres?"

Specific questions:

1. What are the perceptions and attitudes of young people towards the SRHR information and services provided in the different models?
2. What are the barriers to uptake of services in the three different models?
3. What are the enhancing factors to service utilisation in the three different models
4. What are the factors influencing uptake of services in the three models

Assumptions:

(i) Special provisions for provision of youth friendly services in the three models increases the accessibility of services to young people;

2.0 Study Design and Methodology

This section describes the research design, the sample selection, research tools/instruments, data collection, management and analysis. The research process started with the development and adoption of the proposal and tools by FHOK, Globus Associates and the SRHR Alliance OR working team in Netherlands. Ethical clearance was sought from the Amref Ethical Review Committee.

Research Design: This was a cross sectional survey study focusing on the factors affecting access to SRH services for young people in three different health service models: stand-alone, integrated, and regular health facility in Kenya. The study targeted young people between ages 10 to 24 years old in Eldoret, Kisumu, and Nairobi, where the ASK program has already started by FHOK.

Research methods

A mixed methods (quantitative and qualitative) cross-sectional approach was adopted for the study. The mixed-method research process facilitates the generation of detailed examination of the perception of services in the three service models as well as an investigation of the barriers and enhancers of service uptake in the three models. Survey and qualitative data were collected simultaneously.

Study locations

The study focused on 3 sites: Kisumu implementing the regular health facility model, Eldoret implementing the integrated health facility model and Nairobi which implements the standalone service model. FHOK's stand-alone and integrated Model projects aim to overcome the barriers to accessing sexual and reproductive health services that young people face in accessing SRH services experienced when there are no youth focused centres for serving young people at health facilities. These include lack of quality services, lack of a sense of empowerment, belonging and freedom, social stigma and discrimination.

All the three project sites sampled are urban with relatively similar youthful population. The catchment areas where the centres are located are characterised by low income neighbourhoods, with majority of inhabitants unemployed or in informal 'jua kali' sector with irregular income flows. The three sites are geographically in separate regions of the country with diverse socio-cultural practices.

Sampling of study respondents

The study purposively selected 3 study sites each representing the three health service models used by FHOK. These included: Eldoret representing model 1 (integrated service model), Nairobi representing model 2 (Youth stand-alone facility) and finally Kisumu representing model 3 (regular clinics).

This study used purposive sampling to identify respondents. Purposive sampling identified different groups of respondents known to the FHOK facilities using their outreach networks. Youth peer educators linked to FHOK youth friendly centres were used to identify young people. This included young people visiting the FHOK facilities for their SRH services. The study population included young people from the different age groups, gender and special groups. Although purposive sampling is limited in terms of representation and generality to the entire population, it was used in order to assess whether young people in the catchment areas were accessing and utilising services at FHOK health facilities.

Survey sample size determination: To be able to provide a valid description of SRH information and service utilization with a certain degree of accuracy, the survey included a sample size of about 600 young people for the survey study (a minimum of 200 respondents per site). The sample size was determined basing on three factors: the estimated population of young people who may have accessed the centres (in this case, maximum variability proportion of 0.5 has been used); the confidence level at 95%; and the margin of error at 5%. The following formula was used to determine the sample size per group (males and females).

$$n = D\frac{z^2_{1-\alpha/2}P(1-P)}{d^2}$$

Where:

n= required sample size

D = Design effect (assumed to be the value of 1.5 to account for homogeneity among young people sampled from the same health facilities or catchment area);

P= the proportion of young people who have ever used the services;

$Z_{1-\alpha/2}$= the z-score corresponding to the probability with which it is desired to be able to conclude that the observed proportion would not have occurred by chance; and

d^2 = (Absolute precision required) Precision required is set at ±5%

The sample size of young people who ever used the services was calculated to measure any indicator with a minimum of ± 5% absolute precision. This is done by assuming a proportion of fifty percent in the indicator for the formula above, which provides the most conservative sample size estimate. Any measured indicator will have more accurate absolute precision as the indicator approaches 0% or 100%. When accounting for a refusal rate, this sets the sample size at 450 per group.

Focus Group Discussions

A total of 27 focus group discussions were conducted with users (segregated by sex -male/female; 5 year age groups; special groups and region/service provision model. The special groups interviewed included disabled, LGBTI, sex workers, YPLWHIV and refugee adolescents. Recruitment of young people who participated in the FGD was done in three study sites where FHOK operates SRH clinics. Mobilization of young people affiliated to the FHOK programs was done with the support of the FHOK youth peer educators and service providers. To maximise on interactions and sharing during the FGDs, each comprised of 8 participants. A structured guide with questions on different thematic topics was developed prior to data collection, pre tested and adjusted before administering in FGD. The discussions were moderated allowing for probes on emerging trends and issues. The FGDs were used to explore perceptions to services, the barriers, and enhancers as well as perceived strengths and weaknesses of the health facility models. A summary of the FGDs conducted is presented in Annex 11.

Key informant interviews

A total of 24 KIIs were conducted with the health service providers, youth peer providers, youth representatives and program officers involved in the implementation of the ASK program in the selected FHOK centres. The health service providers and youth peer providers directly offer or manage SRH service and information provision to the young people. The interviews explored perceptions of services, barriers, enhancers, strengths and weaknesses of the health facility models. A summary of the respondents interviewed is presented in Annex 11.

Data collection

The qualitative part of the study involved carrying out of KIIs with service providers peer providers and program assistants from the ASK program and FGDs with groups of youth (boys and girls) between 10 and 24 drawn from the general population and special groups namely: LGBTI, Disabled,

FSW, YPLWH and Refugees adolescents. A total of 24 KIIs and 27 FGDs were conducted, tape recorded and transcribed verbatim. The transcripts were submitted for analysis.

The quantitative survey used a standard, structured questionnaire. The questionnaire included both close-ended and open-ended questions. Completed questionnaires were pre-coded, for easier computerised data entry and processing for analysis. In each study site, at least 200 young people aged 10-24 years were included in the study sample. In total, face-to-face interviews were conducted with 600 participants.

Young experienced research assistants were recruited and trained in research ethics, data collection methods, obtaining consent and maintaining confidentiality. During training, research assistants conducted role plays to sharpen their skill. They also pre-tested the study instruments which were adjusted based on the pre-test experience. The study protocol was approved by Amref Ethical Review Committee.

Data analysis

In analysing the qualitative aspect of the study, a tentative coding framework was developed through reading of 5 FGD and 5 KII transcripts as well as the topic guides used to collect the data. A final thematic framework was then developed after review of the data and the research question for the initial coding and management by QSR Nvivo 10 Software © (International Pty 2012, Australia).

Quantitative data collection tools were edited, cleaned and entered into excel spreadsheet package. The data was cleaned and imported into SPSS version 20 for analysis. Frequencies, bivariate and multivariate analysis were conducted to compare the results the three health facility models. Service statistics from the 3 different health facility models were not availed for inclusion into the quantitative analysis.

3.0 Study Findings

This section presents results from both the quantitative and qualitative assessment. First, we present description of the Socio-demographic Characteristics of the respondents; thereafter, SRH service and information sought and utilized by young people; SRH Information and Service Gaps among the young people; Barriers and enhancers to SRH service and information use among the youth; Perception on how facilities can best serve young people and lastly recommendations for increasing utilization of SRH services and information by young people.

3.1 Socio-demographic Characteristics of the Respondents

Table 2 below shows the distribution of young people's background factors of age (5-year age group), sex, marital status, and educational attainment by type of health facility model. The male/female ratio was almost equal in the three study sites with majority of the young people in the three sites reporting not to be married.

Table 2 Socio demographic characteristics of young people disaggregated by FHOK facility model in the catchment area

Age group (in years)	Regular Model	Integrated Model	Stand Alone Model
10-14	69 (34.0%)	74 (35.1%)	48 (23.4%)
16-19	61 (30.0%)	66 (31.3%)	51 (24.9%)
20-24	73 (36.0%)	71 (33.6%)	106 (51.7%)
Sex			
Male	102 (50.2%)	110 (52.1%)	96 (46.8%)
Female	101 (49.8%)	101 (47.9%)	109 (53.2%)
Marital Status			
Never Married	186 (91.6%)	207 (98.1%)	196 (96.6%)
Married	17 (8.4%)	4 (1.9%)	7 (3.4%)
Education Level Attained			
Primary Level	76 (37.8%)	94 (44.5%)	59 (28.8%)
Secondary Level	86 (42.8%)	56 (26.5%)	65 (31.7%)
Post-Secondary Level	39 (19.4%)	61 (29.0%)	81 (39.5%)

Awareness of where to seek services

The study results show that the majority 83.5% (516) of young people in the survey know at least one facility in their neighbourhood where they could get SRH information and services. Qualitative study findings showed that young people access services at different facilities both public and private including VCT centres and Chemists.

Most of the youth had received the information about SRHR services provided at FHOK clinics mainly from friends (38.6%) followed by outreaches conducted by FHOK (36.1%) and other sources (31.8%) such as health clubs, television, in schools and churches among other sources. Social media (8.1%), parents (7.9%) and radios (4.8%) were the least utilized sources of information regarding SRHR services offered at FHOK clinics as shown in Figure 4.1 below:

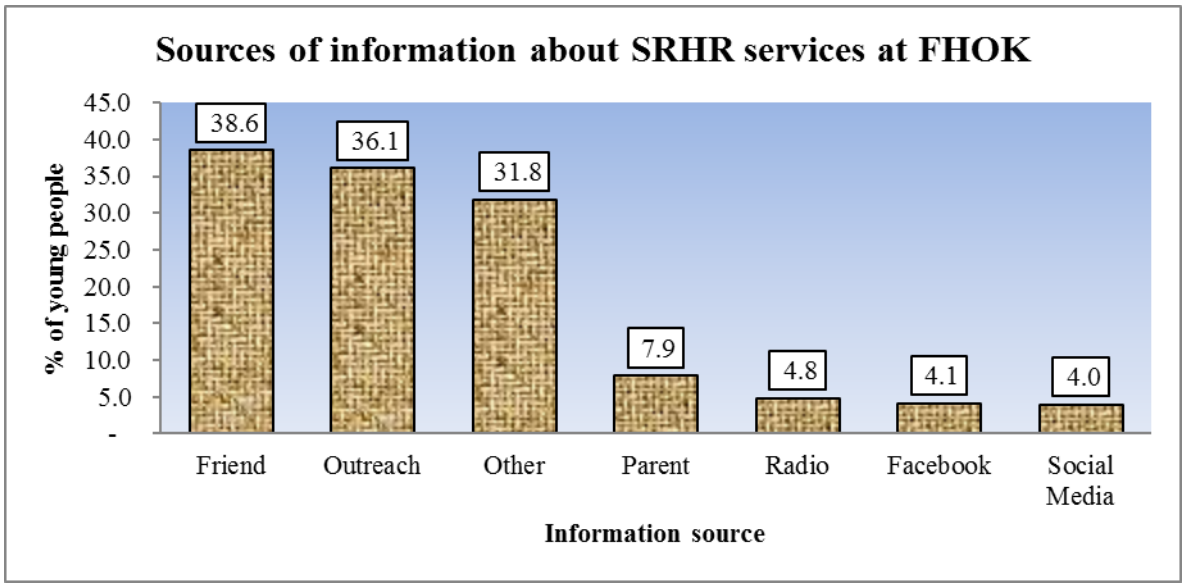


Figure 2 Sources of information about SRHR services in FHOK clinics

Analysis of preferred source of information by young people visiting FHOK facilities revealed similarities in the top three sources of information although variation exist in the ordering and degree of preference. The three most preferred sources of information by young people in the Regular facility model were referrals by friends (33.7%, n=57) followed by outreach programmes (29.7%, n=51) and parents (10.5%, n=18). In the integrated model the preferred sources were outreach programmes (59.2%, n=125), information from friends (38.9%, n=82) and then parents. In the Stand-Alone model friends (43.9%, n=85) were the most preferred source followed by outreach programmes (17.2%, n=34) and parents (10.4%, n=22).

Table 3 Preferred sources of information on SRH services by type of FHOK facility

Source of information	Regular	Integrated	Standalone
Radio	5(2.9%)	20(9.5%)	3(1.5%)
Social media	1(0.6 %)	17(8.1%)	5(2.5%)
Facebook	4(2.3 %)	12(5.7%)	8(4.0%)
Friend	57(33.7%)	82(38.9%)	85(42.9%)
Outreach	51(29.7%)	125(59.2%)	34(17.2%)
Parents	18(10.5%)	22(10.4%)	22(10.4%)

3.2 Utilization of SRH services offered by FHOK

This section focuses on the SRH services sought and utilized by young people and the willingness of the youth to use the SRH services provided by FHOK. The results are discussed below.

i. Accessibility of the services offered by FHOK.

Out of all respondents, 66.7% (378) visited the FHOK clinic in the past year, and 68.0% (385) visited the clinic in the past three months. Of the young people who had visited facilities implementing regular model, 33.1% (55) had sought at least a service in the last 1 year. This was slightly lower than the proportion of the visitors who had visited a facility implementing such a model within the last three months (36.3%, n=66). Of those who had sought services from a facility implementing

integrated model, 87.7% (185) had sought a service within the last year while 82.3% (172) had sought a service within the last 3 months. Finally, of the visitors to a facility implementing a stand-alone model, 72.6% (138) had sought a service in the last year while 84.0% (147) had sought at least a service in the last 3 months. This shows that there were more visits to integrated and stand alone facilities in the last 3 months compared to the last 1 year unlike in facilities implementing the regular model. In the last 1 year, integrated model facilities experienced most visits overall compared to the other two models within the same period.

This study furthermore examined the kind of SRH services provided for the youth in the FHOK health facilities. Three most available services disaggregated by health facility models were:

- VCT for HIV services (68.4%, 130), STI counseling and treatment (51.1%, 97) and family planning services (50.0%, 95) in the regular model;
- SRH Education (82.9%, 175), VCT for HIV (71.1%, 150) and family planning services (42.2%, 89) for integrated model;
- VCT for HIV (81.9%, 167), SRH Education (77.5%, 158) and STI counseling and treatment (59.3%, 121) for stand-alone health facility model.

These suggest that VCT for HIV services was the most commonly available service across all the three facility models implemented by FHOK. Table 4 below shows the common services young people seek at FHOK facilities.

Table 4 SRH information and services provided to young people disaggregated by FHOK facility model**

Available Service:	**FHOK Health Facility Model**		
	Regular	**Integrated**	**Stand Alone**
Education on SRH	40.5% (77)	82.9% (175)	77.5% (158)
VCT for HIV	68.4% (130)	71.1% (150)	81.9% (167)
Miscarriage/Post-abortion care services	8.4% (16)	6.2% (13)	26.0% (53)
Family planning services	50.0% (95)	37.0% (78)	49.5% (101)
STI counseling and treatment	51.1% (97)	42.2% (89)	59.3% (121)
Pregnancy care and delivery	15.8% (30)	18.5% (39)	32.8% (67)

*** services sought irrespective of the time of visit to the health facility*

From the young people interviewed, three SRH services that had been most sought after by the young people who had visited FHOK clinics within the last 1 year were: SRH education (69.5%, 260), VCT for HIV (45.2%, 169) and STI counselling and treatment (13.3%, 50) while the services that were least sought after within the same reference period by young people from FHOK clinics were: post abortion care services (0.8%, 3), miscarriage (1.6%, 6) and pregnancy care and delivery services (2.4%, 9) as shown in table 5below.

Table 5 Services sought by young people from FHOK clinics in the last 1 year*

Service Sought:	% (Cases)
Education on SRH	69.5% (260)
VCT for HIV	45.2% (169)
Miscarriage	1.6% (6)
Post-abortion care services	0.8% (3)
Family planning services	11.5% (43)
STI treatment & counselling	13.3% (50)
Pregnancy care and delivery	2.4% (9)
Get condoms	8.3% (31)

**** for respondents indicating they sought services in the last 1 year only*

Qualitative study findings support these results. The most commonly sought services by young people across the three health models were; contraception; STI screening, treatment and counseling; HIV testing and counseling including treatment; general SRH counseling; RH cancer screening mostly breast and cervical cancer; Abortion and post abortion services; Ante natal clinic; Pregnancy test and picking of condoms. Other services sought by few young people included Voluntary medical male circumcision mostly in Kisumu and pain relief during menstrual cycle.

> *"STI screening and treatment more so keeping in mind that we do have a project that deals with the most at risk population besides family planning and STI screening they come for cervical cancer screening"* **KII Clinical Officer, Eldoret.**

> *"Another service that we are looking is contraceptives, for the young people in higher institutions contraceptives is a key thing. Some even come with eeh... abortion issues. Either they are thinking of procuring abortion or they already did it elsewhere and want post abortion care"* **KII, clinical officer Nairobi**.

ii. Determinants of access to SRHR services within the last one year and last three months prior to survey

The study then sought to further establish if there were any significant differences by health facility model, age, gender, education and the marital status of the young people who had sought services in both the last year and also in the 3 months preceding the study. This would also help highlight any differences in seeking services between the two reference periods among participants as distributed by the mentioned facility models and socio-demographic differentials. Chi-square test found type of facility model, age, and education level to determine service uptake. Gender and marital status of the young people were determined not to be significantly related to seeking SRH services either in the last year or even the last 3 months before the study as is shown in table 6 below.

Table 6 Test of relationship between time of visit to a health facility and facility model and socio demographic factors of young people

Independent variables	Range:	Visit in Last 1 Year		Visit in Last 3 months	
Model of the Facility	Regular	14.6% (55)	χ^2 (2)=128.962, p=0.00	17.1% (66)	χ^2 (2)=124.505, p=0.00
	Integrated	48.9% (185)		44.7% (172)	
	Youth Stand Alone	36.5% (138)		38.2% (147)	
Age in years (grouped)	10-14	26.2% (99)	χ^2 (2)=9.291, p=0.01	21.8% (84)	χ^2 (1)=48.096, p=0.00
	15-19	29.4% (111)		27.8% (107)	
	20-24	44.4% (168)		50.4% (194)	
Sex	Male	50.8% (192)	χ^2 (1)=0.903, p=0.342	49.1% (189)	χ^2 (2)=0.000, p=0.986
	Female	49.2% (186)		50.9% (196)	
Level of education Attained	Primary	34.1% (129)	χ^2 (2)=14.703, p=0.00	29.4% (113)	χ^2 (2)=38.026, p=0.00
	Secondary	31.0% (117)		32.3% (124)	
	Post Secondary	34.9% (132)		38.3% (147)	
Marital Status	Not Married	95.8% (361)	χ^2 (2)=0.000, p=0.995	94.8% (364)	χ^2 (2)=1.740, p=0.187
	Married	4.2% (16)		5.2% (20)	

At 1% level of significance, young people were in the last 1 year 7.981 times more likely to seek information from integrated FHOK clinic compared to regular model clinic and 2.402 times more likely to visit a Stand Alone health facility model within the same period and at the same level of significance. By age, young people aged 20-24 years were 0.923 times less likely at 1% level of significance to visit any of the FHOK health facilities seeking a service compared to young people aged 10-14 years. Within the same period and at the same level of significance, married people were 3.491 times more likely to call in at an FHOK clinic for a service compared to unmarried people.

Within the last 3 months, young people were 4.753 times more likely to visit the integrated health facility model for services and 6.979 times more likely at 1% level of significance to visit the stand-Alone model call in at a facility for services as compared to young people visiting the Regular facility model. Young people aged 20-24 years were also noted to be 4.595 times more likely to call in for a service in the last 3 months compared to young people aged 10-14 years. Young people who had attained post-secondary level of education were also noted to be 4.062 times more likely to seek a service within the same period compared to those who had only attained primary level of education as is shown in table 7 below.

Table 7 Logistic regression examining the determinants of access to SRH services by young people in the last year and in the last 3 months in FHOK health facilities (odds ratios presented)

Indicator:	Used service last year	Used service last 3 months
Health facility model:		
Regular model=0	Reference category	Reference category
Integrated=1	7.981**	4.753**
Stand-alone=2	2.402**	6.979**
Age in Years:		
10–14=0	Reference category	Reference category
15–19=1	1.170	1.415
20–24=2	0.923**	4.595**
Sex:		
Males=0	Reference category	Reference category
Females=1	1.323	0.906
Educational level Attained:		
Primary Level=0	Reference Category	Reference category
Secondary Level=1	0.885	1.338
Post-Secondary Level=2	1.238	4.062**
Marital status:		
Unmarried=0	Reference category	Reference category
Married=1	3.491*	1.355

Significant at *p<0.05, **p<0.01

iii. Determinants of type of SRH service use

Bivariate analysis with service sought as the dependent variables and facility model and the socio demographic characteristics as independent variables reveals that sex determines the young people seeking family planning services from FHOK facilities while age determines the young people seeking education on SRHR, VCT services and family planning services. Marital status of young people determined young people seeking education on SRHR and family planning services. Facility model determined young people seeking education on SRHR and family planning services and finally level of education attained determined education on SRHR, VCT, family planning and STI screening and treatment services sought by young people as shown in table 8 below.

Table 8 Test of significance between health facility model, socio demographic characteristics and services sought by young people

Independent Variables:	Range:	Education on SRHR		VCT		Family Planning		STI Screening and Treatment	
Sex	Male	58.6% (167)	χ^2 (1)=0.583, p=0.583	37.5% (107)	χ^2 (2)=0.997, p=0.318	5.3% (15)	χ^2 (1)=21.644, p=0.00	9.1% (26)	χ^2 (1)=2.193, p=0.139
	Female	60.9% (168)		41.7% (115)		17.8% (49)		13.0% (36)	
Age in years	10-14	68.7% (101)	χ^2 (2)=18.433, p=0.000	23.1% (34)	χ^2 (2)=37.619, p=0.00	1.4% (2)	χ^2 (2)=24.387, p=0.00	6.8% (10)	χ^2 (1)=3.825, p=0.148
	15-19	66.7% (110)		33.9% (56)		10.9% (18)		13.3% (22)	
	20-24	49.8% (124)		53.0% (132)		17.7% (44)		12.0% (30)	
Marital Status	Not Married	61.8% (329)	χ^2 (1)=16.797, p=0.000	39.3% (209)	χ^2 (2)=0.286, p=0.593	10.0% (53)	χ^2 (1)=18.836, p=0.00	10.9% (58)	χ^2 (1)=0.399, p=0.528
	Married	22.2% (6)		44.4% (12)		37.0% (10)		14.8% (4)	
Facility Model	Regular	26.5% (40)	χ^2 (2)=109.746, p=0.000	36.4% (55)	χ^2 (2)=1.238, p=0.539	13.9% (21)	χ^2 (2)=7.661, p=0.022	7.3% (11)	χ^2 (2)=14.382, p=0.112
	Integrated	81.0% (171)		42.2% (89)		6.6% (14)		14.2% (30)	
	Youth Stand Alone	62.3% (124)		39.2% (78)		14.6% (29)		10.6% (21)	
Level of education attained	Primary	67.9% (127)	χ^2 (2)=11.165, p=0.004	23.5% (44)	χ^2 (2)=42.874, p=0.00	5.9% (11)	χ^2 (2)=8.615, p=0.013	7.0% (13)	χ^2 (2)=6.161, p=0.05
	Secondary	60.6% (117)		38.9% (75)		14.0% (27)		11.4% (22)	
	Post Secondary	50.8% (91)		57.0% (102)		14.5% (26)		15.1% (27)	

Multivariate analysis using logistic regression carried out for these significant factors. Access to the various services was regarded as dependent variables with the variables facility model, age, sex, highest level of education attained and marital status of the participants as the confounding factors.

At 1% level of significance, young people in the integrated model were 12.806 times more likely to seek information on SRH services compared to young people seeking services at the regular health facility model, while at 5% level of significance, young people visiting Stand Alone health facilities were 5.499 times more likely to seek information on SRH compared to young people in regular model facilities. At the same level of significance, young people were 1.611 times more likely to seek VCT services and 2.327 times more likely to seek STI treatment in the integrated health facility compared to a regular facility.

Young people aged 15-19 years were established to be 12.616 times more likely at 1% level of significance to go to an FHOK health facility seeking family planning services compared to young people aged 10-14 years. Also, young people aged 20-24 years were 19.435 times more likely to visit a health facility in the year preceding the survey for family planning services compared to young people aged 10-14 years at the same level of significance.

By gender and at 1% level of significance, it was established that females were 3.824 times more likely to seek family planning services compared to males.

Young people who had attained secondary level of education were 2.038 times more likely to seek VCT services compared to those who had attained primary level of education at 5% level of significance. At the same level of significance young people with post-secondary level of education were 3.209 times more likely to seek STI treatment compared to young people with only primary level of education. Finally, at 1% level of significance, young people with post-secondary level of education were noted to be 3.081 times more likely to seek VCT services from any of the FHOK health facilities.

Finally, by marital status, young people in marriage were 0.261 times less likely to seek education on SRH services from any of the FHOK clinic compared to young people not married at 5% level of significance. All these are illustrated in Table 9 below.

Table 9 Facility model and socio-demographic determinants of uptake of SRH services among young people visiting FHOK health facilities in the past year (odds ratios presented)

Characteristics:	Education on SRH	VCT	FP Services	STI treatment
Facility Model				
Regular Model	Ref.	Ref.	Ref.	Ref.
Integrated Model	12.807**	1.611*	0.554	2.327*
Stand Alone Model	5.449*	1.054	1.09	1.478
Age (in years)				
10-14 years	Ref.	Ref.	Ref.	Ref.
15-19 years	0.939	0.976	12.616**	1.264
20-24 years	0.732	1.669	19.435**	0.792
Sex of the participant:				
Male	Ref.	Ref.	Ref.	Ref.
Female	1.213	1.2	3.824**	1.462
Level of Education Attained				
Primary level	Ref.	Ref.	Ref.	Ref.
Secondary Level	1.407	2.038*	0.716	1.903
Post Secondary Level	0.617	3.081**	0.641	3.209*
Marital Status:				
Not Married	Ref.	Ref.	Ref.	Ref.
Married	.261*	1.227	2.4	1.925

***p<.05; **p<.01**

3.4 SRH Information and Service Gaps among the young people

Qualitative data established that some of the gaps in SRH information and services provision in the following areas:

i. Contraception knowledge and uptake

Results indicate that the knowledge of contraception among the young people varied by age and gender of respondents. The older youth tended to know more about family planning compared to younger ones and girls were more likely to know about FP compared to the boys. The most known and commonly used contraceptives were short term methods such as condoms, pills including emergency contraception and Depo-Provera. Very few of the youths were aware of long term methods

such as implants and intra-uterine devices whose utilization is low. Study found that most sources of SRH information for young people emphasize use of short term contraceptive methods compared to the long term methods like implants.

Qualitative data suggests high unprotected sexual activities among the youth. Most young people are concerned more about pregnancies prevention as opposed to HIV prevention with most contraception used only to prevent pregnancy and not HIV. High, unplanned and unprotected sexual activities among young girls was observed as the main cause of abusing Emergency contraception pills.

> *"..Most people are informed about condoms. About the other pills especially the E-pill they are aware of it because most of them when they have unprotected sex they feel they fear getting pregnant so the E-Pill is common among them. As for the others (long term methods of FP) they are preferred by young people in relationships and in marriages including have young people below 18 who are married."* **KII, service provider, Nairobi**

The results show that although there is high awareness of the methods of contraception, knowledge of how to use and how the methods work was reported to be limited. Younger youths and boys were also less likely to have correct knowledge on how to use the different methods of contraception. Marginalized groups reported limited access to SRHR services at FHOK health facilities due to fear of being stigmatized particularly self-stigmatization. This was observed mostly by the YPLWH and refuge youth who feel their cover may be blown for being in the country illegally.

ii) Risk factors to SRH problems among the young people

Various factors were cited by the participants as contributing to SRH problems among the young people. From the qualitative results the highest risk factors leading to most of the SRH problems among the youth according to most participants was are unprotected vaginal and oral sex with multiple sexual partnerships leading to the spread of STIs including HIV. Another risk factor that was mentioned was alcohol and substance abuse which was felt to impair the young people's judgment about their sexual decisions leading to risky sexual behavior. Poverty among the young people was also seen to precipitate their engaging in commercial sex in order to gain material benefits. This was felt to increase HIV risk especially among young girls.

Also noted was to be a risk factor was the poor knowledge of condom use among the young people. It was observed that this led to condom slips or burst during sexual encounters thus not effectively preventing them against the consequences of unprotected sex. Respondents also observed poor health care seeking behaviors among young people. This made the young people not to access the SRH information and services needed to address their sexual needs thus predisposing them to reproductive health problems. Young people were also noted to lack correct SRH information thus were not able to make informed decisions about their sexual behavior. Peer pressure was observed to increase vulnerability of young people into engaging in high risk sexual behavior thus endangering their lives.

> *"What I can say is that actually we are giving out condoms but I don't think all the youth in the community are coming here to get condoms which means most of them might be engaging into sexual activity without using condoms. It is through this that they might end up getting infected with STDs and HIV and AIDS"* **KII Nairobi.**

"Maybe I will start with the lack of proper information. I think that is a big risk. If we don't reach out to so many young people and give them correct information to share with their peers" **KII Nairobi.**

Other risk factors affecting the youth according to both the FGDs and KIIs responses are stigma from society for PLWH, high school drop out of girls so that they could take care of children or due to early or forced marriages. Girls were also felt to be at high risk of sexual violence which would predispose them to reproductive health problems like STIs and pregnancy. It was a common feeling among the respondents that most unplanned pregnancies ended up in unsafe abortions performed by unprofessional. This could lead to loss of lives due and complications such as excessive bleeding and infertility.

"*Sometimes when young girls are raped and procure an unsafe abortion, this can lead to deaths or infertility……..You see that when you perform that abortion maybe some people might not do it well and they destroy their sexual reproductive system like the fallopian tube therefore leading to infertility."* **FGD Females 20-24, Eldoret**

"Unwanted pregnancy…..maybe you want to pursue your studies and you get raped, once you're raped you will get pregnant ….maybe you're forced to do sex and you become pregnant and may be want to continue with your studies you will be forced to take care of your child…..you may drop out of school…..the child will suffer in life because you're not at that age where you can provide for that child" **FGD Boys 15-19 Kisumu.**

The risk factors for the marginalized groups interviewed included Female genital mutilation which led to many side effects for the victims. This was reported by the refuges from Nairobi. Gender Based Violence (GBV) especially rape was also reported among the young girls and was recorded across the three regions. It is important to note that the marginalized groups were vulnerable due to their special circumstances thus making them more likely to be abused. Among the sex workers results indicate that the young sex workers rights were often violated as they were reported to be sexually abused by their clients which led to physical and psychological distress for the victims. They reported that sometimes they were not paid or paid less even after they had an agreement on the fees to be charged for their services. They were also noted to be discriminated against by the members of the society as were their children because of their trade which was not considered socially appropriate.

"*If you have a child and you are a sex worker, they will treat that child as if he or she doesn't have parents and you see, the child is too young to understand that it is the work you do. So the child undergoes bad things and it affects him or her a lot... I mean, a child is told, "go away your mother is a prostitute". You find he or she is sitting down thinking, "why is this person telling me this**?"*** **FGD, Special Groups Sex workers, Nairobi**

"Can I say that for instance that STIs like Syphilis, Gonorrhoea and Genital Herpes which might make one drop out of school…..it may lead to HIV/AIDS infection leading to stigma" **FGD Special Group (YPLWH) Kisumu**

"You see things like rape normally affect ladies. They are psychologically and physically tortured." **FGD Females 20-24 Eldoret**

3.5 Barriers to SRH service and information use among the youth

This section focuses on the various barriers and enhancers to SRH service and information use among the youth and the perception of the respondents towards the service and information provided.

3.5.1 Barriers to SRH service and information use among the youth

The quantitative survey sought from the study participants about the barriers to seeking SRHR services at FHOK health facilities. It was established that the most critical barrier to SRH information and services uptake is limited access to such information and service (53.7%, 326) followed by affordability of the services due to the high cost of getting such information and services (39.7%, 242), low acceptability of the SRH services by the adults (36.2%, 220) and the perceived lack of confidentiality and privacy among the service providers and privacy of their identity (33.3%, 202). Other barriers mentioned included the perception by young people that young people are not expected to get SRHR information (7.6%), perceived lack of need to visit the facilities (4.2%), unfriendly service providers (11.9%) and perceived lack of need for SRHR services by unmarried youth (2.6%). This is shown in Table 10 below.

Table 10 Barriers to uptake of SRH information and services by facility model

Barriers	***Overall***	***Model***		
		Regular	***Integrated***	***Stand-alone***
Lack of access	53.7% (326)	55.7% (107)	58.8% (124)	46.6% (95)
Low acceptability (e.g. parents not allowing youth to go)	36.2% (220)	42.2% (81)	39.3% (83)	27.5% (56)
Youth not expected to get SRHR information	7.6% (46)	2.6% (5)	9.5% (20)	10.3% (21)
There is nothing to go there for	4.2% (26)	1.0% (2)	8.5% (18)	2.9% (6)
High cost of services	39.7% (242)	44.8% (86)	46.9% (99)	27.9% (57)
Unfriendly providers	11.9% (72)	10.9% (21)	15.2% (32)	9.3% (19)
Lack of clients- service providers trust	33.3% (202)	22.9% (44)	37.4% (79)	38.7% (79)
SRHR services not needed by unmarried youth	2.6% (16)	1.6% (3)	2.8% (6)	3.4% (7)

Barriers vary by type of health facility model. The barriers of lack of access to the facility (58.8%; 124), unfriendly youth services (15.2%; 32) and perceived lack of need to visit the facility (8.5%; 18) were most cited in the integrated health facilities model than in the other 2 models. Lack of client-provider trust (38.7%; 79), perception that young people were not expected to get SRH information (10.3%; 21) and SRH services were not needed by unmarried youth (3.4%) were most cited in the Youth stand-alone model than in the other 2 models. Low acceptability by significant adults (42.2%; 81) and high cost of health services (44.8%; 86) were most frequently mentioned in the regular model than in the other 2 models. Generally, the survey shows effects of these barriers are lesser felt by participants sampled from stand-alone than integrated and regular models.

The qualitative study revealed that the young people faced various barriers accessing and utilizing SRH information and services that were specific to individuals, community and facility. Specific barriers are discussed below:

i. Individual level barriers

Some youths experience barriers at the individual level while seeking SRHR information and services. Among the key barriers identified in the qualitative data include:

- Fear and self-stigma reported among special groups that lead to non-disclosure of background or circumstances. Among other youths, fear of knowing HIV status is a major hindrance to testing for HIV.
- Ignorance, misconceptions and negative attitude towards SRH information which may deter them from using or seeking services
- Poor health care seeking behavior with many believing they are not sick until it's too late
- Language barrier especially among refugee youth in Nairobi who are not able to communicate with the health providers.

> *"OK. Maybe like stigma I think maybe you can suffer from like STIs you will feel shy to come and approach the nurse. When you are still young it is not easy to come and tell the doctor, there is that fear"* **KII, Nairobi**.
>
> *"Even if they come with an STI they don't want to pick condoms they will shy away. Most of them it's like they fear taking as they will say they will not do it again."* **KII, Nairobi.**
>
> *"Then another [one] is fear.' They feel "I have had sex with so many men without condoms and now [what will happen] when I am tested and found with the disease?' then you just say, 'let me just continue sleeping around with men until I die, it will end' just the same way you say 'I have had sex with many people and I know myself [that] I have it' and you don't even know it for sure"* **FGD Special Group, sex worker, Nairobi**

ii. Community level barriers

At the community level, the following barriers were observed:

- General lack of support for provision of SRH information and services for young people;
- Socio-cultural factors such as religious beliefs and doctrines prohibited from accessing or utilizing SRH services and information such as pronatalist values, gender power relations including lack of male involvement, restriction of contraception only for married people, religious restrictions on contraception use.

> *"The cultures and religion affect the usage of contraception negatively"* **KII Kisumu.**
>
> *"The other challenge maybe their partners (male) especially the married ones like we had a case where a lady came for contraception,,, she was given the Norplant the one for three years but she did it against the husband so it's like the husband found out when he touched the arm it was there so the husband wanted to remove it with a razor blade then she had to come back here for it to be removed. So it can cause conflict for those young marriages."* **KII service provider, Nairobi**

1. Facility level factors

Facility level barriers identified include:

- Poverty and perceived high and unaffordable cost of services by the young people related to payment for consultation, laboratory testing and diagnosis, and purchase of the medicines
- Perceived lack of availability of services such as Pap smear testing services.
- Fewer centers offer youth friendly services
- Long distance to the facilities
- Perception of lack of confidential and private services from the facilities particularly among young people attending regular and integrated service models. When young people perceived the health services providers as unfriendly, unresponsive to their needs and judgmental they are less likely to utilize the SRH services.

"When you go to FHOK, they ask you for ksh 1000 for card (registration). That is for the card only before they even start to treat you…then 1500 (ksh.) for testing. Imagine where you will get that (money) when it is what you can use to pay rent here" FGD **Sex workers, Nairobi.**

The special groups FGDs also highlighted some barriers to service uptake that were unique to them. For instance, discrimination was observed from service providers who were seen to be unfriendly to sex workers because of their work. Some sex workers reported that they feared going to targeted facilities for sex workers because of fear of disclosing their identity. Young Somali refugees were seen as Al-Shabaab[1] [Somali terror group]. Other special groups of youth like the LGBTI and YPLWH were discriminated against making them not to seek SRH services from the facilities.

> *"And again since that hospital was placed under sex workers, when you come to that hospital [people] identify you as a prostitute…people will start to say that "this hospital is for prostitutes….so this one is also a prostitute! You haven't seen her in that hospital"* **FGD Special group, sex workers, Nairobi.**

IDIs with health service providers additionally reported: language barrier where the providers do not speak same language as the young people for example the Somali refugees; and, lack of specialized communication skills barrier such as dealing with young people with disabilities.

3.5.2 Factors affecting service uptake in the FHOK clinics

Respondents from the survey were asked about their perception of the staff of FHOK clinics. Participants in the FGDs and KIIs conducted across the three clinic models identified the strengths and weaknesses of the facilities and services offered. Due to time constraints at the time of data collection, these perceptions were not been verified independently through observation of the clinics. The results are presented in this section:

i. Perception of young people on health staff at FHOK facilities

Overall, 88.3% (475) of study respondents reported to like services provided at the three service outlets. The survey further investigated reasons why they were attracted to these services. About 73.7%, (376), reported that staff at the facilities were friendly and polite; 66.5% (339) reported that staff are knowledgeable and well qualified, 40.0%, (204) believe that staff are interested in issued

[1] Somali terror group

affecting youths, 38.0%, (194) believe they can get help at the facilities, 36.3%, (185) believe the staff are able to communicate well with youth, 32.2% (164) believe staff are respectful and good listeners. Another 31.6% believe facility staff are honest and direct and 30.8% believe that facility staff are concerned about the young people's privacy as shown in table 11 below.

Table 11 Perception of health staff at FHOK facilities

Reason for liking the service	N	%
Knowledgeable and well-qualified staff	339	66.5
Friendly and polite	376	73.7
Interested in you and your problems	204	40.0
Good communicator	185	36.3
Respectful	164	32.2
Concerned about your privacy	157	30.8
Honest and direct	161	31.6
A good listener	164	32.2
Able to help you	194	38.0
Other	14	2.8

The results of the perceptions of the respondents of health service staff disaggregated by type of model are presented in the table 12 below:

Table 12 Reasons for young people liking type of service provider disaggregated by health facility model

Reasons for liking staff	**FHOK health facility model**		
	Regular	**Integrated**	**Youth Stand Alone**
Knowledgeable and well qualified	61 (46.2%)	147 (70.3%)	131 (77.5%)
Friendly and polite	72 (54.5%)	161 (77.0%)	143 (84.6%)
Interested in you and your problems	40 (30.3%)	69 (33.0%)	95 (56.2%)
Good communicator	19 (14.4 %)	55 (26.3%)	111 (65.7%)
Respectful	22 (16.7 %)	44 (21.1%)	98 (58.0%)
Concerned about your privacy	22 (16.7%)	42 (20.1%)	93 (55.0%)
Honest and direct	25 (18.9%)	35 (16.7%)	101 (59.8%)
Good listener	17 (12.9%)	43 (20.6%)	104 (61.5%)
Able to help you	48 (36.4%)	52 (24.9%)	94 (55.6 %)

The results point to differences in the perception of the health service providers across the different model types. For all the qualities of health providers assessed, those in stand-alone model rated higher than those in the regular or the integrated types of models. This is because of the perception that service providers in the stand alone facility were younger and able to empathise with their fellow youth.

The majority (87.0% n=462) of the young people who had sought services from FHOK health facilities reported willing to return for the same information and/ or services. About 73.7%; (411) of young people in the survey observed that they had friends who had ever sought SRH services from FHOK facilities. Another 81.9%; (394) were willing to recommend the facilities to their peers. Those who cited unwillingness to recommend the facility to their peers cited embarrassment in being seen to have accessed the services, and perception of high cost of services at the facilities as the main reasons they would not recommend the facility to their peers.

ii. Perceived strength and enhancers of the SRH services

Various factors enhancing SRH service utilisation by young people were mentioned across the 3 models of focus. Respondents stated that the strengths to service provision for young people across the three models was the FHOK non-discriminatory policy in offering services to all groups of persons including lesbians, gays and bisexuals and sex workers. This meant that they could cater for the needs of all young people and young people did not feel discriminated against. Provision of SRH information for the youth to make informed decisions, for instance, like prevention of unwanted pregnancy which is a major concern for youths across all the models was felt to promote acceptability of the SRH services.

Another selling point of SRH services to young people cited across the three models was the facility cleanliness and comfortable environment and good quality services attained through training of service providers. The participants argued that most of the young clients visiting the facilities were satisfied with services according to the feedback on client satisfaction questionnaires. Guaranteed privacy and confidentiality of youth SRH issues across the three models was also felt to promote the SRH services for the young people. Provision of integrated SRH services under one roof across the three models, for instance, STI screening and treatment, HIV counselling and testing, Ante natal clinic, pregnancy test enhanced uptake of the services by young people.

Respondents perceived the integrated model and the youth stand alone as pocket friendly. This was a result of the subsidised or free provision of the SRH services for youths under 25 as the costs were covered by ASK project thus improving accessibility of SRH services. In the two models recruiting of young service providers promoted SRH service uptake as they were felt to connect with youth because they understood what the youth experience. From the results it can be deduced that the regular model was perceived as not being pocket friendly and not having young service providers which may discourage young people to access SRH services. The overall strengths of SRH services provided to young people as identified by the respondents per model are illustrated in Table 13 below.

Table 13 Summary of perceived strengths by model of service provision

Reported Strengths		
Category	Specific Strengths cited	Type of model identified in
Affordability	Pocket friendly or free SRH services for youth under 25	Integrated; Youth stand alone
Quality of services	High recorded client satisfaction with services	Integrated; Youth stand-alone & Regular clinic
	Empower youth to make informed choices through provision of SRH information	Integrated; Youth stand-alone & Regular clinic
Accessibility and utilization of services	Facility cleanliness and comfortable environment	Integrated; Youth stand-alone & Regular clinic
	Privacy and confidentiality of youth SRH issues	Integrated; Youth stand-alone & Regular clinic
	Integrated services-many SRH services under one roof	Integrated; Youth stand-alone & Regular clinic
Provider based factors	Recruiting young service providers-	Integrated; Youth stand alone
	Non-discriminatory policy in offering services to all persons	Integrated; Youth stand-alone & Regular clinic
	Trained service providers	Integrated; Youth stand-alone & Regular clinic

iii. Perceived weakness of the SRH services

Across all the models participants felt that some of the SRH services were costly in the clinics for example for some of the long-term family planning methods. It was also felt that there was a general community perception that FHOK serves rich people which may deter the youth from visiting the clinics for the SRH services. The young people expressed that there was lack of extended working hours. They expounded that they were unable to receive services when needed due to other engagements during the day like schooling and work.

Many respondents felt that across all the models inadequate staffing that led to long waiting hours discouraged youths from seeking SRH services from the clinics. Lack of some services in the clinics which forced the youth to get referrals like CCC, X-rays, safe abortion, ultrasound and management of FGM complications was also thought to discourage youth from seeking services from the clinics. This was especially perceived to interfere with privacy of the young people especially if the referral centre is not stand alone.

In the youth standalone model inadequate enough resources to support youth IGAs so they were not able to get out of commercial sex work or afford to pay for the needed SRH services. Moreover communication barriers where refugees are not able to communicate with the providers due to language barrier or special groups who may need sign language (FHOK, Nairobi). Inadequate sensitization and mobilization on availability of services at FHOK youth standalone clinics hence many young people are unaware of the services and are thus left out.

It was observed that for the integrative and youth standalone models the health providers were perceived as too inquisitive asking too many questions for example during HIV testing and counselling which made the youth to shy away from coming back to the facility. Whereas in the youth stand alone and regular models it was noted that they experienced drugs stock out or supplies delay which discouraged the youth from seeking the services.

For the integrated and regular clinics participants reported that sometimes they experienced long queues which made the youths to wait for long to get services thus inhibiting health seeking by the youth. In addition, respondents felt that sometimes providers are unfriendly and discriminate against special groups of youths for example refugees who are seen as *Al-Shabaab* (terror group*)*. In the integrative model few young people stated that that sometimes health providers gave HIV testing without counselling.

The overall weakness of SRH services provided by FHOK clinics to young people as identified by respondents per model are illustrated in Table 14.

Table 14 Summary of the perceived weakness of SRH clinics by model of service provision

Weakness identified		
Category of barrier	Specific barrier cited	**Type of model cited in**
Affordability	Some services very costly e.g. safe abortion	Integrated; Youth stand-alone & Regular clinic
	Lack of enough resources to support youth IGAs	Regular clinic
Accessibility and utilization	Lack of some SRH services	Integrated; Youth stand-alone & Regular clinic
	Stock-outs and delayed supplies	Youth stand-alone & Regular clinic
	Language barriers e.g. refugees	Youth stand-alone & Regular clinic
	Long ques and waiting time	Integrated; & Regular clinic
	Inadequate sensitization and mobilization	Youth stand alone
	Lack of extended working hours	Integrated; Youth stand-alone & Regular clinic
Quality of services	Providing services without counseling e.g. HIV testing	Integrated
Provider based factors	Inadequate staffing	Integrated
	Providers too inquisitive-ask too many questions	Youth stand-alone & Regular clinic
	Sometimes providers are unfriendly	Integrated & Regular clinic

3.6 Perception on how facilities can best serve young people

Various strategies were proposed by the respondents on how to best serve young people. The strategies are discussed in this section:

3.6.1 Meaningful Youth Pparticipation (MYP)

The participants felt that that one of the ways of ensuring the young people are best served with SRH information and services was by ensuring MYP. Generally, most of the participants had a positive perception about the involvement of young people in SRH interventions. The various issues explored in the study on MYP are discussed in this section:

i. Ways in which young people are participating in FHOK SRH interventions

The respondents proposed various ways in which young people are currently involved in the youth SRH program by FHOK. Their views are discussed below:

i . Young people are used as peer educators who are seen as key in reaching fellow youth with SRH information. In earlier results in the study it was established that most young people visiting the FHOK clinics received services from the young peer education. They help build the capacity of the regular staff to reach more youth with SRH information and services.

It was however noted that for special groups like Sex workers the program should consider selecting peer educators from the same group to be able to reach youth with similar issues with SRH information and services. They are the best people to be trained as peer educators in SRH issues because they know what their peers go through. This is also deemed necessary to help empower them with knowledge and skills.

So far, young people have been engaged at different levels in SRHR activities. Some have been recruited to join school health clubs, invited to participate in health talks, involved in planning for SRHR interventions, participating as trained peer educators including during outreach.

> *" For the young people in the program we work with them as volunteers and we train them as volunteers and we train them to be youth resources person in the community in essence the training does not only provide peer education training but we have enriched peer education training so that young people are resources persons because we believe they not only rich their peers but also those young or older in the community the intervention are involved in dissenting to young people in school and out of school we engaged them during our clinic outreaches in the communities so they act as mobilizers and points of reference so they refer and do follow ups to the clients they refer and also publicize the youth clinic and the youth program."* **KII Program Staff, Eldoret.**

ii. Goals for involving young people in SRH interventions

Involvement of young people in SRHR interventions ensure the youths are empowered through giving them SRH information and services. Qualitative data also shows that young people are engaged to foster behavior change reducing risks to unplanned pregnancies and STIs. This benefits the community and the program with increased awareness of SRHR issues affecting youth in the community which may inadvertently lead to older people seeking health services as well.

iii. Cons of involving youth in FHOK SRH programs

1. Capacity- Young Peer educators were noted to lack the capacity to adequately take on the roles assigned to them. The respondents proposed that they therefore need refresher trainings and updates in order to effectively perform their roles and keep abreast with the changing times and dynamics.
2. Sustainability of youth engagement- The respondents stated that they faced setbacks in involving young people as the youths withdrew from the project leaving a gap in mobilization and operations of the program.
3. Also noted was the lack of adequate SRH information by the young people to adequately address the SRH issues affecting their peer. The respondents felt that the young people lacked adequate information on SRH and experience to adequately handle the issues that youth were presenting with at the health facilities.

iv. Benefits of involving youth in SRHR programs

Irrespective of the above mentioned cons of involving youth in the program the qualitative results also pointed out various program and individual benefits of MYP in the health service interventions are illustrated in the Table 15 below.

Table 15 Individual and program benefits of involving young people in the FHOK program

Benefits to the program	Benefits to the youth
Getting referrals by the youth to the facility hence the centers are able to reach more youths and achieve their goal.	Increase in number of youths accessing SRH services
The school programs enhance teacher student relationships and link students to facilities.	Youth receive SRH information and myths and misconceptions demystified.
Youth have a sense of ownership of the project	Positive behavior change- among the youth actively involved and the peers they reached with information and services.
Develop better understanding of SRH issue affecting the youth	Improved health outcomes among the youth
Youth help to market the organization	The youth refer their peers for services who gain by accessing needed services
Help to design more relevant SRH programs for young people	

Benefits to the program

The respondents felt that MYP has benefitted the program in the following ways:

1. Getting referrals by the youth to the facility hence the centers are able to reach more youths and achieve their goal. The respondents further stated that MYP has enhanced the marketing of the SRH services provided at the clinics.

"At least they bring clients to be treated here... you'll find at least the nurse or the doctor who will be here will have some work to do because of the youth resource persons who will be doing mobilization…" Health service provider, Nairobi.

"They really market the organization and they also give the information for example SRH services SRH issues that need to be addressed and carry out sensitization of community members." Field officer, Kisumu

2. The school programs enhance teacher- student relationships and link students to facilities. They explained that the involvement of youth in the school programs has helped the significant adults in the young peoples' lives to understand the program and promote support for young people accessing the services.
3. The respondents felt that MYP has promoted a sense of ownership of the project. They explained that the youth are more willing to come for the services as it has promoted acceptance of the intervention among the youth.
4. Makes the program more relevant to the youth- the qualitative results indicated that the feedback and input received from the young people on the program has helped shape the services thus making them more relevant to young people.

   "It also means as a result of meaningful participation the facility is able to gain from the feedback given by the young people since they own the program. They own the processes and so they will readily give us feedback where they have issues or by commenting", **Program staff, Eldoret**.

5. Youth involvement has helped the program understand better the SRH issue affecting the youth through research and designing interventions to tackle the issues. The respondents stated that involving youth in research has enabled them gather evidence for refining and designing better youth SRH programs.

Benefits to the youth

The respondents felt that MYP has benefitted the individual youth in the following ways:

1. The respondents stated that due to MYP there has been a noted increase in number of youths accessing SRH services as it is easy for them to open up to young people compared to older ones. This, they explained helped them to address their SRH needs and issues thus improving their health outcomes.

   "One we've seen an increase in the number of young people accessing services", **Health service provider, Nairobi.**

2. Many youths receive SRH information through training, myths and misconceptions demystified from the youth peer providers and health service providers. They are mobilised by other youth to come to the forums where they get the SRH information that they can use to make informed sexual decisions and choices.

   "The effects can also be noted through the level of awareness that they have and the level of participation that they have". **Service provider, Kisumu**

3. The respondents observed that there is positive behavior change among the young people actively involved in the program and the peers they reached with information and services.

Results of the project are seen and impact on the youths for instance increased uptake of contraceptives, reduced unplanned pregnancies and reduce new HIV infections The youth refer their peers for services who gain by accessing needed services

> *"I can say it has led to proper use of contraceptives, most youth do not get unwanted pregnancy. Early pregnancy has reduced, cases of HIV has reduced because of the use of contraceptives."* **Youth representative, Eldoret**

4. The respondents also felt that by using young peer providers, some of barriers to accessing SRH information and services by young people like shyness of the youth and age differences are overcome. This they felt enabled them to reach more youth in need of SRH services and information.

> *"We use these young people to reach other young people. We equip them with the required knowledge in different dimensions and in different perspectives trying to explore the different myth and misconceptions about sexual reproductive health and briefing them with the right knowledge so that they are able to reach to the other people."* **Service provider, Eldoret**

v. Suggested strategies for integrating MYP in FHOK SRH services and information provision

Findings from qualitative data indicated the following strategies for integrating youth participation in SRH interventions. These include:

- Involving the community in referring the youth to service points. The youth need parental and other significant adults support to be able to freely access SRH services.
- Promotion of edutainment activities for the youth like games, theatre, internet access to reach more youth with information on SRH and create demand for the FHOK health services for the young people.
- Creation of opportunities for young people especially the peer educators to establish income generating activities. This can help to sustain their involvement in providing health care and education services to their peers.
- Providing motivation for the peer educators through offering them financial, material, training opportunities and recreational activities.
- Incorporating the youths in decision making on issues affecting them and services provided to them. This involves giving the youth and opportunities to air views and suggestions on programs.
- Respect of young people's sexual and reproductive health rights. Making sure that the programs are designed to address youth felt needs and the youth well become the main focus of the operations of the intervention.
- Setting aside certain roles and responsibilities for youth in the program design and implementation. Youth need to be allocated specific roles in the program and these should be clearly communicated to them so that they can develop ownership of the intervention.
- Keeping the youth informed about the progress of the program including the challenges faced in implementing, the achievements made and future plans of the intervention. This can be done by providing regular updates to the youth through youth forums, youth open days at the clinics and through the mass media and E-channels available in the community.
- Engaging youth in evaluating the interventions so that they can see firsthand the impact of the

intervention on the lives of the youths targeted by the program. This can make them to appreciate the program. The results of the intervention should also be disseminated to the young people so that they know the progress.

- Creating youth friendly environment where the youth views and opinions are respected, they feel valued, respected and are involved in making decisions about their lives.
- Creating a platform for youth voices like through youth clubs, forums, and youth groups. These provide avenues where youth can freely air their views on their needs.
- Provision of appropriate skills and training. This will empower the youth to perform roles assigned to them like decision making, promotion of health education and services for their peers.

> *"Ok, another thing, is that like youth who participate here they don't go home empty handed… they receive little money even if its two hundred shillings you know. As I said before, most youth are unemployed and it's homely when they come here to feel that love… it's a homely environment."* **KII service provider, Nairobi**

3.6.2 Suggested recommendations for enhancing uptake of SRH services by young people

Results from the KIIs and FGDs pointed to the following factors as required to enhance uptake of SRH services by young people in the FHOK clinics:

i. Creating youth friendly interventions and environment in the health facilities. This includes:

- Training friendly health service providers who are concerned about the young people's well-being and respect them and their needs of all the youth including the special youths.
- Guaranteed privacy and confidentiality of SRH issues affecting the youth. When young feel that the service providers will keep their issues secret and maintain their anonymity then they are likely to utilize the needed SRH services.
- Staff who are conversant on how to handle the special groups of youth and who are friendly non-discriminatory to special groups of youth like the LGBTI can promote their uptake of the SRH services.
- Positive attitude of the providers towards the young people. Where young people feel accepted by the health providers.
- Delegating some duties to the youth- there is need to deploy young service providers to design and provide SRH services to their peers preferably not from the locality for confidentiality purposes. This was thought to promote the uptake of services by the youth as they were freer to discuss SRH issues with the peer providers than the regular adult providers.
- Offering of free or subsidized SRH services to the youth. Youth under the age of 25 are mainly unemployed, in school or employed in low paying jobs and may not be able to afford the needed SRH services.
- Promotion of Meaningful Youth Participation (MYP) in the FHOK SRH program in order to develop targeted programs that address the felt needs of the young people.

> *"Basically incorporating the youth in their issues because you can't talk of youth challenges or any factors affecting the youths medical seeking behaviors if you are not incorporating the youths in their services, they know what is right for them and what is best for them, it is simply bringing them on board and using them in making key decisions affecting the youths"* **KII Clinical Officer, Eldoret.**

- Respondents felt that constant availability of drugs and other essential commodities motivated them to seek services.
- The respondents also felt that establishing of community-facility Partnerships especially parents to refer the young people to the facilities and gain parental consent for young people to get SRH services. This was believed to promote acceptance of the parents or significant adults for SRH services for young people.
- The young people in the FGDs proposed adopting longer operation hours where facilities run till late and open over the weekends to serve those youth who cannot access day services or weekday services. Some of the youth are engaged during the day like school-going youth, youth in employment and youth who may be shy to visit the center during the day. Flexibility in the operation was thought to give youth increased chance of visiting the facility to SRH access services and information.
- It was also noted that maintaining high quality services by capacity building of staff, providing necessary supplies, hiring of qualified staff and cleanliness of the facility can enhance the acceptability of the SRH services by young people. It was argued that having trained and qualified health service providers was seen to promote uptake of youth SRH services and information. The young people stated that trained providers made them to feel confident and satisfied with the services provided.

Text Box 1: Summary of the Recommendations for improving service provision at FHOK centres from FGD and KIIS

- Training of providers on provision of youth friendly services.
- Use of entertainment to pass SRH information to the people (edutainment).
- Offering of free or subsidized SRH services to the youth.
- Partnering with the community especially parents to refer the young people to the facilities and gain parental consent for young people to get SRH services.
- Ensuring confidentiality which is key in determining whether they will seek services or not.
- Extension of SRH services to remote areas where youths lack the services.
- Deploying young service providers to serve the youth preferably not from the locality for confidentiality purposes.
- Service needs assessments to understand critical unmet needs of the youth for instance through weekly forums with the youth.
- Conduct outreaches to create awareness on youth SRH and sensitize the youth and community at large on availability of services so as to increase uptake of services.
- Longer operation hours where facilities run till late and open over the weekends to serve the youth who cannot access day services or weekday services.

4.0 Conclusion and recommendations

This study explored perception of young people in seeking services in integrated, standalone and regular service models. Results from both qualitative and quantitative assessments show that young people are indeed accessing information and services in the three models albeit at different levels. In general, most youth tend to go to the integrated model, although it differs slightly per type of services sought. The integrated and stand-alone model are much more often accessed for SRHR education and information compared to the regular model. Both standalone and integrated models have specialised centres that attract young people for information and services. VCT services are popular among young people, but slightly less often accessed at regular facilities compared to the other two models. Family

planning and STI services follow as third and fourth most often accessed type of services and are equally accessed in all facility models

The study also investigated the factors affecting utilisation of services in the three clinic models. Results show that perception of friendliness, good listening and communication skills for service providers, observation of privacy and confidentiality in service delivery, nearness to facility, parental support, are critical in attracting young people for services irrespective of model. Other qualities of staff attracting young people for services are Knowledgeable and well-qualified staff, honest and direct staff, willingness and ability of staff to help young clients.

Low scores on factors that attract young people for services at the FHOK clinics may inhibit uptake of services. These include poor parental acceptance of SRHR services in the community reducing support for youth to access these services, perceived poor-client provider relationships, unfriendly opening hours (regular clinic), language barriers including for those with disabilities, unfriendly providers especially to refugee youth in standalone clinic and LGBTIs in the integrated and regular clinics, inadequate staffing, high provider-patient ratios, long queues and waiting time for service in regular clinics, unawareness of services due inadequate sensitization and mobilization among youth in communities on availability of services at FHOK centers hence many young people are left out, lack of income generating activities are some the factors inhibiting access to SRHR services.

The study shows that young people have similar concerns and perception around youth friendly services irrespective of model types. Although marginal differences exist in uptake of services by model, the youth stand-alone services appear more attractive for more sensitive types of services like PAC and STI/HIV services. Irrespective of model, critical elements of quality of services and youth friendly service provision should be maintained and promoted to attract uptake of services by young people.

Study Recommendations

From the study results the following strategies are proposed in order to enhance uptake of SRH services by young people in the FHOK clinics:

- Create awareness on the availability of services including contraceptives services among young people through outreach across the models. Extension of SRH services to remote areas where youths lack the services and carrying out of outreach and extension services for the hard to reach youth. Since the location of the FHOK facilities is in town organizing outreaches can help reach the rural youth. It can also help reach the special groups of youth like the refugees who are afraid of venturing out of their homes and the disabled whose mobility is limited.
- The study established that some of the health providers were not conversant in handling special groups of youth. There is thus need for continuous capacity building of staff to influence provider attitude and improve the quality of services especially in serving special groups of youth such as refugees and LGBTIs. Maintaining high quality services by capacity building of staff, providing necessary supplies, hiring of qualified staff and cleanliness of the facility can enhance the acceptability of the SRH services by young people.
- Results indicate that lack of consent from significant adults deterred the youth from seeking SRH services. The study recommends engaging of parents and communities to support provision of YFS. Establishing of community-facility Partnerships especially parents can

encourage them to refer the young people to the facilities and gain parental consent for young people to get SRH services. This was believed to promote acceptance of the parents for SRH services for young people.

- One of the barriers cited for not seeking SRH services and information from the FHOK clinics was the high cost of services. Therefore, offering free services for youths under 25 - high and creating awareness on which services are available free of charge or the actual cost of the service can promote their utilization of those services. This can also help to dispel the common community perception that FHOK services are for the rich. Youth under the age of 25 are mainly unemployed, in school or employed in low paying jobs and may not be able to afford the needed SRH services.
- Youth in the study pointed to the fact that there was inadequate mobilization and awareness creation on the SRH services available for young people in the FHOK clinics. Results in the study pointed to the fact that some of the young people feel that SRH services are not meant for unmarried youth, they feel that they do not receive the needed help from the facilities and believe that the health service providers are unfriendly. Strategies to help the young people to understand the purpose of SRH services and information in their lives can promote their appreciation and hopefully their uptake. The study thus suggests the use of new media to create awareness of the SRH services available and reach the youth in remote areas with SRH information. For instance, the organization can give them a toll free number to call for enquiries and information.
- The study established that the accessibility and utilization of SRH services is limited by the lack of longer operation hours where facilities run till late and open over the weekends to serve the youth who cannot access day services or weekday services. The organization should consider flexible working hours working to be able to reach more youth with SRH services and information.
- The results did not deduce clearly which model is more effective in reaching youth with SRH information and services. Although marginal differences exist in uptake of services by model, cost effective studies on provision of YFS in the three models is needed in order to answer this question conclusively.

Annex 1: Participants interviewed in the FGDs

REGION	Type	Number	Venue
NAIROBI	Young refugees girls 20-24	8	FHOK-Eastleigh branch
NAIROBI	Boys 10-14	8	Neema Primary School
NAIROBI	Boys 15-19	8	Neema Primary School
NAIROBI	Boys 20-24	8	Nairobi South B
NAIROBI	Girls 10-14	8	Neema Primary School
NAIROBI	Girls 15-19	8	Nairobi youth centre
NAIROBI	Girls 20-24	8	Nairobi youth Centre
NAIROBI	Young refugees boys 20-24	7	FHOK-Eastleigh.
NAIROBI	Sex workers	8	Eastleigh
KISUMU	Disabled 10-19 YRS	7	Joyland Special Secondary sch.
KISUMU	LGBTI	8	Nyarwek Facility
KISUMU	Sex workers	8	Nacilica Hotel
KISUMU	YPLWHIV	12	Kisumu District hospital
KISUMU	Female 10-14	7	Kosawo Primary School
KISUMU	Male 10-14	7	Kosawo Primary School
KISUMU	Female 15-19	7	Alliance Milimani
KISUMU	Male 15-19	7	Alliance Milimani
KISUMU	Female 20-24	7	Manyatta Amazone
KISUMU	Male 20-24	7	Manyatta Amazone
ELDORET	Female 20-24YRS	8	EL Top College
ELDORET	Boys 10-14YRS	9	Kidiwa Primary School
ELDORET	Girls 10-14YRS	10	Langas Primary School
ELDORET	Sex workers	8	FHOK- Eldoret
ELDORET	Young men 20-24yrs	8	EL Top College
ELDORET	Girls 15-19yrs	8	High school
ELDORET	LGBTI	8	FHOK- Eldoret
ELDORET	PLWHIV 10-14YRS	10	FHOK-Eldoret

ANNEX 2: Participants interviewed in the KIIs

REGION	Type	Number
NAIROBI	Health service provider	4
	Youth representatives	3
	Youth resource person	1
	Sex worker	1
KISUMU	Field officer	1
	HTC (service provider)	1
	Health service provider	1
	Youth coordinator	1
	Youth representatives	5
ELDORET		
	Health service provider	2
	Program staff	1
	Youth representatives	3
Total		**24**

Annex 3 survey tool

ACCESS, SERVICES AND KNOWLEDGE ON SEXUAL REPRODUCTIVE HEALTH AMONG YOUNG PEOPLE IN NAIROBI, KISUMU AND ELDORET

FAMILY HEALTH OPTIONS KENYA

Questionnaire number: _____ Date: _____

Name of Research Assistant: _____

Supervisor Signature: _____ Date: _____

Hello my name is..... and my colleague is …… We are conducting this study on behalf of Sexual and Reproductive Health Alliance to understand the current knowledge, attitude and practice in relation to sexual reproduce health (SRH) among youth in Nairobi, Eldoret and Kisumu. We are gathering information to inform on promising approaches and strategies that will ensure youth are equipped with accurate and relevant information for informed decision making.

The information you provide will remain confidential, for research purposes only. Participation in this discussion is purely voluntary and there is no any penalty for refusing to respond to any question. If you have any questions regarding this study, please direct to: Stephen Njoka of Family Health Options Kenya, Tel: 020- 6003923/7 or Johnstone Kuya of the Sexual and Reproductive Health Alliance (SRHA), P.O BOX 19329-00202 Nairobi, Tel 0710630635.
Thank you.

Do I have your consent to continue with the discussion? 1=Yes 2=No
Do you have any questions to ask me before we begin? 1=Yes 2=No

Target respondents:

1. *Younger adolescents aged 10-14 years old*
2. *Older adolescents aged 15-19 years old*
3. *Young adults aged 20-24 years old*

A.PERSONAL DETAILS

1. How old are you (in years) or Date of birth ? ☐☐ or ___/___/☐☐☐☐

2. Where do you live?

☐Kisumu ☐Eldoret ☐Nairobi

3. What is your current marital status?

☐Single ☐Engaged ☐Married ☐Widowed ☐Divorced

☐ Other, please specify. ……..

4. What is your level of education?

☐No education ☐Primary school ☐Secondary ☐Technical/Polytechnic

☐University graduate

5. What is your religion?

☐Christian ☐Muslim ☐Don't know ☐Others, specify

B. SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE

Indicate whether you think the following statements are true or false, or that you don't know.

(If adolescent below 15 years, skip statements deemed not relevant)*

Statements	**True**	**False**	**Don't know**
1. Girls can get pregnant first time they have unprotected sexual intercourse.			
2. Women can get pregnant through kissing or touching			
3. Within the menstrual cycle, there is a period during when there is a high possibility of pregnancy			
4. *Condoms distributed by Family Health Options (FHOK) are only for family planning			
5. *Using emergency contraception after unprotected sexual intercourse is like committing abortion			
6. It is bad / immoral for youth to access contraceptives			
7. Abstinence is the best way to prevent HIV infection amongst youth			
8. *Abortion is one of the methods for family planning.			
9. Young people with disability should not have sex			
10. ARV treat HIV and AIDS if you start using it earlier			
11. It is not possible for a healthy-looking person to have HIV virus			
12. Male circumcision reduces the chances of getting infected by HIV/AIDS			

C. ACCESS TO SERVICE AND UTILIZATION

No	Questions	Response
General issues		
1a	Are there places in this area where young people like you are able to seek sexual and reproductive health (SRH) information and services? *List all the places if response is yes.* …… …… …… ……	• Yes (proceed to Q.2) • No • No response • Don't know_____
1b	If no, explain …… …… ……	
2	What kinds of sexual and reproductive health information and services are provided for youth? *Tick all Mentioned*	• Education on SRH • VCT for HIV • Miscarriage/Post-abortion care services • Family planning services • STI counselling and treatment • Pregnancy care and delivery • No response • Don't know • Can't recall
3	What are some of the barriers that have	• Accessibility

	made young people not to seek SRHR services?	• Acceptability (e.g. parents do not allow me to go) • Young people are not expected to get SRHR information • There is nothing to go there for • Affordability (cost) • Not friendly • Confidentiality • Unmarried people do not need SRHR information • Other (specify)_____
4	In your opinion, who should go for SRHR services Tick all that apply	• The married • Young people like us • Sex workers • Street children • Older people • Girls • Girls and boys • Other (specify)_____
Individual		
5	Have you ever visited a Family Health Options Kenya (FHOK) facility in the last one-year?	• Yes • No • Wanted to, but FHOK not accessible • No response • Don't know • Can't recall

6	Have you ever visited FHOK facility in the last three months?	• Yes 1 • No 2 • Wanted to, but FHOK facility not accessible • No response • Don't know • Can't recall
7	How did you get to know about the FHOK facility?	• Radio • Social Media • Facebook • Friend • Outreach • Parent • Others (specify)……..
8	What was the reason for your most recent visit to FHOK facility? *Tick all mentioned*	• Education on SRH • VCT for HIV • Miscarriage • Post-abortion care services • Family planning services • STI treatment and counseling • Pregnancy care and delivery • Vaccination • Get condoms • Other (specify) _____ • No response • Don't know

9a	Did you like the information and/or services?	• Yes • No • I don't know
9b.	If yes, what did you like about the services? *Tick all mentioned*	• Knowledgeable and well-qualified staff • Friendly and polite • Interested in you and your problems • A good communicator • Respectful • Concerned about your privacy • Honest and direct • A good listener • Able to help you • Other (specify) _____ • No response • Don't know
10	Would you return to FHOK facility again?	• Yes (skip to Q.9) • No (proceed to Q.8) • No response • Don't know
11	What is the reason that you won't return to the FHOK facility? *Tick all mentioned*	• Not easy to access • Takes too much time • Expensive • Too embarrassing • No privacy

		• Staff not friendly • No staff of the same sex available • All the staffs are like my parents • Other (specify)_____ • No answer • Don't know
12	Whom did you talk to or see at FHOK facility the last time you went? *Tick all mentioned*	• Doctor • Nurse • Nurse Aid • Youth peer educator • Other (specify)_____ • No answer • Don't know
13	On a scale of 1-5, how would you rate the *quality of service* of staff on the following? *Indicate the score against each attribute (REMEMBER 1 is weakest score and 5 the strongest)*	• Knowledgeable and well-qualified [1], [2], [3], [4], [5] • Friendly and polite [1], [2], [3], [4], [5] • Interested in you and your problems [1], [2], [3],[4], [5] • A good communicator [1], [2], [3],[4], [5] • Respectful [1], [2], [3],[4], [5] • Concerned about your privacy [1], [2], [3], [4], [5] • Honest and direct [1], [2], [3], [4], [5] • A good listener [1], [2], [3], [4], [5] • Able to help you [1], [2], [3], [4], [5] • Other (specify) _____ [1], [2], [3], [4], [5]

		• No response • Don't know
14	Do you have peers who also visit the FHOK SRHR services?	• Yes • No • I don't know
15a	Would you feel comfortable recommending FHOK Facility to a friend for sexual and reproductive health services?	• Yes • No (proceed to Q.12)
16	Why wouldn't you feel comfortable recommending FHOK facility for sexual and reproductive health services? *Tick all mentioned*	• Not confidential • Too embarrassed • Staff unfriendly • Costs too much • Other (specify)_____ • No response • Don't know
17	Should young people who are not sexually active supposed to go for SRHR information and services?	• Yes • No • I don't know
18	Do you have peers with whom you discuss SRHR issues openly and regularly?	• Yes • No • I don't know
19	Are there young people whom you work with to link you up to FHOK SRHR services?	• Yes • No

	List all those mentioned *if yes.* …… …… …… ……	• I don't know
20	What should FHOK facility do to encourage more young people to seek these SRH information and services?	List all those mentioned: …… …… …… …… ……

Thank you so much for your participation