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Original Article

The Utilization of Youth Friendly Sexual and Reproductive Health Services and its Association with Socio-demographic Factors and Knowledge in Nakuru County, Kenya

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ABSTRACT

There are global drives towards supporting adolescents' sexual and reproductive health and rights, access to and use of these services among young people in low- and middle-income countries. However, the utilization of Friendly Sexual and Reproductive Health Services remains inadequate, posing a major challenge to progress in this area. This study aimed to examine the utilization of Youth Friendly Sexual and Reproductive Health Services and its association with socio-demographic factors and knowledge in Nakuru County, Kenya. This was a cross-sectional study done in one county in Kenya purposively selected and involved a sample of 400 youths (10-24 years). The response rate was 90 % (n=400). About two-thirds (64%, n=340) of the sampled youths were affirmative to using the Youth-Friendly Sexual and Reproductive Health Services which is considered suboptimal. Whereby it is evident that Kenya is doing better in the utilization of Youth-Friendly Sexual and Reproductive Health Services than its peer countries in the region, it has not achieved the target of 85% utilization as envisaged in the Adolescent Reproductive Health and Development Plan of Action 2005-2015. The utilization of Youth-Friendly Sexual and Reproductive Health Services of significantly associated with the level of education (x2(2) =0.256, p=0.002) and awareness/being knowledgeable (x2(1) =0.019, p=0.001) on Youth Friendly Sexual and Reproductive Health Services. This study thus recommends that policies and programs to upscale the utilization of Youth-Friendly Sexual and Reproductive Health Services should focus on building a knowledge base for the youths on the said subject. Furthermore, the curriculums should introduce aspects of Youth-Friendly Sexual and Reproductive Health Services early enough in the primary school level to formally expose them to sexual health knowledge and eventually improve utilization.

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INTRODUCTION

Globally, there are 1.8 billion young people aged 10 to 24 years, representing about 25% of the world's population, with over 90% living in developing countries (Population Reference Bureau, 2024). In Kenya, statistics from the Kenya National Bureau of Statistics (KNBS) census report estimate the youth to be about 46% of the population and youth aged 10-24 years makeup 22.2% of the population (KNBS, 2019).

The International Conference on Population and Development (ICPD) identified and recommended that adolescent, sexual, and reproductive health issues be addressed by promoting responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and providing appropriate services and counselling tailored to that age group. Countries were asked to guarantee that healthcare providers' policies and attitudes do not limit youth access to and use of the services and information they require. These services must protect adolescents' rights to privacy, confidentiality, respect, and informed consent while also respecting cultural values and religious beliefs, as well as parents' rights, duties, and responsibilities (National Guidelines for the Provision of Adolescent Youth-Friendly Services (YFS) in Kenya, 2015). Youth Friendly Sexual and Reproductive Health Services encompass a combination of health facility attributes, service delivery approaches, and the range of health services provided, all of which serve as critical strategies for enhancing adolescent health outcomes across Africa (Ninsiima et al., 2021).

In pursuit of the reproductive health agenda which was deliberated in ICPD, the government adopted the National Reproductive Health Strategy (NRHS) for Kenya 2007-2010 whose strategy identified reproductive health priority areas as: family planning and unmet needs; safe motherhood and child survival initiatives; promotion of adolescent and youth health; gender and reproductive rights; management of STIs/HIV/AIDs; management of infertility; and other reproductive health issues. Within the context of the Strategy, standards for reproductive health service providers were released in 1997 and implementation plans were developed to guide reproductive health needs in the country (National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya, 2015).

The National Reproductive Health Strategy (NRHS) for Kenya 2007-2010 was adopted by the government in pursuit of the reproductive health agenda discussed at ICPD. The strategy identified the following as priority areas for reproductive health: management of STIs/HIV/AIDS; management of infertility; promotion of adolescent and youth health; safe motherhood and child

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survival initiatives; gender and reproductive rights; family planning and unmet needs; and other reproductive health issues. Standards for reproductive health care providers were published in 1997 as part of the Strategy, and strategies for execution were created to direct the nation's reproductive health requirements (National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya, 2015).

In order to establish a framework for the equitable, effective, and efficient provision of high-quality reproductive health services to the populace, particularly those deemed vulnerable like the youth, the Kenyan Ministry of Health formally approved the nation's first National Reproductive Health Policy (NRHP).

The policy's objectives are to direct the planning, standardization, execution, monitoring, and assessment of reproductive health care delivered by different stakeholders. Adolescent/youth sexual and reproductive health and gender issues, family planning, safe motherhood, and maternal and neonatal health are its main concerns (NRHP, 2022-2032). The primary focus of the health care services provided to children in schools is on issues like the physical environment and sanitation of the school, nutritional status, vaccinations, and the management of common childhood ailments. The National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya (2015) state that reproductive health issues receive inadequate attention.

However, in spite of these efforts, young people's use of reproductive health services is still hindered by a number of issues, including the delicate nature of teenage sex and sexuality and inadequate evaluation and policy frameworks, which lead to underutilization. The Ministry of Public Health and Sanitation started the process of integrating priority concerns into the Kenya Essential Package for Health (KEPH) Program, especially at the community level of health care in response to the demands of young people in terms of reproductive health. With a commitment to addressing concerns related to adolescent reproductive health brought up by the Kenya Health Policy Framework of 1994 and the National Population Policy for Sustainable Development, the government also approved the Adolescent Reproductive Health and Development Policy (ARH&D) in 2003(National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya., 2015).

Adolescent sexual health and reproductive rights; harmful practices, such as female genital cutting, early marriage, and gender-based violence; drug and substance misuse; socioeconomic considerations; and the unique needs of adolescents and young people with disabilities were all intended to be addressed by the policy. The goal of this program was to reduce the percentage of women under 20 who had their first birth from 45% in 1998 to 22% and raise the percentage of facilities providing Youth-Friendly Sexual and Reproductive Health Services to 85%, up from 7% at the time(National Council for Population and Development(NCPD), 2010) (NCPD, 2010).In terms of providing for the reproductive health requirements of Kenya's more than 40% youth population, this fell well short of expectations (KNBS and ICF., 2023)

In an attempt to address the sexual and reproductive health needs of young people, the Adolescent Reproductive Health and Development Plan of Action 2005-2015 was created to direct the policy's implementation. Later, a National Guideline for Provision of Youth-Friendly Sexual and Reproductive Health Services was created, and funding was made available. In an evaluation of HIV/AIDS progress and youth reproductive health in Sub-Saharan Africa, including Kenya, Mutua et al. (2020) came to the conclusion that peers, parents, teachers, and religious leaders all have an impact on the health of young people.

Lack of proper information exacerbates teenage sexuality issues since, in the past, grandparents and aunts provided this information, but as urbanization

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has risen, this is no longer the case (Embleton et al., 2023). Additionally, they stated that urbanization has caused a breakdown in the traditional channels of communication that adults used to provide information and guidance to the youth, leaving them vulnerable to sexually related issues. The majority of ethnic moral and traditional codes forbid premarital sex and pregnancy, and any youth found to be using family planning services is reprimanded, which instils fear in the youth, particularly regarding the use of family planning.

A number of studies done in Kenya showed that the utilization of Youth-Friendly Services is suboptimal at less than 50%. Furthermore, these studies elucidate several factors including socio-demographics and knowledge that may influence the utilization of Youth Friendly Sexual and Reproductive Health Services (Embleton et al., 2023; Murigi et al., 2020; Mutua et al., 2020; Ninsiima et al., 2021; Nyaga, 2023). Thus this study aimed to examine the utilization of Youth Friendly Sexual and Reproductive Health Services and its association with socio-demographic factors and knowledge in Nakuru County, Kenya

METHODOLOGY

Study Area

The study was carried out in the Gilgil sub-county in Nakuru County, Kenya. The town is located between Naivasha and Nakuru and along the Nairobi - Nakuru highway. It is to the west of the Gilgil River, which flows south to feed Lake Naivasha. Gilgil has a population of 185,891 according to the Health Information Records 2015. Gilgil sub-county is made up of 5 wards Gilgil Ward, Eburu/Mbaruk, Malewa West, Morendat Ward and Elementaita Ward. Gilgil is the centre of the Gilgil Sub-County in Nakuru County. Agriculture is the main local economic activity.

Study Design

The study was a descriptive cross-sectional study design whose main purpose was to observe/describe/document all aspects of the situation as it naturally appears. The aim of this design was to gain more information about the characteristics within the study.

Population and Sample

The target populations were all youth in Nakuru county in Kenya and the accessible population is the 39,049 youths in Gilgil subcounty in Nakuru county. The sample included youths (10-24 years) who consented.

Sampling Techniques

The researcher used a two-stage sampling method. Cluster sampling was used to identify the wards in Gilgil sub-county and a simple random sampling method was used to identify a village/estate in the cluster where the respondents in this village/estate were interviewed.

Sample Size Determination

The sample size was calculated using the Yamane formula (1967) which yielded 396 which was rounded off to 400 respondents to accommodate sampling error.

Data Collection Tools

A self-administered questionnaire was used to collect primary data from the residents under study.

Validity and Reliability

The questionnaire design was pre-tested by hand delivering them to a sample of 10% of the desired sample size and thereafter collecting them dully filled followed by refining of errors to ensure it is reliable for collection of data relevant to this study. Refining errors on the questionnaires to ensure it is valid for the collection of data relevant to this study. The questionnaire was developed in consultation with experts to ensure validity. The enumerators were trained prior to the study.

Data Analysis

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The data collected was edited, coded, cleaned, categorized and tabulated as appropriate. Statistical Package for Social Science version 28 was used to analyze and present the data respectively. Quantitative data was analyzed by descriptive statistics and further subjected to inferential statistics precisely the Chi-Square test of significance to measure the association of variables. The information generated was presented in prose, tables and graphically.

STUDY FINDINGS

Socio-demographic Factors

The Response rate for this study was 90% (n=400) with 51 % (n=340) of the respondents being female respondents and 49% (n=340) being male respondents. Most of the respondents (81%, n=340) were in the age bracket of 20 – 24 years, followed by 15-19 years (12%, n=340) and the least in numbers (7%, n=340) were the 10-14 years age bracket. The majority of the respondents (55%, n=340) were or had gone through tertiary education, followed by those who were or had gone through high school education (38%, n=340) and the least in numbers (7%, n=340) were in or dropped studies at the primary education level. The highest level of education was boarding status for 68% (n=340) and day status for the remaining 32% (n=340). The study established that 78% (n=340) of the respondents were of Christian religion while 22% (n=340) were of Muslim religion. Twenty-eight per cent (28%, n=340) were full-time students while the rest assumed three occupational statuses namely; business/self-employment (38%, n=340), casual labourers (24%, n=340) and formal employment (10%, n=340).

Knowledge of Youth-Friendly Sexual and Reproductive Health Services

The majority of the respondents (72%, n=340) were aware of youth-friendly services and 28% (n=340) were not aware of Youth-Friendly Sexually and Reproductive Health Services.

Table 1: Knowledge of Services Offered by Youth-Friendly Sexual and Reproductive Health Facilities

	Youth –Friendly Sexual and Reproductive Health Services items	Frequency	Percent
1.	Family planning	24	7.0
2.	Voluntary Counseling and Testing	143	42.0
3.	Treatment of all diseases	27	8.0
4.	Treatment of STIs	65	19.0
5.	Care of pregnant young persons	37	11.0
6.	General health information/counselling	31	9.0
7.	Sport and recreational activities	14	4.0
	Total	**340**	**100.0**

The Youth-Friendly Sexual and Reproductive Health Service item most known is Voluntary Counseling and Testing (42%, n=340) and the least known was Sports and Recreational Activities (4%, n=340) as demonstrated in the preceding table.

On inquiring about the source of information, the leading sources were friends/peers (33%, n=340) and the least were their teachers (19%, n=340) as demonstrated by Figure 4.1 below.

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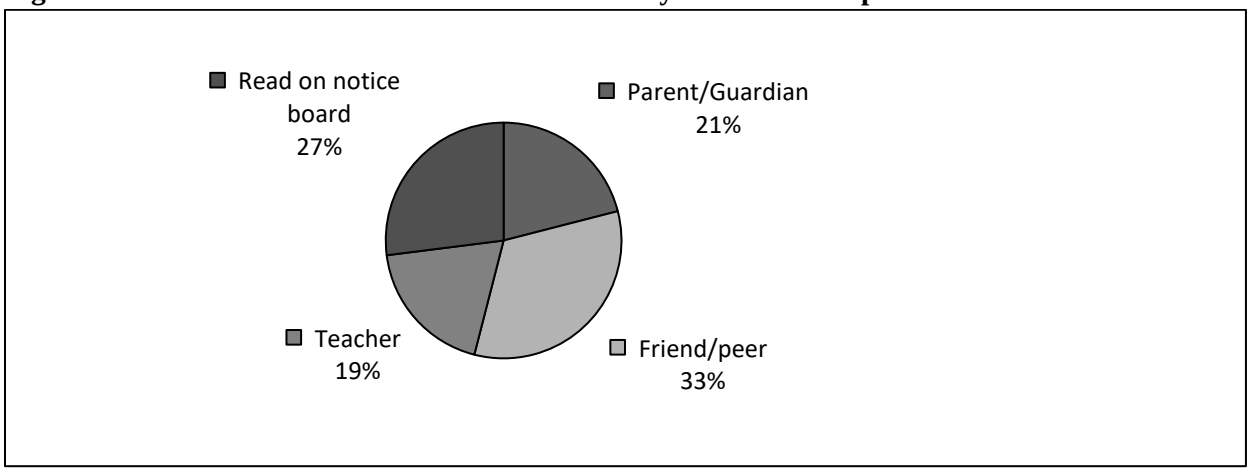
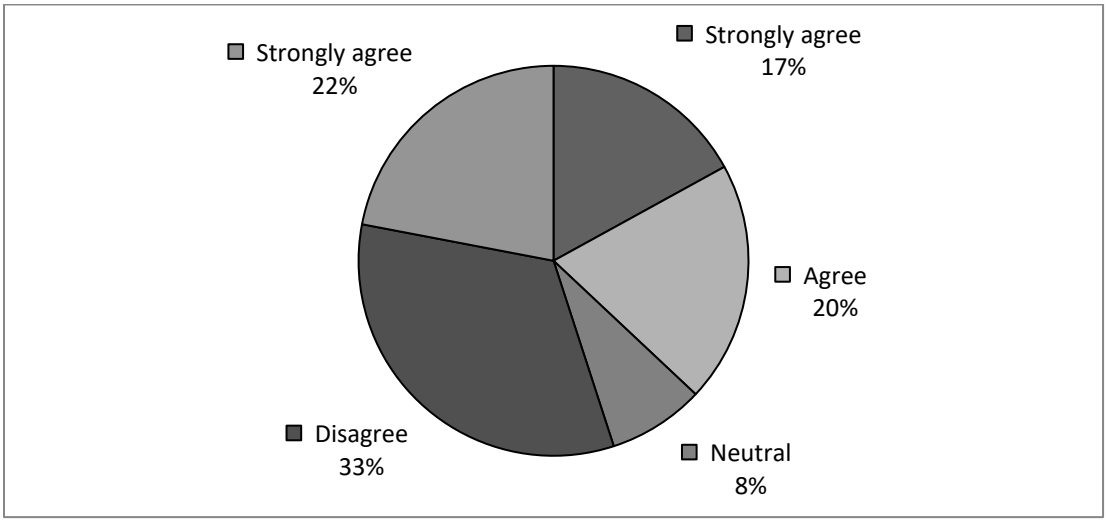
Figure 4.1. Source of Information on Youth-Friendly Sexual and Reproductive Health Services



Utilization of Youth-Friendly Sexual and Reproductive Health Services

About two-thirds (64%, n=340) of the sampled youths were affirmative to ever-use the Youth-Friendly Sexual and Reproductive Health Services while the rest have never utilized the services. Those who had utilized the Youth-Friendly Sexual and Reproductive Health Services were asked if they considered the service friendly, and 37%(n=218) either agreed or strongly agreed and the majority either disagreed, strongly disagreed or were neutral as shown in Figure 4.2 below.

Figure 2: The Youth-Friendly Sexual and Reproductive Health Services are friendly Services



Those who did not utilize the contemporary Youth-Friendly Sexual and Reproductive Health Services were probed on who offers alternative services and most of them answered that it's the community leaders (35%, n=122). Other providers were spiritual leaders (33%, n=122), teachers (17%, n=122) and parents/relatives (15%, n=122).

The Association between Dependent Variables and Utilization of Youth-Friendly Sexual and Reproductive Health Services

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Table 2: The Association between Socio-demographic Characteristics and Utilization of Youth-Friendly Sexual and Reproductive Health Services

	Variable	Categories	Utilization of Y-FS&RH Services			
			Frequency N=218	Percentage	X^2	p-value
Age	**10-14 years**		**12**	**48.0%**	**0.458[a]**	**.499**
	15-19 years		**24**	**59.0%**		
	20-24 years		**182**	**66.0%**		
Gender	**Females**		**115**	**69.0%**	**1.058[a]**	**.559**
	Males		**103**	**59%**		
Education	**Primary Sch**		**10**	**42.0%**	**0.256[a]**	**. 002**
	High sch		**66**	**51.0%**		
	Tertiary		**142**	**76.0%**		
Sch Status	**Day**		**47**	**43.0%**	**0.358[a]**	**.568**
	Boarding		**171**	**68%**		
Religion	**Muslims**		**35**	**47.0%**	**0.458[a]**	**.499**
	Christians		**183**	**69%**		
Occupation	**Formal employment**		**141**	**63.0%**	**0.658[a]**	**.569**
	Casual labourer		**57**	**67%**		
	Self-employed/bus		**22**	**65%**		
Knowledge	**Knowledgeable**		**194**	**79.0%**	**0.019[a]**	**.001**
	Not Knowledgeable		**24**	**25%**		

A Pearson Chi-Square test of independence was employed to compare the socio-demographic characteristics and knowledge by the utilization of utilization of Youth-Friendly Sexual and Reproductive Health Services. A significant association was demonstrated in one socio-democratic variable namely the level of education ($x^2(2) =0.256$, p=0.002). Additionally, a significant association was also shown in being knowledgeable ($x^2(1) =0.019$, p=0.001) on Youth-Friendly Sexual and Reproductive Health Services and its utilization. The results of the test of association using Pearson Chi-Square test of independence as summarized in Table 4.2.

DISCUSSIONS

Socio-demographic Characteristics of Respondents

The overall response rate was 90% (n=400) which represents good participant engagement and motivation in the study and also improves the reliability of the results. The female participants made up 51% while the male fraction comprised 49%. Respondents aged from 20 to 24 years old made up 81% of respondents, followed by 15 to 19-year-olds with 12% and 10 to 14-year-olds with 7%. The general population age structure is youthful which suggests that the population is in transition of education and early adulthood (KNBS, 2019).

55% of the respondents had attained tertiary education, 38% with high school education and only 7% with primary-level education. Hence, an educated youth population is living in urban and peri-urban areas (UNESCO, 2021). Respondents who lived in boarding schools accounted for 68% while those who attended as day scholars were only 32%, suggesting that the level of control a school has on students may affect access to SRH information. Most Christians made up 78% followed by Muslims who represent 22%. This is similarly in line with the general demographics of Kenya (Pew Research Center, 2017).

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Knowledge of Youth-Friendly Sexual and Reproductive Health Services

The research discovered that 72% of those surveyed were knowledgeable about the Youth-Friendly Sexual and Reproductive Health (YFSRH) services, in comparison to 28% who were not knowledgeable. This is indicative of positive improvements in the SRH information dissemination process among youths in the country and corresponds with the policies aimed at increasing the health service accessibility for young people (Ministry of Health (MOH), Kenya, 2018). Among the services, Voluntary Counseling and Testing (VCT) had the highest recognition rate (42%) while the lowest recognition rate (4%) was associated with sports and recreational activities. This trend demonstrates a lack of awareness of more comprehensive approaches to SRH care apart from clinical services (UNFPA., 2021).

Peers and friends were mentioned as the leading source of SRH information (33%), while teachers were mentioned the least (19%). Despite the influence of peers being a powerful channel of information, the very low dependence on teachers demonstrates a missed opportunity from within the education system to provide comprehensive SRH educational services (Mbeba et al., 2012; UNESCO, 2021). There is a need to bolster the active participation of educators and provide comprehensive sex education in schools to improve the scope and quality of SRH educational materials. A profile review of the respondents indicated that 28% were full-time students while others reported being business owners or self-employed (38%), working as casual laborers (24%), or working in formal jobs (10%). These findings indicate a mixed socioeconomic distribution alongside a range of health service access (World Health Organization (WHO), 2020).

Utilization of Youth-Friendly Sexual and Reproductive Health Services

The study indicated that 64% of respondents reported utilization of YFSRH services suggesting moderate usage of health services. However, only 37% of those who had used the services considered the service friendly, the majority being neutral or outright dissatisfied. It appears that some level of accessibility is being achieved, but the construction of youth-friendly services remains problematic. Provider's attitude, confidentiality and youth participation are among the most important aspects argued to define the friendliness of the service (Chandra-Mouli et al., 2014).

For the respondents who had not used formal YFSRH services, the other available sources of support included community leaders 35%, spiritual leaders 33%, teachers 17%, and parents or relatives 15%. This identifies reliance on informal community-based figures as a gap in scholarly literature but also showcases the value of social support on health behaviours, while raising concerns about non-systematic or non-research-based advice (Chidwick et al., 2022).

The results from the Pearson Chi-Square test confirmed a notable correlation in regard to the difference in education achievements and the level to which they utilized services ($\chi^2(2) = 0.256$, $p = 0.002$). It also deepens the understanding of education's effect on promoting desired health-seeking behaviour. Moreover, the level of knowledge one possesses regarding YFSRH services and its use was significantly correlated as well ($\chi^2(1) = 0.019$, $p = 0.001$), reaffirming prior studies that argue that knowledge is the most active factor of participation and use of SRH services(Mmari & Sabherwal, 2013). This data calls for a distinct blended approach in focusing the adolescents that combines awareness, youth empowerment, and improved quality of the services to effectively address the uptake of Youth-Friendly Sexual and Reproductive Health services.

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CONCLUSION

About two-thirds (64%, n=340) of the sampled youths were affirmative to ever-use the Youth-Friendly Sexual and Reproductive Health Services which is considered suboptimal. Whereby it is evident that Kenya is doing better in the utilization of Youth-Friendly Sexual and Reproductive Health Services than its peer countries in the region, it has not achieved the target of 85% utilization as envisaged in the Adolescent Reproductive Health and Development Plan of Action 2005-2015. The utilization of Youth-Friendly Sexual and Reproductive Health Services of significantly associated with the level of education ($x^2(2) = 0.256$, p=0.002) and awareness/being knowledgeable ($x^2(1) = 0.019$, p=0.001) on Youth-Friendly Sexual and Reproductive Health Services

Recommendations

Therefore, this study indicates policies and initiatives aimed at:-

- Increasing the use of youth-friendly sexual and reproductive health services ought to focus on educating young people about this subject matter.
- Additionally, in an effort to formally expose youngsters to sexual health information and ultimately improve utilization, the curricula should incorporate elements of Youth-Friendly Sexual and Reproductive Health Services early enough at the primary school level. For more precise results, similar research must be conducted with a larger scope and investigating experimental or quasi-experimental designs.

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