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Original Article

Availability and Readiness of Health Facilities to Deliver Sexual and Reproductive Health Services for Young People: A Case of the "Get Up Speak Out" Programme Implemented in Western Kenya

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ABSTRACT

Young people have reported poor Sexual and Reproductive Health (SRH) indicators over the years including teenage pregnancy, unsafe abortion, neonatal mortality, and Sexually Transmitted Infections (STIs) including HIV/AIDs, among others. Further, study findings have shown barriers to young people's access to and utilization of SRH services at health facilities include lack of confidentiality and privacy, stigma and discrimination, the unfriendly and negative attitude among service providers, long waiting time for services, and lack of information among young people on availability of SRH services at the health facilities. The limited access to SRH services among young people poses greater health risks to these groups such as a high risk of sexual and gender-based violence, a higher risk of unwanted pregnancies, and unsafe abortions. It is on this basis that the researchers conducted a study aimed at assessing the availability and readiness of Health Facilities to Deliver SRH Services for Young People in its implementation sites. A full-coverage survey across all 24 link health facilities of the Get Up Speak Out (GUSO) program implementation was conducted in May 2020 adopting an electronic approach in adherence to the MOH Covid-19 preventive guidelines. The study shows the alignment of health facilities' activities with the Youth Friendly Services (YFS) guidelines, such as staff YFS training, YFS time allocation, and meaningful youth participation in governance and decision-making structures. However, the study has highlighted gaps such as inadequate display of SRH information; inadequate engagement and adoption of young people's recommendations in health facilities' governance structures for improved delivery, access, and uptake of SRH services by young people.

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INTRODUCTION

The Get Up Speak Out program, a young people's SRHR program, since its inception in 2018, has been implemented in the Western Kenya region in 4 counties: Kisumu, Kakamega, Siaya, and Homabay in 5 sub-counties: Alego Usonga, Butere, Nyakach, Nyando, and Rachuonyo East in 29 Community Health Units (CHUs). GUSO's community-based approach engaged link health facilities (all public; Tier 2, 3, and 4) to the CHUs. GUSO trained service providers in the health facilities for improved access to SRH services among the young people. GUSO engaged a total of 24 health facilities in the 5 sub-counties from the initial 31 communities (Get Up Speak Out, 2020).

Studies and national surveys have reported poor Sexual and Reproductive Health (SRH) outcomes including teenage pregnancy, unsafe abortion, neonatal mortality, and Sexually Transmitted Infections (STIs) such as HIV/AIDs, among others in Kenya among young people aged 15-19 (Obare et al., 2016). Further, study findings have shown barriers to young people's access to and utilization of SRH services at health facilities, including lack of confidentiality and privacy, stigma and discrimination, the unfriendly and negative attitude among service providers, long waiting time for services, and lack of information among young people on availability of SRH services at the health facilities (Godia et al., 2013). A report of the public inquiry regarding sexual and reproductive services for the young people and the marginalized by the Kenya National Commission on Human Rights (2012) indicated that there was limited access to SRH services which posed greater health risks to these groups such as the high risk of sexual and gender-based violence, higher risk of unwanted pregnancies, and unsafe abortions.

It is on this basis that TICH in collaboration with Simavi designed the Get Up Speak Out (GUSO) program that adopted health facilities and linked Community Health Units; trained service providers on Youth Friendly service provision with an aim to improve access and utilization of Sexual and Reproductive Health (SRH) services among the young people (Pandey et al., 2019). TICH-GUSO therefore engaged 24 health facilities within the program implementation sites in five sub-counties in four counties of Western Kenya as shown in *Table 1*.

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Table 1: GUSO-CHU link Health Facilities

Sub-County	No. of Health Facilities
Alego Usonga	3
Butere	8
Nyakach	4
Nyando	3
Rachuonyo East	6
Total	24

MATERIALS AND METHODS

A health facility assessment survey was conducted among 24 public health facilities that serve as link health facilities to 29 Community Health Units where GUSO activities were implemented in Alego Usonga, Rachuonyo East, Butere, Nyakach, and Nyando Sub-counties. GUSO program was implemented for a period of five years. The survey aimed to assess the availability, accessibility, and utilization rates of SRHR services among the young people in the various communities. The survey targeted health facility personnel responsible for the youth-friendly services.

The survey was conducted during the Covid-19 period; hence the virtual approach was adopted to control the risk of spread of Covid-19. A questionnaire was developed, coded into Google Forms then shared with Health Facility in-charges for self-administration. The respondents were facilitated with data bundles to support the filling of questionnaires as the process was internet dependent. The health facility in-charges filled and submitted their forms to the Google Form server, which was only accessed by authorized personnel to maintain data quality and privacy. The data was later downloaded from the server, cleaned, and analysed using Ms. Excel.

RESULTS

A majority of the health facilities were located in rural areas (82.6%) while the rest were located in the peri-urban regions (17.4%), with the highest proportion comprising tier 3 health facilities (43.5%) followed by tier 2 (30.43%) and tier 4 at 21.7%.

Table 2: Health Facility Background Information

Background Information		N	%
Health Facility Location	Rural	19	82.61
	Peri-Urban	4	17.39
	Total	**23**	**100**
Facility Level	2	7	30.43
	3	10	43.48
	4	6	26.09
	Total	**23**	**100**

Service charters were found to have been displayed prominently according to the practice in the Kenyan health system by 91% of the health facilities. However, despite having the service charters, 22% of these health facilities did not include SRH services in their service charters as part of the services they offer.

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Table 3: Health Facility Services

Health Facility Services		**N**	**%**
Availability of Service Charters	Yes	21	91.30
	No	2	8.70
	Total	**23**	**100**
SRH on Service Charters	Yes	18	78.26
	No	5	21.74
	Total	**23**	**100**

Only about a quarter (26%) of the total personnel surveyed were trained on youth-friendly service provision. However, 61% of the staff in these health facilities were involved in providing SRH services to young people regardless of whether they were trained on Youth Friendly Service provisions or not.

A majority of the health facilities set aside time for youth-friendly SRH service access (61%). However, over a third of the health facilities, 39% did not allocate any specific time for young people, see *Table 4.*

Table 4: Health Facilities' YFS Time Allocation

		N	**%**
YFS Time Allocation	Yes	14	60.87
	No	9	39.13
	Total	**23**	**100**

Across the link health facilities, in the service providers' opinion regarding the frequency of SRH service uptake among the young people, a higher proportion (48%) noted that young people utilize SRH services frequently, followed by very frequently (34.78%) with somewhat frequently (17.39%).

Table 5: Frequency of SRH Service utilization by young people

		N	**%**
SRH Service Utilization	Frequently	11	47.83
	Somewhat Frequently	4	17.39
	Very Frequently	8	34.78
	Total	**23**	**100**

Up to 83% of the health facilities displayed SRHR information relevant to young people. However, up to 17% of the health facilities did not provide information on SRHR information and services. Almost half of the health facilities surveyed had no plan of conducting outreach for the young people (47.83%), while 52.17 had outreach plans for young people.

Findings showed that a majority of the health facilities had engaged young people in their management structures (78%), with up to 22% of health facilities that had not established meaningful youth engagement in their governance structures. Furthermore, despite the engagement of young people in governance structures at the health facilities, only 67% of health facilities integrating young people in their governance and management structures adopted recommendations from the young people.

DISCUSSION

The National Guidelines for Provision of Youth-Friendly Services (YFS) in Kenya 2016 reports that health care providers and clinic staff play a key role in ensuring that adolescents and youth access health care services. However, in the surveyed health

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facilities, only a small proportion of health personnel providing SRH services to young people are trained in Youth Friendly Service provision. This finding reaffirms evidence from a previous study that healthcare providers lack the knowledge and skills needed to attend to young people (Kibaru et al., 2016). Training has been shown to equip staff with good interpersonal communication skills and be able to interact freely with young people, put them at ease, and encourage them to share their needs and concerns freely (Mazur et al., 2018). This implies that personnel involved in SRH services delivery are most likely unaware of the sensitivity and complexity with which their client, the young people present in service access. Lacking the awareness and skill of how to take care of young people could most likely be a contributor factor to low utilization of SRH services by young people in the community.

Findings show that one in three health facilities did not allocate specific time for young people's SRH services. Time allocation for young people's SRH service has been identified as one of the topmost drivers of youth friendliness, where it has been noted to bring convenience for the young people hence offering success to youth-friendly SRH service delivery (Eva et al., 2015). There could be inadequate information on resources required for young people's SRHR among health facilities that haven't allocated time for SRHR services for young people. Consequently, implying inadequate resource planning and funding for young people's SRHR. This could possibly be the reason for unpreparedness among health facilities for responsive and quality SRH service delivery.

While a high proportion of health facilities displayed SRHR information relevant to young people, about 4 in every 23 health facilities failed to provide such information on SRHR information and services to their catchment young people. This finding reaffirms that some young people would still remain ignorant of the availability of SRHR information and services at their link primary healthcare facilities (Starrs et al., 2018). The absence of information at health facilities only reinforces the cultural and community barriers that surround issues of sexuality, making it a controversial topic. The importance that all young people need to receive reliable information in order to prepare them for safe, productive, and fulfilling lives, has been established (Herat et al., 2018). Indeed, one of the key goals of Sexual and Reproductive Health Services (SRHS) is the provision of health information, education, and counseling; provide a range of safe and affordable contraceptive methods; quality obstetric and antenatal care for all pregnant girls; testing (pregnancy and HIV); prevention and management of STIs; conduct promotional activities; and encourage active participation of adolescents (Hindin & Fatusi, 2009). Therefore, the lack of service charter and display of SRH information leaves many young people, including those who take their time to visit the health facilities, to be uninformed about the services provided. Ignorance can be powerful in keeping young people away from seeking healthcare services.

Findings indicate that a majority of health facilities had no plans to conduct young people SRHR outreaches. Evidence from other studies recommends outreach services in acceptable scenarios for improved interaction and understanding of the young people's choice of SRH service provider. Additionally, this leads to a better understanding of preferences for outreach services compared to clinic-based services (Michaels-Igbokwe et al., 2015). The absence of outreach plans may mean an underestimation of resources required for the health facility to deliver SRH services for young people in the manner and sensitivity that is required as a consequence of low reach in access for the service, especially in a situation where some young people are leaving under hard-to-reach circumstances.

While one in every three health facilities lacked structures to meaningfully engage young people in their governance systems, a third of those with structures did not show any evidence to have ever taken in recommendations from young people on governance boards. This finding is consistent with evidence elsewhere that showed that uptake of youth perspectives is restricted to matters already "approved" by adult decision-makers and that youth-led efforts to introduce new priorities face continuing obstacles, confirming further the fact that there exists a critical gap between the widespread insistence around the need to involve young people in policy and the reality of their

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engagement in practice (Wigle et al., 2020). Effective representation is important in ensuring interests are considered. This implies that a number of health facilities still lack the required platform and commitment to maximize recognition and adoption of young people's interests in so far as SRH service delivery is concerned. This would most likely reduce the ability for the services to be responsive to the needs of the target clients and therefore reduce demand and uptake of the same.

CONCLUSION

The study shows that there is an improvement as demonstrated by a high number of health facilities in aligning their activities with the YFS guidelines, such as YFS training, YFS time allocation, and meaningful youth participation in governance and decision-making structures. However, the results also reveal some grey areas that County ministries of health would need to investigate to accelerate gains in improving access to SRH services by young people. The study has identified gaps in a display of service charter and SRHR information; absence of participation of young people on health facility governance boards, and inadequate commitment to engage the young people meaningfully for boards that have integrated young people; some facilities failed to allocate time for SRH service to young people; and lack of plans for outreach services to enhance reach to the hard-to-reach young people.

Recommendation

This study finds six areas that County Ministries of Health need to address to strengthen the delivery of appropriate SRH services to young people. These include;

- Display of service charters by all health facilities,
- Display of SRHR information by all health facilities,
- Integration of young people on health facility governance boards to represent the interest of the young people,
- Improve the adoption rate of young people's agenda and recommendations by the boards,
- Facilitate all health facilities to allocate time for SRH service to young people, and
- Health facilities to include outreach services in their operational plans.

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