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Influence of Youth Socio-Demographic Characteristics on their Perceptions of Health Facility Factors in Kisumu, Kakamega and Homabay Counties

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Worldwide, societal shifts and behavioural patterns exacerbated by unique developmental vulnerabilities create a confluence of factors that place today's adolescents and youth at heightened risks for poor health outcomes. Youth's Sexual and Reproductive Health (SRH) has emerged as an area of key concern globally and a major topic regarding planning and establishing health goals, as noted by the importance brought out by World Health Organization. The purpose of this study was to determine the influence of youth socio-demographic characteristics on their perceptions of Health Facility factors in Homabay, Kisumu, and Kakamega Counties. The study utilised a cross-sectional descriptive design to understand the perceptions of youth seeking SRH services on health facility factors in Homabay, Kisumu, and Kakamega Counties. Findings indicate that SRH services received among youth were comparable, where 97% of males and 100% of females who visited health facilities for services received SRH services, respectively. Furthermore, findings show that only the sex variable among the socio-demographic characteristics had no significant difference, while age, education, and marital status all show significant differentials in perceptions among the youth seeking and utilising SRH services. The study also found statistically insignificant perceptions for the cost of service, opening hours convenience, cleanliness at the facility, and privacy in healthcare delivery, as a statistically significant difference was found in feeling comfortable to return any time for service and youth users to recommend health facility to friends, availability of prescribed drugs, knowledge, and skills of health personnel, waiting time, and overall satisfaction in manner youths was treated. This study recommends maximum optimisation of the opportunity presented by

the existing healthcare system to provide SRH services to youths with the aim of reducing or eliminating differentials in SRH services access due to socio-demographic characteristics of youths.

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INTRODUCTION

Sexual Reproductive Health (SRH) among young people has emerged as a major topic in planning and establishing health goals that stipulate the need for youths to have quality health care (WHO Factsheet, 2010). Continental population remain high at approximately 1.2 billion with the highest number being youth aged 15–24 years, 226 million—19% of the global youth population—of whom live in sub-Saharan Africa (Mazur *et al.*, 2018). Youth is characterised as a period of optimum health with a series of physiological, psychological, and social changes that may expose them to unhealthy explorative sexual behaviour such as early sex engagement, unsafe sex, and numerous sexual partners. In many African countries, especially Sub-Saharan Africa, youth SRH needs are often underserved and underestimated despite their demonstrated need and the urgency of these services (Ninsiima *et al.*, 2021). In Kenya, youth-friendly SRH services strategic improvement is classified under youth-friendly policies, friendly health service providers and support staff, and friendly service delivery mechanisms such as convenient opening hours, privacy, and comprehensiveness of services which have so far been cited as essential

(Godia *et al.*, 2014). Poor performance of SRH among youth has received a lot of attention which has led to program adoption by a consensus of 179 governments during the International Conference for Population Development (ICPD) 1994, which emphasised that SRH is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (Adan *et al.*, 2018).

Despite these efforts, youth still constitute over half of all new HIV infections (Ayehu *et al.*, 2016), condom use among youth is still very low, uptake of HIV testing is only slowly increasing, and they experience the highest unmet need for contraception (Youth Reproductive and Sexual Health Report, 2008; Godia *et al.*, 2013). In Kenya, the majority of young people (90%) know where to obtain an HIV test, but less than half have ever done so (KDHS, 2014). A majority of youth are still vulnerable to SRH risks, including early marriage, early and unwanted pregnancy, unsafe abortions, and sexually transmitted infections and HIV/AIDS (UNFPA, 2008). This is associated with inadequate SRH information arising from lack of access to SRH education (de Castro *et al.*, 2018), early marriage and pregnancy-associated with adolescents' having

minimal or no voice in decision making in SRH matters, poor quality SRH services where concerns about privacy and confidentiality related to the health care provider and health facility infrastructure, unsafe abortion, gender-based violence, sexuality, and family planning (Guatam *et al.*, 2018; de Castro *et al.*, 2018). It is against this background that this study seeks to find empirical evidence on the influence of socio-demographic characteristics on youth perceptions of health facility factors in Kisumu, Kakamega and Homabay Counties.

METHODS

The study utilised a cross-sectional descriptive design which is aimed at generating quantitative information on factors influencing the perceptions of youth seeking SRH Services on Health Facility Factors in Homabay, Kisumu, and Kakamega Counties. The study was conducted in the Western Region of Kenya in 3 Counties; Homabay, Kisumu, and Kakamega. Purposive sampling was utilised in the selection of the 55 health facilities in consideration of health facilities within areas with high proximity to places with the highest number of youth and also project implementation areas – which were also considered due to relatively low utilisation level of SRH services by youth compared to other regions. The health facilities were situated in prep-urban and rural parts of the Counties. The study population comprised youth between the ages of 18 to 24 years, both females and males, who sought SRH services in a health facility setup. All youths were included irrespective of characteristic differences, which include age, sex, level of education, marital status, and geographical location. The study utilised Yamane's formula for sample size determination having a confidence level of 95% and a significance level of 0.05 (Yamane, 1967). Data was collected using structured health facility client exit assessment forms comprising different sections. The first part of the tool measured personal variables. The second part ascertained the respondents' feelings on the services accessed at the health facility and the type of services offered or availed like awareness of types of contraceptive use (8 methods of contraceptives) and lastly, the satisfaction level on the services offered.

The study utilised Test-retest reliability which assesses the external consistency of a test. Content validity was utilised to ensure that the questionnaire includes an adequate set of items that tap the concept. Face Validity was utilised as a basic and minimum index of content validity, which is determined after the test is constructed (Mohajan *et al.*, 2017). Data was analysed using quantitative methods using a computer program, Statistical Package for Social Sciences (SPSS Version 25). Basic descriptive statistics (frequencies, percentages, mean and standard deviation) were used to summarise data. Inferential statistics (Chi-Square test and Regression) was used to infer relationships between variables. All data analysed was summarised in the Ms Excel program and presented in tables and charts. Analysis was done at a 95% confidence level with significant P values ≤ 0.05 . Study variables were: (i) Independent variables were demographic, attitude, and health care factors and were measured using quantitative methods (ordinal and nominal measures), and (ii) Dependent variable was uptake of SRH services by youth and was measured using accessibility and satisfaction scale. Ethics approval was granted by the Great Lakes University of Kisumu Ethical Committee and was sought for the use of SIMAVI project data regarding the Ministry of Health (MOH) and District Health Management Team (DHMT). Consent was based on an initial and still ongoing partnership between Great Lakes University of Kisumu (GLUK) and MOH in areas that had adopted the Community Health Strategy (CHS). Verbal consent was obtained from all participants. No personal identifying information was recorded on questionnaires, and confidentiality was explained to all participants prior to the commencement of the interview.

RESULTS

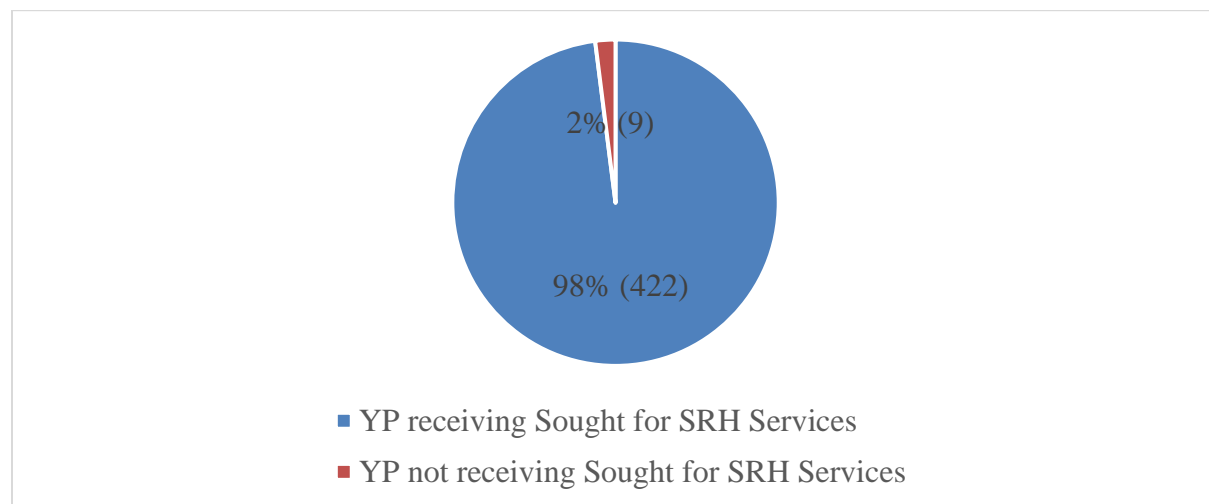
The majority of the respondents were female (73%) while male (27%). Most of the respondents were aged 20 years (29%) and the least were aged 22 years (9%). Primary (51%) was the highest attained education level among the respondents and below primary was the least at 1%. Most respondents were married or living together with their partners (54%).

Table 1: Proportions of Youth participants in the study by general Characteristics

Variables		n	%
Age in Complete Years	18	63	15%
	19	42	10%
	20	124	29%
	21	42	10%
	22	39	9%
	23	51	12%
	24	70	16%
Sex of Respondent	Male	116	27%
	Female	315	73%
Education Level	Never attended school	1	0%
	Nursery/pre-unit	1	0%
	Primary	219	51%
	Secondary/'A' level	199	46%
	College (middle level)	8	2%
	University	3	1%
Marital Status	Never married	196	45%
	Married/living together	233	54%
	Widowed	2	1%

A majority of the respondents (98%) interviewed had received the SRH service that they had come for with 2% not having received the services they came as shown in figure 1 below:

Figure 1: SRH Services sought and received by youth



SRH services sought were contraceptives, family planning advice, HTS/ VCT, STI testing & treatment, Services related to experiences of sexual, physical, or emotional violence, and maternal services (Post and antenatal care) and delivery. Generally, all the seven SRH Services sought

recorded over 96% access level by the youth who visited the health facilities, the highest being contraceptives at 99% and the least maternal services (Post and antenatal care) at 96%.

Table 2: Proportions of SRH Services Sought & Received

Variables	n	%
Contraceptives	416	99%
Family planning advice	415	98%
VCT	411	97%
STI testing and treatment	413	98%
Services related to experiences of sexual, physical, or emotional violence	413	98%
Maternal services (Post and antenatal care)	406	96%
Delivery	413	98%

The levels of youth not receiving SRH services sought were generally low ranging from 1-2% of total youth who visited health facilities seeking those services. Reasons for not receiving SRH services ranged from 7% to 12%. The reasons were as follows: respondents did not feel ready to start services/treatment at that moment, the provider was

not available, the provider was too busy, the respondent did not have money to pay for services, and SRH services the respondent came for are given on a different date, respondent was referred to another health facility and respondent came for observation only.

Table 3: Percentage - SRH Services Sought and Not Received

Variables	n	Per cent
Contraceptives	4	1%
Family planning advice	5	1%
VCT	7	2%
STI testing and treatment	7	2%
Services related to experiences of sexual, physical, or emotional violence	7	2%
Maternal services (Post and antenatal care)	7	2%
Delivery	7	2%

Government/ Council health facilities (91%) were the most visited by respondents compared to dispensaries and clinics (9%). The majority of the health facilities visited by the respondents were health centres and hospitals (66%), while the rest visited dispensaries and clinics (34%). The findings show that there is no significant difference in levels of SRH services sought and received among between youth of different demographic

characteristics. For instance, findings show that irrespective of age, youth's seeking levels for SRH services ranged from 93% to 100%, with a non-statistically point difference of 7%. Similarly, the utilisation was comparable, where 97% of males and 100% of females received SRH services, respectively, irrespective of whether they were married (98%) or not married (97%).

Table 4: Proportional Distribution of study Health Facilities

Variables		General Facility Factors	
		Frequency	Percentage
Type of Sector	Government/ Council	286	91%
	Others (NGO, Private, Faith Based/Mission/Church)	145	9%
Facility Type	Health Centre & Hospitals	393	66%
	Dispensaries and Clinics	38	34%
Facility "Location"	Rural	414	96%
	Urban	17	4%
First Time at Clinic	Yes	100	23%
	No	331	77%

Findings under the influence of socio-demographic characteristics on the perceptions of youth regarding health facility environmental factors showed no significant difference in youth's perceptions of the cost of SRH service due to socio-demographic characteristics. For example, findings show that irrespective of age, a majority of youth agreed or strongly agreed that cost of services was acceptable, with minority disagreement among those aged 18 years (22%), 20 years (11%) and 24-year-old (9%). Findings also show that among the socio-demographic characteristics tested, only education had a significant difference in youth ready to recommend others to the health facility (p-value 0.032) with a reducing percentage acceptance to recommend with progressive education levels. There was no significant difference in the perceptions of youth regarding opening hours. For instance, findings show that irrespective of age, respondents' perceptions of opening hours convenience had a point differential of 17% (ranging from 8% to 25%).

The age of the youth showed significant differentials regarding the perceptions of the availability of prescribed drugs in the health facilities at a p-value of 0.035. However, sex, education, and marital status all showed no significant differences in perceptions of the availability of prescribed drugs. Findings also show that there is no significant difference in perceptions of youth regarding health facility cleanliness. For instance, findings show that irrespective of age, respondents' perceptions of the cleanliness of the health facility had a point differential of 26% (ranging from 4% to 30%). There was also no significant difference in perceptions of youth regarding health facility environmental factors except for one demographic characteristic variable – marital status (p-value 0.009). However, findings show that irrespective of age, respondents' perceptions of feeling comfortable returning to the health facility had a point differential of 27% (ranging from 7% to 34%).

The influence of socio-demographic characteristics regarding perceptions of youth on Health Facility personnel's level of knowledge and skills as measured by testing P-Value, odds ratio, and confidence level. Age of youth showed significant difference regarding perceptions on level of

knowledge and skills of health personnel (p-value 0.038) where advancement in age appeared to influence higher rating of the personnel's knowledge and skills. The rest of the characteristics (sex, education level, and marital status) tested showed no significant differentials in perceptions of the provider's level of knowledge and skills. Out of the variables tested (age, sex, education level, and marital status), all except one (Marital Status) had no significant influence on perceptions regarding the waiting time being acceptable, with all having a P-Value higher than 0.05; they include; Sex of respondent (P = 0.119), age in complete years (P = 0.076), and Education Level (P = 0.786). The findings show that there is no significant difference in perceptions of youth regarding privacy. Out of the variables tested (age, sex, education level and marital status), none achieved significant influence on socio-demographic characteristics – all have a P-Value higher than 0.05. Out of the socio-demographic characteristics tested against youth's perceptions in terms of style treated by health providers, none achieved a significant difference in perceptions of youth regarding HF personnel factors.

DISCUSSION

Youths of different socio-demographic characteristics have fairly the same SRH utilisation level (90% and above). The differentiation in utilisation between socio-demographic characteristics was widest for age group 22 (93%) compared with categories that recorded 100%, even though this difference was not statistically significant. This implies that efforts that have been put in to eliminate differentials between different groups by socio-demographic factors are yielding health equity improvement outcomes. This study is consistent with these findings as it demonstrated that indeed the goal of narrowing and/ or eradicating differentials due to socio-demographic characteristics of an individual equal utilisation of SRH services is in fact a realisable goal for the health system. Therefore, the findings of the study nudge for policies and interventions that aim at narrowing and eliminating the differences in SRH service utilisation due to socio-demographic characteristics of youths.

The findings of this study confirm findings with other study findings, such as a paper by P. Godia in 2014, indicating that facility type where public health facilities have been reported to be the most preferred source of contraceptives and HIV testing among youth, level of the facility, staff, infrastructure, equipment, the opening time has been associated with influence on youths' access to SRH services (Godia *et al.*, 2014), longer waiting for time (Westin *et al.*, 2014) and accessibility of all services at one Health centre (Godia *et al.*, 2014). Consequently, the findings in the study show that while significant differentials have been reported in other studies, there are scenarios where significant differences have been lessened to the point of insignificance, a good example being the study site. Similar to other parts of Africa, Kenya has reported cases of youths not accessing SRH services due to influenced perceptions regarding health facility environmental factors. For example, a study indicated that the number of youths who had used non-facility-based SRH services was relatively higher than those who had used facility-based sexual reproductive health services (Daapah *et al.*, 2015). It is because of this concern the Kenyan government, through National Health Sector Strategic Plan III and Vision 2030, has recognised and prioritised youth SRH within the Kenya Essential Package of Health (KEPH).

Within KEPH, the Ministry of Health commits itself to providing services that are specific to this age group (18 to 24 years), including reproductive health counselling, contraceptives and HIV/AIDS-related services. This is to be achieved through the establishment of youth-friendly SRH health services within the existing health facilities (KSSHP III 2014/15; Vision 2030). Consistent with these interventions put in place, the findings of the study show that certainly, the aim of reducing differentials due to socio-demographic influence on perceptions of youth regarding health facility factors is in fact, a goal that can be achieved within our health system if concerted and deliberate effort is put in the interventions and investments, as shown by this study for the cost of SRH service received, health facility opening hours convenience and cleanliness. Therefore, the findings of the study support the government initiative to prioritise youth SRH by providing SRH services specific to this age group; and strengthening health system interventions that

purpose to limit or do away with the differentials in SRH services access due to socio-demographic of a youth.

Advancement in the age of youth was associated with both the high rating for knowledge and skills of personnel and the level of satisfaction in the manner treatment was delivered. The widows were more agreeable with waiting time as compared to those married or not married. Education and sex of youth had no significant differentials on any personnel variable, just like the privacy variable among the personnel factors showed no significant differentials among the youth seeking SRH services. The findings of this study corroborate with other study findings such as a paper by Levinson in 2016, showing that youth reported that they were treated well by service providers and also noted recent improvements in treatment from other providers (Newton-Levinson, A *et al.*, 2016). However, there is also the existence of other studies that have shown differentials with regard to the attitude of a service provider, which is perceived to influence youths' access to SRH services. For example, recent studies have shown that differentials exist by establishing that youths in developing countries are hindered from accessing SRH Services due to stigma and discrimination by health care providers and lack of youth-friendly reproductive health services (Kesterton *et al.*, 2010).

Other studies have shown that for instance, fear and shame related to attitudes regarding youth sexual behaviour were the most significant reasons why youths found it difficult to access SRH services, thus contributing to perceptions among youth that they were 'underage' or 'too young' to be sexually active or seek SRH services and fear of disclosing sexual activity to judgmental providers (Kennedy *et al.*, 2013); also perceptions of the level of skills and knowledge of service providers and satisfaction with the manner treated by a service provider (Newton-Levinson, 2016), confidentiality and privacy (Godia *et al.*, 2014), treatment by Service Providers (HSP) (Godia *et al.*, 2014). Initial findings from other studies had shown mixed results, thereby posing a contradiction in findings, such as in the case of how well the providers treated the youths when they accessed SRH services, where Newton's study states that it is not a differential

determinant while a paper by Kesterton in 2010 indicates that it is a determinant. However, the study confirms the findings of the study that has not shown a significant difference in SRH service access influenced by socio-demographic characteristics on perceptions of youth regarding health facility staff. Just as it is in other developing countries, Kenya has reported differentials regarding socio-demographic characteristics influencing youths' perceptions regarding health facility staff factors as a major barrier to SRH services access. For example, in the 2014 KDHS, the level of contraceptive consumption among youth was reported to be relatively low and influenced by socio-demographic characteristics.

Contraceptive use (any modern method) among sexually active girls aged 15–19 years had increased from 20% in 2003 to almost 25% in 2008–09. Currently, married women aged 15–19 mostly use the injectable contraceptive (14.4%), while unmarried women in the same age group commonly use the male condom (19.6%). Among currently married women, the unmet need for contraception among girls aged 15–19 years is 30 per cent (KDHS 2014). The HIV prevalence among young people aged 15–24 years is 3.8%, with women (5.6%) being four times more likely to be infected than young men of the same age (1.4%) (KDHS 2014). Although the majority (90%) of young people aged 15–24 years know where to obtain an HIV test, less than five out of ten have ever gone for an HIV test and received a result (KDHS 2014). It is because of this concern that the Kenyan government has put in place an explicit policy framework for the implementation of youth SRH services. The National Reproductive Health Policy and Strategy (National Reproductive Health Policy (NRHP) 2007 and the Adolescent Reproductive Health and Development Policy (ARHDP) 2003) both identify youth SRH as a key priority component and outlines key priority actions to be instituted to address the SRH problems of adolescents. Consistent with these interventions put in place, the findings of the study show that undoubtedly the aim of reducing differentials due to socio-demographic influence on perceptions of youth regarding health facility staff factors is in fact, a goal that can be achieved within our health system if concerted and deliberate effort is put in the interventions and investments. Therefore, the findings of the study suggest

maximum optimisation of the opportunity presented by the existing healthcare system to provide SRH services to youths with the aim of reducing or eliminating differentials in SRH services access due to socio-demographic characteristics by youth.

CONCLUSION

This study has produced three important pieces of evidence. Firstly, that youth of different socio-demographic characteristics have fairly the same levels of SRH services received among those visiting the health facilities. Secondly, while health sector efforts have eliminated some differential causing factors that affect the uptake of SRH services among the youth (e.g., sex in this study with no significant differentials across all tested factors), some differentials causing factors still persist (e.g., age, education and marital status as shown in this study). Thirdly, while the health sector has managed to reduce insignificant differentials for some health facility factors (including the cost of service, opening hours convenience, cleanliness at a facility, and privacy in healthcare delivery as per this study), some areas have persisted with significant differential causing effects among youth users (including the ability to cause feeling comfortable to return any time for service and youth users to recommend health facility to friends, availability of prescribed drugs, knowledge and skills of health personnel, waiting time and overall satisfaction in manner treated, as per this study)

Therefore, the findings from this study imply that:

- Concerted efforts that have been put in place to eliminate differentials in SRH service utilisation by youth are improving health equity outcomes.
- Existing policies and guidelines around SRH are essential for the harmonisation of SRH service delivery to all youths at all levels; including the general population

Recommendations

- Findings of the study nudge for policies and interventions that aim at narrowing and eliminating the differences in SRH service utilisation due to socio-demographic characteristics of youths.

- Findings of the study support the government initiative to prioritise youth SRH by providing SRH services specific to this age group and strengthening health system interventions that purpose to limit or do away with the differentials in SRH services access due to socio-demographic of a youth.
- The findings of the study suggest maximum optimisation of the opportunity presented by the existing healthcare system to provide SRH services to youths with the aim of reducing or eliminating differentials in SRH services access due to socio-demographic characteristics by youth.

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