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Original Article

Responsiveness and Uptake of Sexual Reproductive Health and Rights Education and Information Among Young People 10-24 Years Old: A Case Of 'Get Up Speak Out' (GUSO) Program Implementation Period in Western Kenya Region

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Keywords: *SRHR, Information, Education, Young People, Access.*

ABSTRACT

Young people and girls suffer from some of the worst SRHR outcomes in Kenya such as sexual abuse and violence; STIs including HIV; unintended pregnancies; unsafe abortions; early and forced marriages; obstetric fistula; and maternal mortality. Some of the main causes to these poor outcomes include lack of correct and comprehensive information on key SRHR issues. The GUSO program was implemented in western region of Kenya from 2018-2020 with an aim of aim of increasing uptake of SRHR education and information among young people 10-24 years old through 3 strategies: Capacity development for information providers (SRHR curriculum based trainings); Direct access to SRHR information e.g. Electronic & Media platforms (direct messaging and WhatsApp group discussions); and Community approach (table talks and clarification sessions).The findings show that the number of educators trained increased through the three years. There was incremental in number of young people reached with SRHR information and similarly incremental in program realization over targets, meaning increase in willingness among the young people to utilizing the deployed strategies of direct and indirect SRHR. This also means that the deployed strategy of training of trainers to enhance capacity for young people to access information was effective in creating demand for SRHR information. The findings imply that it is possible to realize desired targets on SRHR information access by young people through capacity building and adopting the correct strategies. This study has identified such approaches to

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include table talks, clarification sessions, and direct messaging. Therefore, the health sector can indeed, by adopting these strategies improve SRHR service utilization among young people that may have a reducing effect to the now high levels of teenage pregnancies and other related consequences. The study has tested and determined that it is feasible to improve access to SRHR education and information among young people through training of educators and adopting proper strategies through which young people access SRH information. Furthermore, the findings have proved that these approaches lead to improved knowledge level, attitude for and SRHR service seeking behaviour for young people.

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INTRODUCTION

Access to information, education and services is central in the promotion of sexual and reproductive health and rights (SRHR) among young people. It enables young people make informed choices on sexuality matters, hence reduce teenage pregnancies and sexually transmitted infections (STIs), (Ngilangwa *et al*, 2016).

Adolescents (10-19) and young people (10-24) years old constitute 18% and 26% of the world population (UN, 2011). In Sub-Saharan Africa (SSA), young persons aged 10 to 24 accounts for 30% of the population (UNFPA, 2014). Young people (10-24 years of age), around the world face tremendous challenges to meeting their sexual and reproductive health (SRH) needs. Inadequate access to health information and services, as well as inequitable gender norms contributes to a lack of knowledge and awareness about puberty, sexuality, and basic human rights *(*Cortez *et al., 2014)*.

Sexual and Reproductive Health (SRH) becomes a major area of concern during adolescence stage because of the apparent risky sexual behaviours which include early age sexual debut, multiple sexual partners, unprotected sexual intercourse, and sexual intercourse while under the influence of alcohol or drugs (DiClemente, 2011).

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Young people and girls suffer from some of the worst SRHR outcomes in Kenya mainly due to lack of correct and comprehensive information on key SRHR issues including HIV and AIDS and lack of knowledge on where to access services (SRHR, 2014). Currently, the life skills education program meant to provide comprehensive sexuality education (CSE) in schools is not examinable and thus teachers put less emphasis on it. Studies further indicate that most parents lack capacity to communicate with their children on sexuality (SRHR, 2014).

Many young people in need of SRH services are unable to access the same given that only few public health facilities are youth friendly. This consequently affects uptake and utilisation of SRHR services such as HIV testing and counselling, STI screening, and contraceptives (Ninsiima *et al*, 2021). The limited coverage of youth friendly services can be attributed to: limited number of trained service providers on adolescents and youth friendly service provision; shortage of health personnel; inadequate infrastructure for provision of adolescents youth friendly services (AYFS); and limited resources to support the establishment of adolescents and youth friendly facilities.

Globally, and in Sub Saharan Africa region in particular, many young people lack education and have poor access to services related to SRHR (Braeken & Rondinelli, 2012).

While Kenya has made remarkable progress in addressing HIV and AIDS in the last five years, with the national HIV rate decreasing from 7.2% in 2007, to 6.04%. In 2014, of the estimated 89,000 new HIV infections in Kenya, 21% were among young women aged 15-24 years. NASCOP reports that 5% of all STIs occur among young people below 24 years annually. This figure is much lower in rural areas where majority of young people reside. Some of the counties in the western region covered by the GUSO programme are characterized as some of the counties with a heavy burden attributed to HIV, such as HomaBay, Kisumu, and Siaya at 25.7%, 19.3% and 23.7% respectively (NACC, 2014).

According to the KDHS (2014), comprehensive knowledge on AIDS among women is 85.6%, 87.7%, 86.7%, and 83% in Kakamega, Siaya, Kisumu, and Homabay counties respectively. The trend is not much different among the men at 88.1%, 90.5%, 86.4%, and 93.6% in Kakamega, Siaya, Kisumu, and Homabay respectively. Although majority of people have comprehensive knowledge on AIDS, quite a sizable number still lack comprehensive knowledge. The rate of condom use is 61% and 75% among young men and young women respectively. This is a pointer that more needs to be done to upscale the access to information on HIV. The percentage of women and men aged 15-24 with comprehensive knowledge of HIV stands at 54% and 64% respectively.

Poor access to SRHR has been associated with young people's vulnerability to sexual health risks, such as early pregnancies and sexually transmitted diseases (Braeken & Rondinelli, 2012; UNAIDS, 2013).

Globally, approximately 12 million girls aged 15–19 years and at least 777,000 girls under 15 years give birth each year in developing regions (WHO, 2020). Complications during pregnancy and childbirth are the leading cause of death for 15–19-year-old girls globally. Of the estimated 5.6 million abortions that occur each year among adolescent girls aged 15–19 years, 3.9 million are unsafe, contributing to maternal mortality, morbidity and lasting health problems (WHO, 2020). The World Health Organization (WHO) estimates that one in 20 adolescents contract a sexually transmitted infection (STI) each year (WHO, 2016).

Worldwide, almost half of new HIV infections occur in the 15-years age-group, identifying this group as high-risk; and in Sub-Saharan Africa, one in six adolescent deaths are attributed to HIV (UNAIDS, 2014). According to the Africa Youth Report, in 2011 about 28% of women aged 20-24 in the Sub-Saharan Africa region gave birth before the age of 18, with almost half of them having had their first sexual experience before their 15th birthday (UN, 2011).

In Kenya, young people experience some of the poorest reproductive health outcomes including sexual abuse and violence, STIs including HIV, unintended pregnancies, unsafe abortions, Female Genital Mutilation (FGM), early and forced marriages, obstetric fistula, and maternal mortality (DRH, 2013). The main causes include lack of correct and comprehensive SRHR information;

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harmful cultural practices; lack of essential health commodities and services; lack of access to YFS; attitude of service providers; retrogressive cultural and religious practices; poor or lack of adolescents-parents communication on SRHR (SRHR, 2014).

More than 25 years since the 1994 International Conference on Population and Development, significant progress has been made in adolescent sexual and reproductive health and rights (ASRHR). Trend analysis of key ASRHR indicators at global, national, and subnational levels indicates that adolescent girls today are more likely to marry later, delay their first sexual experience, and delay their first childbirth, compared with 25 years ago; they are also more likely to use contraceptives (Liang *et al*, 2019).

Despite overall progress, however, unequal progress in many adolescents' sexual reproductive health and right (ASRHR) outcomes are evident both within and between countries, and in some locations; the state of adolescents' lives has worsened. Population growth in countries with some of the worst shortfalls in ASRHR mean that declining rates, of child marriage, for example, coexist with higher absolute numbers of girls affected, compared with 25 years ago. Emerging trends that warrant closer attention include increasing rates of ovarian and breast cancer among adolescent girls and sharp increases in the proportion of adolescents who are overweight or obese, which has long-term health implications.

Tropical Institute of Community Health and Development (TICH) worked in partnerships with 29 community health units (CHUs) in Homabay, Kisumu, Kakamega, and Siaya Counties of the Western region of Kenya by implementing a SRHR program known as Get up Speak out (GUSO) with the aim of accelerating access of SRHR information and services among young people aged between 10-24 years old.

Research Purpose

This paper therefore seeks to demonstrate the responsiveness and uptake of SRHR education and information among young people 10-24 years old during the GUSO program implementation period in Western Region of Kenya. The study was guided by the following objectives:

- To describe the proportion of Educators trained on Sexual Reproductive Health and Rights (SRHR)
- To describe the proportion of young people, 10-24 years old reached with comprehensive SRHR Education
- To describe the proportion of young people, 10-24 years old reached with comprehensive SRHR information
- To describe the approaches for provision of comprehensive SRHR information among young people, 10-24 years old.

METHODS AND MATERIALS

This was a quasi-experimental study utilizing quantitative data across the intervention period (2018-2020). The intervention aimed at accelerating access to SRHR education and information among young people.

The study was done in 29 youth groups in 29 CHUs in five Sub-counties (Alego Usonga, Butere, Nyando, Rachuonyo East, and Nyakach) in Western region of Kenya. These sub-counties are predominantly inhabited by the Luo speaking communities except Butere which is inhabited by the Luhya community. These areas are operating under similar County health systems and all are implementing the community health strategy.

In these areas, TICH implemented an intervention aimed at accelerating access to SRHR information and education. The program aimed at having increased utilization of SRHR information and education among young people aged 10-24 years old with three specific deliverable output indicators: 1. Number of Educators trained on SRHR; 2. Number of young people reached with comprehensive SRHR education; and 3. Number of young people reached with comprehensive SRHR information. To achieve these, three strategies were employed: i). Capacity development for information providers (number of educators trained and number of young people reached with comprehensive SRHR education); ii). Direct access to SRHR information e.g., Electronic & Mobile Health channels; iii). Community approach (number of young people reached with comprehensive SRHR

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information). Five activities were implemented including: Curriculum-based SRHR trainings; young people round table talk discussions; conducting SRHR clarification sessions; online WhatsApp group discussions on SRHR topics, and sending of direct SRHR key messages to young people through their mobile phones. The activities were conducted according to well-defined protocols which outlined the following key areas; identification of participants; planning (setting appropriate date based on the availability of young people, identifying required resources such free venues, stationaries and refreshments, identification and contextualization of necessary standardized curriculums or guidelines); mobilization; framework of outcome (knowledge, attitude, and practice), and facilitation of the activity.

The study population included a complete coverage of young people aged 10-24 years old who were members of the 29 youth groups in the five Sub-counties within the intervention areas. GUSO's community-based approach engaged young people who were trained and recruited as members of the youth groups.

Data was obtained from the routine Monitoring and Evaluation (M&E) reports across the three years intervention period. Data was cleaned before analysis to check for completeness. Trained TICH M&E Officer was in charge of routine M&E data entry and management.

The unit of analysis was young people aged 10-24 years old. Data was analysed per objective. Data was analysed by use of a spread sheet excel, where proportions and frequencies were run to describe the uptake level of SRHR education and information. Data was analysed by a trained TICH data manager.

The data was collected in areas where TICH worked in partnership with and relevant permissions had been obtained from the relevant authorities. Participants of the study were members of youth groups which were formed and integrated in Community Health Units, through a signed agreement by a mentor (who is one of the community health volunteers from the CHUs).

RESULTS

Number of Educators Trained on SRHR

This indicator illustrates the general number of people trained to provide SRHR Education to young people. It is a curriculum-based training using a standardized curriculum. The following curriculums were used during these trainings: Youth for youth (YY) curriculum; Menstrual Hygiene management (MHM) curriculum; Creative thinking; and Family Planning-Knowledge as a chance.

The number of educators trained increased through the three years with as illustrated in *Table 1*. As shown in *Table 1*, the number of the educators trained in 2018 is slightly lower than 2019 because this was the initial training. 2019 recorded higher number of Educators trained and this could be attributed to full establishment of the youth groups and also carrying out of another training (Menstrual hygiene management).

In terms of gender, there were more females than males trained in the years 2018 and 2019 save for 2020 where analysis for gender was a bit of a challenge due to the anonymity and the complexities of online training, where it was difficult to identify the gender of participants in some instances.

The performance recorded an average of 313% realization over targets with incremental increase between year one and both the second and the third year. Capacity building showed positive effect for program goal realization. Increased number of Trainers trained accelerated reach to many young people thereby surpassing the targets. Increased number of trainings such as: menstrual hygiene management training of young using the Simavi MHM curriculum and Innovations for reusable pads; Family planning-knowledge as a chance; digital platforms and creative thinking on SRHR enabled targets to be overshot overall in all the regions.

In the rural set up, it is more girls who are responding to mobilization than boys with ranges from 56-68% across 2018 and 2019 compared to 32-44% for boys as shown in *Table 2*. Adoption and use of standardised curriculum such as the Simavi MNH

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Curriculum ensured comprehensiveness of training. This is affirmed by some of the young people who underwent these trainings as shown in their testimonies below:

> *"I have gained skills on SRHR and menstrual health" – A youth beneficiary 1*

> *'It has boosted my confidence through empowerment, and capacity building. This has enabled me to express myself before clients in the field, counsel, and train young people in the field. It has also improved my coordination capacity as a young person and as such I can easily conduct my activities with less supervision'-A youth beneficiary 2.*

Table 1: Proportion of educators trained on SRHR

	Target	Achieved	Proportions
2018	495	801	161%
2019	341	1650	485%
2020	183	539	294%

Table 2: Proportion of educators trained on SRHR analysed by gender

Sex	2018	2019	2020
Females	56%	68%	153
Males	44%	32%	16
Unclassified			370
Total	100%	100%	539

Number of Young People Reached with Comprehensive SRHR Education

This indicator represents young people (10-24 years old) who have been reached with SRHR education. Since 2018, the number of young people reached with SRHR information has continued to increase surpassing yearly target as shown in *Table 3*.

Generally, holding other factors constant, the strategy (capacity building for information providers) worked. The number of young people reached by SRHR education recorded increment from 2018 to 2019. The year 2020 was an exceptional one because of the Covid-19 pandemic. Increased number of trainers trained accelerated reach to many young people thereby surpassing the targets. Strengthened capacity of peer educators increased catchment coverage and reach.

Over the years, most female young people were reached with SRHR education in 2018 and 2019 with range of 48-63% compared to males with range of 37-52% in 2018;54-74% compared to males with range of 26-46% in 2019 as shown in table as shown in *Table 4.* Young people in the age bracket of 15–19-year-old were more receptive to SRHR education uptake as compared to their younger counterparts as shown in *Table 5*. However, the year 2020 was exceptional because of the online training, therefore hindering comparative analysis for gender and ages.

Table 3: Proportion of young people reached with SRHR education

	Target	Achieved	Proportion
2018	620	733	118%
2019	620	1525	254%
2020	620	507	82%

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Table 4: Proportion young people reached with SRHR education analysed by gender

Sex	2018			2019			2020		
	F	M	Total	F	M	Total	F	M	Total
10-14	63%	37%	100%	74%	26%	100%	100%	0%	100%
15-19	62%	38%	100%	68%	32%	100%	100%	0	100%
20-24	48%	52%	100%	54%	46%	100%	95%	5%	100%
Unclassified							370		

Table 5: Proportion of young people reached with SRHR education analysed by ages

Sex	2018		2019		2020	
	F	M	F	M	F	M
14-Oct	14%	11%	40%	31%	2%	0%
15-19	66%	57%	50%	51%	58%	0%
20-24	21%	32%	10%	19%	40%	100%
Total	100%	100%	100%	100%	100%	100%
Unclassified					370	

Number of Young People Reached with Comprehensive SRHR Information

Since 2018, the number of young people reached with comprehensive SRHR information has continued to increase over the years as shown in *Table 6*. The year 2020 has recorded the highest numbers and this can be attributed to two main reasons: change of strategy to virtual SRHR information provision because of the Covid-19 Pandemic and later the village-based table talk sessions with young people. These strategies necessitated the reach of a large number of audiences thereby surpassing the target.

Going by gender, females are more receptive to SRHR information than males across the three years, with ranges of 54-61% access levels for females compared to 39-44% for males in different age categories in 2018; 53-62% for females compared to 38-47% for males in 2019: 55-72% for females compared to 28-45% for males in 2020 as shown in *Table 7*. This can be affirmed by another study which found that gender norms and the traditional approaches used to implement reproductive health and family planning programs are some of the factors influencing male involvement in Sexual and Reproductive Health in Western Kenya (Onyango *et al.*, 2010).

Young people in the age bracket of 15–19-year-olds were more receptive to information uptake as compared to their younger counterparts as shown in table 8. Overall, the strategies (community approach and direct access to SRHR information e.g., Electronic & Mobile Health channels direct) are effective in achieving the targets. Over the years the program recorded incremental progress that may mean increasing acceptance of SRH interventions that were being rolled out by young people. The program has reached and surpassed all the expected outputs and planned activity results. During the Period, key opportunities that the program leveraged on include: receptive Ministry of Health (providing 24 link health facilities and 5 supportive sub-county health management teams); receptive communities (providing 29 community health units for integration of SRHR). Village-based table talks, clarification sessions, and direct messaging were the highest contributing strategies to the number of young people reached with SRHR information as shown in *Table 9*. Therefore, these should be primary focal strategies for SRHR information provision.

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Table 6: Proportion of young people reached with comprehensive SRHR information

	Target	Achieved	Proportion
2018	5700	4681	82%
2019	12836	13641	106%
2020	12836	17290	134%

Table 7: Proportion of young people reached with comprehensive SRHR information analysed by gender

Sex	2018			2019			2020		
	F	M	Total	F	M	Total	F	M	Total
10-14	61%	39%	100%	62%	38%	5320	72%	28%	100%
15-19	60%	40%	100%	58%	42%	6332	68%	32%	100%
20-24	54%	46%	100%	53%	47%	1984	55%	45%	100%

Table 8: Proportion of young people reached with comprehensive SRHR information by age

Sex	2018		2019		2020	
	F	M	F	M	F	M
10-14	35%	33%	41%	36%	28%	23%
15-19	51%	50%	45%	47%	60%	57%
20-24	14%	17%	13%	17%	12%	20%
Total	100%	100%	100%	100%	100%	100%

Table 9: Approaches for provision of comprehensive SRHR information

Approach	Proportion achievement
Table talks	45%
Clarification sessions	35%
Direct messaging	18%
WhatsApp	2%
Total	100%

Testimonies of some of the GUSO program beneficiaries include:

> *"Before TICH came, I was used to multiple partners, and I took sexual intercourse for enjoyment. So, after TICH came, we have been trained and now I have been taught on how if I want to play sex, I must protect myself because I cared less; previously I took sexual intercourse for enjoyment. Now I know having sex without protection I can contract STIs such as AIDS, Gonorrhoea and there are some bad effects that can harm my health. Thank you". – A youth beneficiary from Kabura Youth Group, Alego Usonga Sub-County, Siaya County.*

DISCUSSION

The findings showed that there was incremental in number of young people reached with SRHR information and similarly incremental in program realization over targets, meaning increase in willingness among the young people to utilizing the deployed strategies of direct and indirect SRHR.

This also means that the deployed strategy of training of trainers to enhance capacity for young

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people to access information was effective in creating demand for SRHR information. Further, the findings show that the young people who accessed services were more likely to have increased knowledge, attitude, and practice regarding SRHR. This is consistent with existing evidence that shows that community-based education sessions influence knowledge of youth SRH issues and some related behaviours (Maclean *et al., 2006).*

Findings of this study reaffirms that it is feasible to trigger improvement in SRHR information access using community-based approaches. This is consistent with another study which showed that community-based sessions have potential added advantage of reaching out to vulnerable young people, who are out of school. The study found that the community-based sessions were more informal and relaxed, thereby promoting greater openness and participatory discussion than in school (Senderowitz, 2000). Trained educators appear to be the trigger to the improvement in SRHR information access among young people

The result of this study shows that while various approaches can be used to trigger access, the most important that responded within the 3 years of program implementation include; Table talks, RHRH clarification sessions, and direct messaging of key SRHR messages to young people's mobile phones.

Furthermore, testimonies of young people who had accessed SRHR education and/or information showed that there was a positive impact on young people's knowledge level, skills, and practice with regards to SRHR services.

It is possible to realize desired targets on SRHR information access by young people through capacity building and adopting the correct strategies, which accordingly, can be a Ministry of Health's guideline for community frontline workers on levels of capacity building for SRHR educators and identification of key access approaches for SRHR information among young people. This study has identified such approaches to include; table talks, clarification sessions and direct messaging. The findings also imply that young people who access SRHR education and/or information through these processes, experienced positive impact with regards to their knowledge level, skills, and practice with regards to SRHR service access.

CONCLUSIONS

The study has tested and determined that it is feasible to improve access to SRHR education and information among young people. This improvement is enhanced by training of Educators and adopting proper strategies through which young people access SRHR information.

Furthermore, the findings have proved that these approaches (Table talk sessions, SRHR clarification sessions and direct messaging of key SRHR messages) lead to improved knowledge level and attitude for SRHR service seeking behaviour for young people.

RECOMMENDATIONS

The health sector can indeed, by adopting these strategies improve SRHR service utilization among young people that may have a reducing effect to the now high levels of teenage pregnancies and other related consequences.

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