Adolescent-Friendly Health Services in Kenya

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By Health Action International and Faith to Action Network

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Access to sexual and reproductive health (SRH) services forms a crucial building block of health systems. Poor access to SRH services can result in early and unintended pregnancies, maternal mortality, HIV and sexually transmitted infections (STIs), as well as complications from untreated STIs, such as pelvic inflammation, specific types of cancer, and pregnancy and fertility issues. A health system is well equipped to provide SRH commodities and services when people are enabled to decide on pregnancy, to have a healthy pregnancy and safe childbirth, to protect themselves against STIs and HIV/AIDS, and are properly treated in a timely manner if transmission occurs. For a thriving society, it is also crucial that adolescents, a group often faced with additional challenges in accessing services, can access the adolescent-friendly services in Kenya they need to live healthy lives and protect themselves against key health risks.

Unfortunately, Kenya experiences many challenges with the adequate provision of adolescent-friendly SRH (AFSRH) services. This research was conducted to study the provision of AFSRH services and the attitudes of healthcare workers in Isiolo, Mandera and Marsabit Counties in Kenya.

Recommendations

Provision of adolescent-friendly services

a. Establish processes for regular input and feedback from adolescents to gauge the reality of service provision. Facility level feedback can be subjective to healthcare providers who may not give very accurate information in order to protect their facility from scrutiny or surcharge.
b. Improve functionality of adolescent/ youth friendly centres (YFCs) in the public health facilities to include modified operating hours, during evenings or weekends, and manning by youthful HCWs to increase coverage and encourage health facility visits by adolescents and youth.
c. Plan for and support integrated medical outreaches that are free-of-charge to the community members, including adolescents. Targeted mobilisation of adolescents should be done by youth peer educators or young community health volunteers (CHVs).
d. Incorporate sensitisation on attitudes change among HCWs into supportive supervision

exercises to promote positive attitudes towards comprehensive adolescent SRH services and increase acceptability of contraceptive uptake by adolescents and unmarried women.

e. Establish adolescent-friendly linkage and referral systems between faith-based organisations, private and public health facilities for healthcare workers to be able to effectively refer adolescents for services that they might not be able to offer. Such services could include provision of modern contraceptives, management of HIV, management of complicated sexual and reproductive health cases.

Provision of SRH services

a. Sensitise CHVs within the existing community health units (CHUs) to provide adolescent SRH information and referrals at household level. This will ensure that preventative health, which is proven to give better outcomes (teen pregnancies, post-abortion care, perinatal care, STI/HIV testing and treatment), is enhanced.
b. Mainstream and integrate provision of ASRH information and services within primary healthcare services and programmes to increase access and enhance confidentiality and privacy. This includes routine screening using the available MoH checklist for detection of ASRH health needs.
c. Prioritise training, and mentorship on SRH service provision and commodity management for healthcare workers charged with offering AFSRH services to improve quality, increase access and increase uptake as well as to eliminate stock-outs due to poor commodity management.
d. Increase access to post-rape care, SGBV response and abortion care services, which were the least offered SRH services. This can be achieved through trainings and mentorship, availing of commodities, documentation tools, job aids, standard operating procedures to guide the HCWs and strengthening of referral systems between health facilities.
e. Health facilities should strengthen meaningful involvement of adolescents in their own health by incorporating them in the health facilities management committees. The baseline evaluation findings were that adolescents were asked for input into or feedback on the design, planning, implementation and evaluation of SRH services in only 13% of health facilities.

Policies, management and oversight

- Allocate a specific budget line for level 2-3 health facilities to support AFSRH for increased availability of services, information and commodities.
- Disseminate key supportive policies and guidelines, such as the FP/SRH/MNCH policies, to healthcare workers to fully implement for increased access and improved coverage and quality.
- Advocate for the full implementation of domesticated FP/RMNCAH/AFSRH policies by ensuring a budget and allocation of resources for optimal service and information delivery at public health facilities.
- Advocate for the development, enactment, dissemination and implementation of guidelines and standards of operation at county level to ensure the SRH needs of

adolescents are anchored in policy.
- Strengthen oversight and monitoring through regular supportive supervision by the relevant County Health Management Team members. In 21% of health facilities, SRH services were never monitored through a visit by a government official, and in 14% of HFs, this was only once per year.

The state of the health facility

- Improve quality of service provision as well as the state of the health facility through strengthening utilisation of the Kenya quality model for health monitoring and evaluation tools[1] and establishing or activating quality improvement teams to identify gaps, implement interventions, and track improvement in the state of the health facility and provision of AFSRH services. This should include availing a conducive space for provision of AFSRH services and display of edutainment and communication materials.