ADOLESCENT-FRIENDLY HEALTH SERVICES IN **KENYA**

Healthcare Workers' Perspectives on Barriers and Services Offered

sharp
Solutions for Supporting Healthy Adolescents

ADOLESCENT-FRIENDLY HEALTH SERVICES IN **KENYA**

HEALTHCARE WORKERS' PERSPECTIVES ON BARRIERS AND SERVICES OFFERED

Authors
Janneke van Oirschot, Research Officer, Health Action International
Gaby Ooms, Research Manager, Health Action International
Judy Amoke, Programme Manager, Faith to Action Network
Maria Tororey, SRHR Technical Lead, Faith to Action Network

Acknowledgements
Special thanks to the data collectors for the collection of research data, and the healthcare workers who participated in the research.

JULY 2023

Publisher
Health Action International
Overtoom 60 (2) | 1054 HK Amsterdam
The Netherlands
+31 (0) 20 412 4523

HAIWEB.ORG

Funded by the European Union

This publication has been produced with the financial support of the European Union. Its contents are the sole responsibility of Health Action International and do not necessarily reflect the views of the European Union.

TABLE OF CONTENTS

1	**BACKGROUND**	**4**
2	**METHODOLOGY**	**4**
3	**FINDINGS**	**5**
3.1	Provision of Adolescent-friendly Services	5
3.2	Provision of SRH Services	9
3.3	Policies, Management and Oversight	14
3.4	Training, Education and Outreach	16
3.5	The State of the Health Facility	17
3.6	Recommendations by Healthcare Workers	17
4	**RECOMMENDATIONS**	**18**

1. BACKGROUND

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 SRH services 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.

2. METHODOLOGY

This study was conducted by Faith to Action Network and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the AMREF Ethics and Scientific Review Committee and National Commission for Science, Technology and Innovation (NACOSTI).

This study used an adjusted version of the HAI/World Health Organization (WHO) Methodology[1] and, through a cross-sectional survey design, gathered insight into the provision of AFSRH services in Kenyan health facilities. Teams of data collectors visited 86 health facilities from the public, private and faith-based sectors to assess:

1. The type of SRH services being offered at the health facility.
2. To whom these services were offered, and whether parent/guardian consent was needed.
3. The measures in place at the health facility to improve access to SRH services for adolescents.
4. The attitudes and perspectives of the healthcare worker on AFSRH services.
5. Indicators on the general state of the health facility.

Health facilities that were included in the research ranged from health posts to teaching hospitals. One healthcare worker in every health facility was requested to provide the above information. In addition, eight questions were answered by the data collector based on their observations at the health facility. Healthcare workers were asked for their consent to participate in the study.

1. Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. World Health Organization, Health Action International. (2008). Geneva: Switzerland.

3. FINDINGS

Table 1 shows the distribution of surveyed healthcare workers across sectors and urban/rural locations. A total of 48 healthcare workers from the public sector, 25 from the private sector, and 13 from the faith-based sector were surveyed.

The specific findings from this report are presented in six different sections: Section 1 describes the provision of adolescent-friendly services, Section 2 goes into detail on the SRH services being offered as well as their costs, Section 3 highlights some of the processes for policies, management and oversight, Section 4 sets out the findings around training, education and outreach, and Section 5 shows statistics on visible characteristics of the health facility, as filled in by the data collectors. Finally, Section 6 focusses on recommendations from healthcare workers to improve the provision of AFSRH services.

Table 1. Number of surveyed healthcare workers per sector and urban/rural location.

	Public	Private	Faith-based	Total
Urban	5	19	3	**27**
Rural	43	6	10	**59**
Total	**48**	**25**	**13**	**86**

3.1 Provision of Adolescent-friendly Services

Overall, 60% of healthcare workers indicated that their health facility was officially accredited as an adolescent-friendly health centre (see Table 2). These numbers were similar across health facilities from the public, private and faith-based sectors. Slightly more healthcare workers said that their health facility offered AFSRH services, irrespective of whether they were officially accredited as an adolescent-friendly health facility, with percentages ranging from 65% in the public to 80% in the private sector.

Table 2. Health facilities accredited and offering AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Health facility is an accredited adolescent-friendly health facility	58	64	62	**60**
Health facility provides AFSRH services	65	80	69	**70**

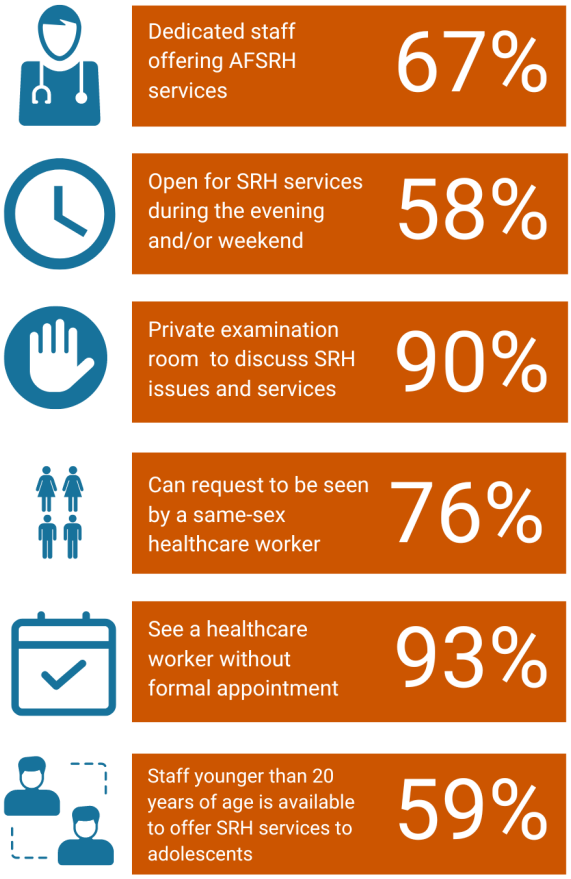
If health facilities did not offer AFSRH services, the healthcare worker was asked why. Twenty-one healthcare workers answered this open question and gave a total of 24 reasons. A word cloud specifying these reasons can be found in Figure 1. The reason healthcare workers mentioned most often was by far a lack of medicines (10 times). In addition, three mentioned the health facility lacked a space or room for adolescents. Finally, the reasons that the Catholic church doesn't allow it, that they lacked support, that they lacked training of staff and that there is stigma among adolescents were all mentioned by two healthcare workers.

Figure 1. Reasons health facilities do not offer AFSRH services (Word Cloud).

Figure 2 lists some common characteristics of adolescent-friendly health services. The study found that, overall, health facilities in Kenya scored well on some indicators, and lower on others. For instance, while at 93% of health facilities adolescents could see a healthcare worker without a formal appointment, and 90% had a private examination room, only 67% had dedicated staff offering AFSRH services. Further, 58% of health facilities were open during the weekend and/or evening, and 59% of health facilities had staff who are younger than 20 years old and who can offer SRH services to adolescents.

When comparing findings across the sectors, the three sectors score relatively similar on most indicators (see Table 3). A clear exception is health facilities being open during the evening and/or weekend, as only 33% of public health facilities are, versus 96% of private and 77% of faith-based health facilities. In addition, fewer faith-based facilities have dedicated staff offering AFSRH services compared to the other sectors. In the private sector fewer health facilities have staff younger than 20 years of age that can offer SRH services to adolescents (see Table 3).

Figure 2. Adolescent-friendly organisation of care.



Finally, interestingly in the private sector, sharing of information on the SRH of adolescents is happening on a much larger scale than in the public and faith-based sector. Half of all private health facilities share SRH information with the adolescent's parents, and a quarter share it with their schools and community/faith leaders.

Table 3. Adolescent-friendly organisation of care, per sector.

	Public (%)	Private (%)	Faith-based (%)
Dedicated staff offering AFSRH services	71	68	54
Facility open for SRH services during the evening and/or weekend	33	96	77
Adolescents can see a healthcare worker without a formal appointment	94	92	92
Adolescents can request to be seen by a same-sex healthcare worker	79	68	77
Private examination room at the facility where healthcare workers meet with clients to discuss SRH issues and services	92	80	100
Staff working at the health facility who are younger than 20 years and can offer SRH services to adolescents	65	44	69
Information about the SRH of adolescents who visit the health facilities is shared with:			
Their parents/guardians	13	50	0
Their schools	7	28	8
Community/faith leaders	9	24	8

When zooming in on the ways in which adolescents could make an appointment for SRH services, we found, this time, that in all health facilities (100%) no appointment was needed (see Figure 3). In the public sector, in 6% of health facilities appointments could also be made at the reception, compared to 24% in the private and 31% in the faith-based sector (See Table 4). Appointments could rarely be made over the phone in the public sector (2%), and slightly more often in the faith-based (8%) and private sector (16%). Other methods for making appointments, such as via text messaging/ WhatsApp or online, were generally barely used.

Figure 3. Ways in which clients can make appointments for SRH services.

Table 4. Perspectives of healthcare workers on AFSRH services.*

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
At the reception	6	24	31	**15**
Over the phone	2	16	8	**7**
Via text messaging/WhatsApp	0	4	0	**1**
Online	0	0	0	**0**
No appointment needed/walk in	100	100	100	**100**

*Multiple answers were possible.

The survey further asked healthcare workers about their personal opinions on 11 different statements. Their perspectives on these statements can be seen in Table 4. Almost all (91%) healthcare workers believe that adolescents feel welcome and safe at the health facility, and at ease to access SRH services. Further, 96% of healthcare workers indicated that the health facility was easily and safely accessible for adolescents by foot or public transportation, and 95% said that they have enough time to sufficiently treat and answer questions of adolescents accessing SRH services. Waiting times at the health facility were seen as a barrier for adolescents by 22% of surveyed healthcare workers. However, this percentage differed significantly between the sectors, with 46% of private sector healthcare workers believing that waiting times were a barrier, versus 12% of public and 8% of faith-based sector healthcare workers. Costs were thought to be a barrier to adolescents by 54% of private sector healthcare workers, compared to lower numbers among those working in the public (14%) and faith based (17%) sectors.

Regarding attitudes of healthcare workers, 71% of healthcare workers said they are okay with providing contraceptives to unmarried women, and only 55% said they are okay with providing contraceptives to adolescents under 18. Percentages differed considerably between the sectors with the faith-based sector having much lower scores on both indicators and the private sector scoring highest (see Table 5). Interestingly, much higher percentages of healthcare workers say they feel comfortable talking about contraceptive and SRH matters with adolescents (total 91%). Further, a notable 49% of healthcare workers in the public sector, 84% of healthcare workers in the private sector, and 69% of healthcare workers in the faith-based sector advise adolescents to abstain from sex when they seek contraceptives at the health facility. The percentages of healthcare workers who believe adolescents should not have sex is lower across the sectors, with 33% of public-, 40% of private, and 54% of faith-based healthcare workers believing this. About 42% of the surveyed healthcare workers indicated contraceptive use goes against their religion and should therefore not be provided to adolescents.

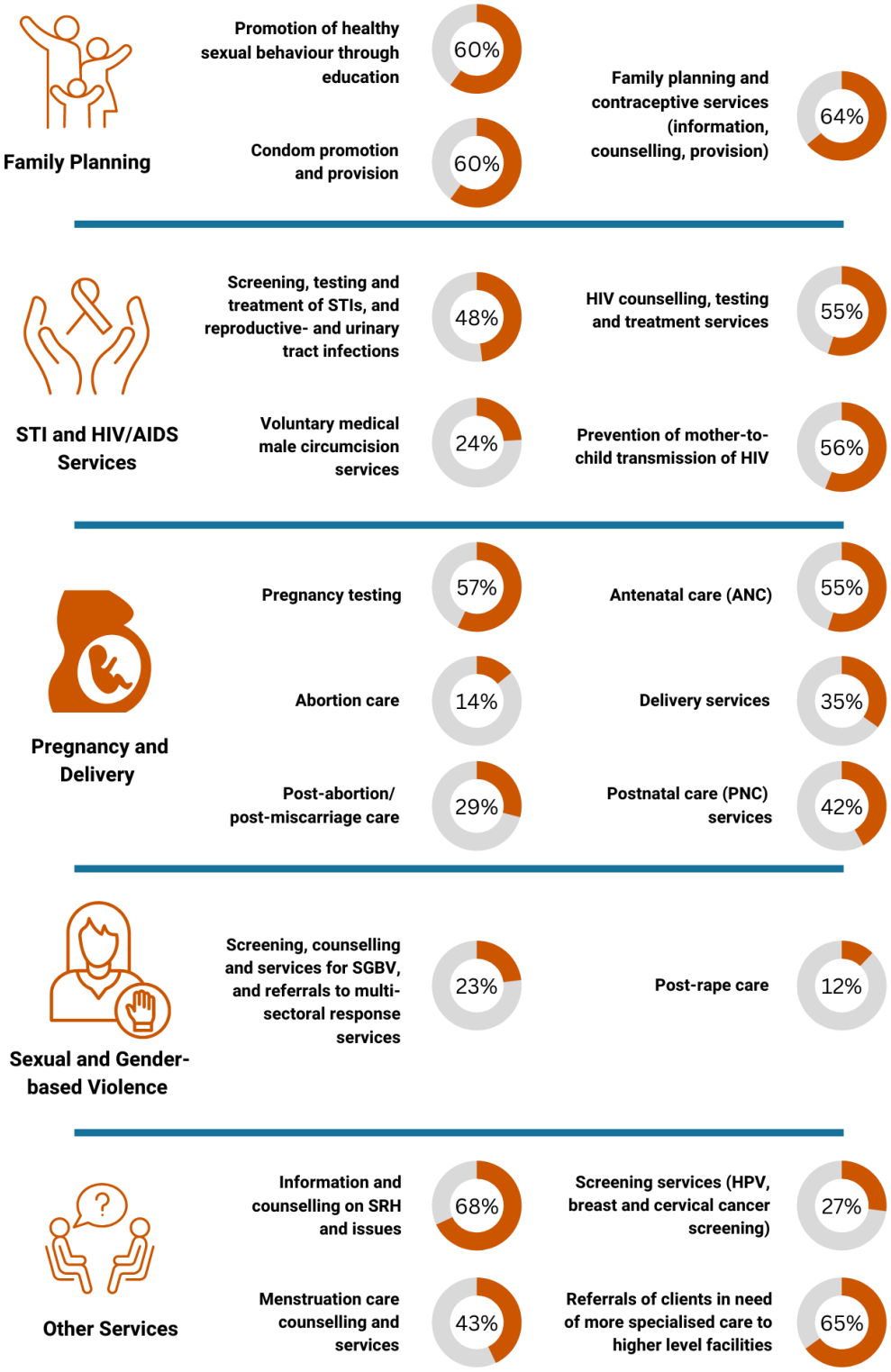
Table 5. Perspectives of healthcare workers on AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
I advise adolescents to abstain from sex when they seek contraceptives at the health facility	49	84	69	**63**
Adolescents should not have sex	33	40	54	**38**
I am okay with providing contraceptives to women who are not married	72	88	38	**71**
I am okay with providing contraceptives to adolescents younger than 18 years	54	75	23	**55**
Contraceptive use goes against my religion and should therefore not be provided to adolescents	39	42	54	**42**
I feel comfortable talking about contraceptives and sexual health matters with adolescents	98	96	58	**91**
This facility is generally easily and safely accessible by foot or public transportation for adolescents	95	100	92	**96**
Costs of SRH services are a barrier to adolescents at this facility	14	54	17	**26**
Waiting times at this facility to receive SRH services are a barrier to adolescents	12	46	8	**22**
Adolescents feel welcome and safe at this facility, and feel at ease to access SRH services	88	100	83	**91**
When offering SRH services to adolescents, I have enough time to sufficiently treat and answer their questions	93	96	100	**95**

3.2 Provision of SRH Services

Figure 4 shows the provision of a broad spectrum of SRH services in all surveyed health facilities. Overall, none of 19 services were offered at 80% or more of health facilities. The most offered SRH services are information and counselling on SRH and issues (68%) and referral to higher level facilities (65%). The least offered SRH services are post-rape care (12%) and abortion care (14% of health facilities).

Figure 4. Overall percentage of health facilities offering specific SRH Services.



In addition to the SRH services provided, the survey also assessed whether these services are offered to certain specific population groups, including married versus unmarried women and adolescents. Table 6 shows to whom specific SRH services are offered. The study found that, in general, married women (18+ years of age), have better access than unmarried women (18+) across the four SRH services. In addition, only about 80% of health facilities that provide information and counselling on SRH and education on healthy sexual behaviour, also offer this service to adolescents. When further looking at sub-groups of adolescents, married girls have better access than unmarried girls, while adolescent boys have lowest access. The health facilities which offer education on healthy sexual behaviour to adolescents were asked whether they provided other means or information to prevent pregnancy besides abstinence. In total, 87% of these health facilities said that they do (94% public; 92% private; 67% faith-based).

Furthermore, only about 60% of health facilities that provide family planning and contraceptive services and condom promotion and provision, also offer this service to adolescents. When further looking at sub-groups of adolescents, for family planning and contraceptive services, again married girls have better access than unmarried girls, while adolescent boys have the lowest access. For condom promotion and provision, adolescent boys have highest access, followed by married girls, while only in 69% of health facilities unmarried girls are offered this service.

Table 6. Provision of SRH services by health facilities including to specific adolescent groups.

	Information and counselling on SRH and issues	Promotion of healthy sexual behaviour through education	Family planning and contraceptive services	Condom promotion and provision
HFs offering service (%)	68	60	64	60
HFs that offer the service, offer it without permission of guardian/spouse to (%):				
Unmarried women (18+)	80	74	75	83
Married women (18+)	98	98	94	100
HFs offering service to adolescents under 18 (%)	79	78	59	66
HFs that offer the service, offer it without permission of guardian/spouse to (%):				
Boys (10-17 years)	63	65	53	91
Married girls (10-17 years)	91	89	97	84
Unmarried girls (10-17 years)	74	73	70	69

When comparing the differences in provision of SRH services between sectors, some differences were found (see Table 7). Notably, in the faith-based sector no health facilities offered abortion care or post-rape care. In addition, fewer faith-based health facilities offered family planning and contraceptive services as well as condoms compared to the public and private sectors. Interestingly, the faith-based sector did score highest on provision of information and counselling on SRH (85%); menstruation care services (77%); HIV counselling, testing and treatment services (69%); postnatal care services (62%); as well as provision of referrals to higher level facilities (92%), compared to the other sectors. The private sector scored highest on provision of abortion care (26%) as well as post-abortion or post-miscarriage care (39%), and lowest on provision of screening, counselling and services for sexual- and gender-based violence (SGBV; 17%). Interestingly, the public sector generally performed similar or worse compared to the other sectors. The exception is provision and promotion of condoms, which is offered most at public health facilities (67%).

Table 7. Percentage of health facilities offering specific SRH services per sector.

	Public (%)	Private (%)	Faith-based (%)
Information and counselling on sexual and reproductive health and issues	58	78	85
Promotion of healthy sexual behaviour through education	48	78	69
Family planning and contraceptive services (information, counselling, provision)	60	78	54
Condom promotion and provision	67	61	31
Menstruation care counselling and services	25	61	77
HIV counselling, testing and treatment services	50	57	69
Prevention of mother-to-child transmission of HIV	58	52	54
Screening/testing and treatment of STIs, and reproductive- and urinary tract infections	38	61	62
Abortion care	13	26	0
Post-abortion/post-miscarriage care	27	39	15
Pregnancy testing	46	70	77
Antenatal care (ANC)	58	43	62
Delivery services	35	30	38
Postnatal care (PNC) services	40	35	62
Screening services (HPV, breast and cervical cancer screening)	21	35	38
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services	25	17	23
Post-rape care	15	13	0
Voluntary medical male circumcision services	21	35	15
Referrals of clients in need of more specialised care to higher level facilities	65	52	92

Provision of SRH services further differed significantly between the three Counties surveyed. The differences between the counties can be found in Table 8. Especially in Mandera, provision of all SRH services was notably low.

Table 8. Percentage of health facilities offering specific SRH services per county.

	Isiolo (%)	Mandera (%)	Marsabit (%)
Information and counselling on sexual and reproductive health and issue	93	21	89
Promotion of healthy sexual behaviour through education	90	39	48
Family planning and contraceptive services (information, counselling, provision)	79	25	89
Condom promotion and provision	69	25	85
Menstruation care counselling and services	66	14	48
HIV counselling, testing and treatment services	66	21	78
Prevention of mother-to-child transmission of HIV	76	14	78
Screening/testing and treatment of STIs, and reproductive- and urinary tract infections	69	14	59
Abortion care	28	0	15
Post-abortion/post-miscarriage care	45	0	41
Pregnancy testing	76	11	85

	Isiolo (%)	Mandera (%)	Marsabit (%)
Antenatal care (ANC)	83	7	74
Delivery services	28	11	67
Postnatal care (PNC) services	55	0	70
Screening services (HPV, breast and cervical cancer screening)	38	4	41
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services	24	7	37
Post-rape care	10	4	22
Voluntary medical male circumcision services	28	4	41
Referrals of clients in need of more specialised care to higher level facilities	55	43	100

The survey also asked how much supply of birth control pill clients are given per visit; 70% of health facilities provide supply for three months, while 23% provide clients with a one-month supply. Some common long-acting contraceptives are intra-uterine contraceptive devices (IUDs) and implants. They require a trained healthcare worker to insert the product. In the public sector, 42% of the health facilities had a trained healthcare worker who could insert an IUD, versus 64% in the private, and 23% in the faith-based sector (see Table 9). Numbers for contraceptive implants were slightly higher: Fifty-two percent of public health facilities had someone who could insert contraceptive implants, versus 76% in the private, and 46% in the faith-based sector.

Table 9. Capability insertion and removal of intra-uterine contraceptive devices (IUD) and implants.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Someone at the health facility is trained, and can insert and take out an IUD	42	64	23	**45**
Someone at the health facility is trained, and can insert and take out contraceptive implants	52	76	46	**58**

Table 10 displays for which SRH services clients have to pay. Only in 2% of public health facilities, clients pay for maternal health services and STI treatment services. In 98% of public health facilities all SRH services are for free. In the private sector, generally clients had to pay for SRH services, with clients having to pay for HIV/AIDS services in fewest private health facilities (68%). Only in 4% of private health facilities all SRH services were for free, compared to 38% of faith-based health facilities. When looking at the type of products and procedures that clients have to pay for, in the private sector they commonly pay for a range of things, including medicines, consultation fees, hospitalisation, surgical procedures and lab tests. In the faith-based sector, clients always pay for prescription medications and lab tests, and regularly also consultation fees and charges for hospitalisation. In the public sector, clients always pay for lab tests, and never for the other products and procedures.

Table 10. Costs of services.

	Public (%)	Private (%)	Faith-based (%)
SRH services at the facility which clients need to pay for			
Family planning	0	92	15
Maternal health services	2	84	23
STI treatment services	2	96	62
HIV/AIDS services	0	68	8
All the services are for free	98	4	38
If any, type of products clients have to pay for			
Prescription medications	0	67	100
Over the counter (non-prescription) medications	0	67	50
Disposable medical equipment (gloves, needles, personal protective equipment)	0	50	25
Consultation fee	0	71	63
Day charges for hospitalisation	0	83	63
Imaging diagnostics	0	71	13
Surgical procedures	0	88	25
Lab tests	100	83	100

3.3 Policies, Management and Oversight

Table 11 provides information on policies and monitoring of the health facility. Overall, the availability of policies at health facilities was low across the sectors. In the public and private sector, the most commonly available guideline was the National Family Planning Guidelines for Service Providers (2016) at 50% and 64% of health facilities respectively. In the faith-based sector, this was the National Guidelines for HIV Testing and Counselling in Kenya (2008) at 54%. The study further found that monitoring of the health facility's SRH services by government officials was done irregularly. In 21% of facilities, government officials visit zero times during the year; in 26% of health facilities, government officials visit one or two times per year, and in 20% of health facilities they visit at irregular intervals. Furthermore, community committees that provide input into the facilities' services and activities were available at 81% of public health facilities compared to much lower numbers of private (32%) and faith-based health facilities (38%). Lastly, the involvement of adolescents in the design and implementation of SRH services was very low (13%). If adolescents are involved, it is done via health education or counselling sessions, during committee election, or during their visit at the health facility.

Table 11. Policies and monitoring.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
The HF has soft or hard copies of the below guidelines/ policies available for use:				
National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya (2016)	24	54	31	**34**
Management of Sexually Transmitted/Reproductive Tract Infections (2009)	29	57	38	**38**
National Family Planning Guidelines for Service Providers (2016)	50	64	33	**51**
National Guidelines on Management of Sexual Violence in Kenya (2014)	29	38	25	**31**
National Guidelines for Quality Obstetrics and Perinatal Care (2011)	35	41	23	**35**
National Guidelines for HIV Testing and Counselling in Kenya (2008)	41	50	54	**46**
Processes are in place at the HF to ensure that staff is updated and informed about changes when a new policy is developed	50	72	69	**59**
Frequency at which a government official visits to monitor how the health facility is performing with regards to SRH service provision:				
Zero times during the year	15	32	23	**21**
One time during the year	13	24	0	**14**
Two times during the year	6	16	23	**12**
Three times during the year	0	0	15	**2**
Four times during the year (quarterly)	21	8	23	**17**
Five or more times during the year	0	0	0	**0**
At irregular intervals	29	8	8	**20**
Don't know	17	12	8	**14**
The HF has a community committee that provides input into the HF's services and activities	81	32	38	**60**
Adolescents are asked for input into or feedback on the design, planning, implementation and evaluation of SRH services at the HF	15	12	8	**13**

3.4 Training, Education and Outreach

Only in few health facilities healthcare workers seemed to receive continuous training on AFSHR: in 19% of the public sector facilities, 24% of the private facilities, and 8% of the faith-based facilities, healthcare workers had received a refresher training in the last 24 months (see Table 12). Educational SRH materials for adolescents were available at only 21% of public, 28% of private and 15% of faith-based facilities. Education materials for parents/guardians on adolescent SRH services to increase their support were available at similar percentages of public and private health facilities, but at none of the faith-based facilities. Regarding outreach and education on SRH, again low numbers of health facilities provided this across the sectors, with interestingly, the highest percentage found in private health facilities (40%) compared to public (21%) and faith-based (8%). A total of 23% of health facilities organised group discussions on SHR for adolescents with similar percentages found across the sectors. How often these group discussions were organised ranged from once a year to once a month. Peer educators were utilised by 19% of public health facilities, 20% of private health facilities, and none of the faith-based health facilities.

Table 12. Training, education and outreach of the health facility.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Staff have received a refresher training on how to provide AFSRH services in the last 24 months	19	24	8	**19**
Educational materials on SRH and healthy sexual behaviour, such as posters, pamphlets, videos or booklets, targeted at adolescents are available at this facility	21	28	15	**22**
Educational materials with key messages on adolescent SRH targeted at parents/guardians to support adolescents to access services, are available at this facility	21	32	0	**21**
The facility provides outreach and/or education on SRH for adolescents within the community	21	40	8	**24**
If yes, frequency per year:				
Less than one time	14			
One time	21			
Two times	14			
Four times	7			
Five times	7			
Twelve times	36			
The facility organises group discussions or talks for adolescents on SRH	21	28	23	**23**
If yes, frequency per month:				
One time	21			
Two times	36			
Four times	14			
Twelve times	29			
The facility works with adolescent peer educators to provide outreach services to other adolescents	19	20	0	**16**

3.5 The State of the Health Facility

The information in Table 13 was collected based on observations made by the data collectors when they visited the health facilities. It shows that health facilities, overall, scored high. Areas of improvement include materials on SRH targeted at adolescents being visible or provided at the health facility for health facilities across the three sectors, and the availability of soap and running water, and electricity for public sector facilities.

Table 13. Information on the state of the health facility based on observations of data collectors.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Signage with services offered is available and visible at the health facility	85	88	100	**88**
Signage with operating hours is available and visible at the health facility	85	88	100	**88**
Materials targeted at adolescents on SRH are visible or provided at the facility (posters, leaflets, videos, etc.)	19	44	23	**27**
The health facility is clean	98	96	100	**98**
The health facility has private rooms where consults are held	98	100	100	**99**
The health facility has electricity	77	100	100	**87**
The health facility has soap and running water	75	92	92	**83**
The health facility has clean toilet facilities	83	96	100	**90**

3.6 Recommendations by Healthcare Workers

Thirty-seven healthcare workers gave suggestions on how to improve access to SRH services for adolescents. A Word Cloud based on their responses can be found in Figure 5. From this cloud it becomes clear that many healthcare workers talked about the need for training, SRH materials and education. Many healthcare workers also mentioned the need for regular supply of SRH commodities and improvements in the offering of SRH services. Below are specific quotes from healthcare workers who voiced what could be done.

"Peer educators should get support throughout the year, parental involvement [should be promoted] to help their daughters access SRH services, and adequate [supply of] SRH commodities should be ensured throughout the year."- **Public community dispensary**

"Introduce youth friendly and adolescent policies and provide information, education and communication materials and youth friendly services."- **Public district hospital**

"One—providing of education on SRH. Two—providing drugs in a timely manner. Three—outreach targeting particular groups should be implemented."- **Private medical clinic**

"Private institutions [should be] involved in decisionmaking. Training [should] also involve private hospitals."- **Private dispensary/clinic**

"Family Planning should be provided at all health facilities regardless of religion, as well as frequent training of health care workers."- **Religious dispensary/clinic**

Figure 5. What could be improved to enable better access to AFSRH services at the health facility (Wordcloud).

4. RECOMMENDATIONS

The study showed that overall, 60% of healthcare workers indicated that their health facility was officially accredited as an adolescent-friendly health centre. From the perspective of the healthcare worker, a barrier to adolescent SRH was waiting times at the health facility (22% of surveyed healthcare workers). Costs were thought to be a barrier to adolescents by 54% of private sector healthcare workers, compared to lower numbers among those working in the public (14%) and faith-based (17%) sectors. The most offered SRH services are information and counselling on SRH and issues (68%) and referral to higher level facilities (65%). The least offered SRH services are post-rape care (12%) and abortion care (14% of health facilities). A total of 63% of surveyed healthcare workers advise adolescents to abstain from sex when they seek contraceptives at the health facility and only 55% were okay with providing contraceptives to adolescents under 18. In addition, only 71% were okay with providing contraceptives to unmarried women.
When comparing access to four SRH services among unmarried and married women (18+), married women seemed to have slightly better access. In addition, only about 80% of health facilities that provide information and counselling on SRH and education on healthy sexual behaviour also offer this service to adolescents. When looking further at sub-groups of adolescents, married girls seem to have slightly better access than unmarried girls, while adolescent boys have the lowest access. In the public sector, 42% of the health facilities had a trained healthcare worker who could insert an IUD, versus 64% in the private, and 23% in the faith-based sector. Numbers for contraceptive implants were slightly higher: fifty-two percent of public health facilities had someone who could insert contraceptive implants, versus 76% in the private, and 46% in the faith-based sector. On the state of the health facilities, areas of improvement include materials on SRH targeted at adolescents being visible or provided at the health facility for health facilities across the three sectors, and the availability of soap and running water. The following are some recommendations for responding to the above findings.

A. Provision of adolescent-friendly services

- 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.
- Improve functionality of adolescent/ youth friendly centres 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.
- 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).
- 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.
- 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.

B. Provision of SRH services

- Sensitise CHVs within the existing community health units 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.
- 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.
- 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.
- 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.
- 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.

C. 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 family planning/SRH/maternal and newborn child health policies, to healthcare workers to fully implement for increased access and improved coverage and quality.
- Advocate for the full implementation of domesticated family planning/reproductive maternal, newborn, child and adolescent health/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.

D. 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[2] 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.

2. Kenya Ministry of Health. Core Standards for Quality healthcare. Kenya Quality Model for Health. (2018). http://guidelines.health.go.ke:8000/media/Core_Standards_for_Quality_Healthcare_-_Kenya_Quality_Model_for_Health_-_March2018.pdf.

Funded by
the European Union

sharp
Solutions for Supporting Healthy Adolescents