Access, Service and Knowledge Baseline Study Report
Youth Empowerment Alliance

Contents

SUMMARY

The ASK Baseline Study was a mixed methods study conducted to provide baseline indicators that would be used to monitor and evaluate the youth alliance ASK programme. The study was conducted in 5 counties sampled from the region of coverage, and targeted respondents of ages 10 – 24 and key persons in the community. The specific study aims were:

1. To estimate the knowledge levels on Sexual and Reproductive Health among adolescents within the ASK implementation sites
2. To determine the level of access to reproductive health commodities for adequate SRH services provision
3. To assess the quality of SRH services sought by young people in the public and private facilities at baseline
4. To ascertain the level of support for young people's SRH in study sites

The baseline survey utilized both primary data (from Target Respondent Questionnaires, Client Exit Interviews, Focus Group Discussions and Facility Observation Assessments) and desk reviews of published secondary data sources to generate baseline data.

Key findings include:

a) While a majority of young people have the right information and attitudes and on various SRHR issues, a significant number amongst them still lack the correct information and the right attitudes i.e. knowledge on HIV/AIDS of HIV/AIDS, STI and contraceptives.

b) Socio-cultural and health system barriers are impeding youth's access to sexual and reproductive health services, and these need to be addressed in order to observe gains.

c) Health facilities need to increasingly focus and prioritize on offering quality Youth Friendly Services, actively addressing the fears of lack of confidentiality resident among the youth. This would lead to increased uptake of these services.

d) There was no significant gender disparities found in access to Sexual and Reproductive health services and Rights, but rather the socio-cultural and health system barriers applied across board to all the youth.

e) Sexual and Reproductive health Rights for young people across all the counties are discouraged by the community and even discussion of sex and sexuality is still considered taboo.

The survey reveals that there is still a need for SRH advocacy and public education among the youth in the areas of focus. Greater focus is required targeting the gatekeepers to change perceptions on sexual and reproductive health and rights of the youth. Health facilities need to prioritise and upscale the quality of their Youth Friendly Services to meet the minimum quality criteria.

CHAPTER 1: INTRODUCTION

Introduction of the baseline

The Youth Alliance's Access, Services and Knowledge (ASK) programme is a 3 year programme (2013-2015) funded by the Dutch Ministry of Foreign Affairs with the aim of enhancing uptake of SRH services among young people aged between 10-24 years, including underserved groups. It is implemented in 7 countries namely Kenya, Uganda, Ethiopia, Ghana, Senegal, Pakistan and Indonesia.

The purpose of the study was to provide baseline information that will form the basis for measuring the programme's results, impacts and long lasting change in the lives of the beneficiaries at the end of the programme. The specific study aims were:

1. To estimate the knowledge levels on Sexual and Reproductive Health among adolescents within the ASK implementation sites
2. To determine the level of access to reproductive health commodities for adequate SRH services provision
3. To assess the quality of SRH services sought by young people in the public and private facilities at baseline
4. To ascertain the level of support for young people's SRH in study sites

Project Inception, Planning and Target Setting

The baseline project began with an inception meeting of the consulting firm and the representative of the Youth Empowerment Alliance. A review of existing data with an aim of contextualising the study issues was conducted. The data collection tools provided were reviewed and revised and ethical approval sought from AMREF ethical committee. Four day training was held with the selected research assistants.

The Access, Services and Knowledge (ASK) programme

The Access, Services and Knowledge (ASK) programme aims to improve the Sexual and Reproductive Health (SRH) Rights of young people in Kenya (10-24 years) by increasing their uptake of SRH services.

The Objectives of the country program

The program works to impact the youth and envisions that through their work:

- Young people are better informed and are thus able to make healthier choices regarding their sexuality

- A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health
- Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using.
- Greater respect for the sexual and reproductive rights of people to whom these rights are denied.

The Project Area

In Kenya, the Project is being implemented in 13 counties namely: Nairobi, Mombasa, Kisumu, Kakamega, Busia, Bungoma, Trans-Nzoia, Kwale, Migori, Kisii, Siaya, Uasin-Gishu and Homabay as shown in Figure 1 below.

Figure 1: County reach of the ASK program in Kenya (with baseline survey sampled counties in Grey) *courtesy of Google Maps*

Description of the target groups

The Project Targets the youth (ages 10 – 24) both school going and non-school going; vulnerable populations within this group (e.g. YPLHIV); County Health Management teams; focal point persons of partner organisation within the Alliance; community leaders including parents; selected health facilities; and youth CBOs working with partners organizations.

Short description of the partner organisations involved

The ASK programme in Kenya is implemented by 15 partners working in the regions specified in Table 1.1, and comprises of Africa Alive (AA), Centre for the Study of Adolescence (CSA), Clinton Health Access Initiative (CHAI), Child Line Kenya (CLK), Family Health Options Kenya

(FHOK), Great Lakes University of Kisumu (GLUK), Maximizing facts on AIDS (MAXFACTA), Nairobits Trust, Network of Adolescence and Youth of Africa (NAYA), National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK), UNESCO, Women Fighting AIDS in Kenya (WOFAK),the World Starts With Me Alumni Youth Advocacy Network (WAYAN), KMET and ADS Nyanza.

Below is a profile of implementing partner organizations:

Africa Alive! Is a youth-serving organization started in 1998 with a vision to build and empower a healthier HIV/AIDS free generation of African youth. *Africa Alive* seeks to promote positive behaviour change among young people through advocacy, empowerment, partnership and resource/community mobilization. The organization promotes the full participation of young people at every level of programme implementation using audience and message strategy of edutainment (entertainment education).

Great Lakes University of Kisumu (GLUK) is an academic university whose aim is to develop effective managers of health and developments through community mobilization, organisation, training, technical support and management improvement. Through its programs, GLUK facilitates poverty reduction, health care and development by bridging training with service delivery programs, focusing on the needs of the most vulnerable members of the society. It develops tests and disseminates innovative and effective models of community based initiatives through research.

Nairobits Trust is a not-for profit organization registered in 1999 and based in Nairobi working toward changing the lives of vulnerable (15 to 24 year old youth in Kenya by improving their access to productive employment as well as their ability to cope with their social environment through creativity and innovation. Nairobits provides these youth with training in multimedia, entrepreneurship, reproductive health and rights (SRHR) and life skills in order to enhance their confidence and self-esteem as well as their chances for gainful employment. Since inception, Nairobits has provided more than 6,500 youth from disadvantaged backgrounds with multimedia, SRHR, entrepreneurship and life skills. Over 60% of these are gainfully employed both formally and informally. Nairobits works closely with community based organizations in reaching and training youth. This involves partnering with the CBOs to set up information centres within their premises to ensure ease of access to the training by the youth and community ownership in the larger context.

The Centre for the Study of Adolescence: The Centre for the Study of Adolescence is an independent non-partisan, non-profit organization established in 1988 working in the field of adolescent sexual and reproductive health including HIV/AIDS. CSA's mandate is to advocate and implement policies and programs that enable young people to exercise choice, access to services and participate fully in activities that promote their health and well-being. CSA has a strong background in Community mobilization, adolescent program design and

development, research, monitoring and evaluation and advocacy. CSA works with a wide range of youth, in and out of school and special groups of adolescents such as married young girls. CSA has been at the fore front of policy development and advocacy both at the grassroots level and at the national level working with public sector and parliamentarians in promoting and creating visibility for ASRHR issues. CSA has been working Rutgers/WPF and Simavi to provide comprehensive sexuality education through innovative approaches including ICT.

Clinton Health Access Initiative: In 2002, President Clinton launched the Clinton HIV/AIDS Initiative (CHAI) to bring care and treatment to people living with HIV/AIDS and to strengthen health systems in resource-poor countries. Over the past few years, CHAI have expanded their work to increasing access to high-quality treatment for malaria, accelerating the rollout of new vaccines, and lowering infant mortality in the countries in which they work.

Child Line Kenya: Child line Kenya: Is a non-governmental organization (NGO) that works in the child protection sector. Child line Kenya's work represents the resonating message that child abuse and violence against children have no place in our society. The organization operates the National Child Helpline 116, Kenya's only 24-hour, toll-free telephone and web-based helpline for children. They work with Government, other NGOs and civil society to break the silence on child abuse and create awareness of children's rights.

Family Health Options Kenya: Family Health Options Kenya (FHOK) is a local Non-Governmental organization which has been a leading service provider of sexual and reproductive health services in the country for the last five decades. It has presence in seven of the eight provinces with a strong grassroots network. FHOK has played a leading role in providing sustainable, innovative and comprehensive services in response to health and socio-economic needs of all Kenyans. Since its inception, it has been a center of excellence in providing capacity building in sexual and reproductive health. It is also committed to offering quality services as well as championing sexual and reproductive health and other rights. It works to ensure the empowerment of young people so that they can exercise and enjoy these rights.

Maximizing Facts on AIDS (MAXFACTA): It is a group founded by young people living with HIV/AIDS. It's a community-based organization founded in the year 2002 and registered it in 2003 to provide quality care, prevention and as a forum for mutual empowerment and support to enable them to live positively. With continuing need to support all the affected and infected youth, Maxfacta saw it fit to start a rescue centre for the affected youth.

Network of Adolescence and Youth of Africa (NAYA): The goal of NAYA is to contribute towards an enabling environment that will foster the empowerment of adolescent and youth sexual and reproductive health and rights. A society where the reproductive health and rights of adolescent and youths are recognized provided for and respected. NAYA

advocates for the implementation of policies and legislation on adolescent and youth sexual reproductive health through dissemination of information, championing and promoting their rights at national and community level.

National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK): The National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK) is a national Network that unites people living with HIV and those affected by TB and HIV/AIDS through posttest clubs, support groups, community based organizations, non-governmental organizations and networks.

UNESCO: In 1945, UNESCO was created in order to respond to the firm belief of nations, forged by two world wars in less than a generation that political and economic agreements are not enough to build a lasting peace. Peace must be established on the basis of humanity's moral and intellectual solidarity. UNESCO strives to build networks among nations that enable this kind of solidarity, by Mobilizing for education so that every child, boy or girl, has access to quality education as a fundamental human right and as a prerequisite for human development and building intercultural understanding through protection of heritage and support for cultural diversity.

Women Fighting AIDS in Kenya (WOFAK): Women Fighting AIDS in Kenya (WOFAK) is a national non-governmental organization founded and registered in Kenya in 1994 by a group of women most of whom had tested positive to HIV. The founding group had in mind an entity that would provide them with a forum for mutual support and empowerment. Since inception, WOFAK has continued to grow to its present status of a national network of women living with HIV and AIDS, contributing significantly to national efforts aimed at prevention and to provide comprehensive care and support to women and children living with and affected by HIV and AIDS to enable them lead more wholesome lives. WOFAK's vision under strategic plan 2007- 2011 was crafted along the Kenya National HIV and AIDS strategic plan (KNASP III) 2008-2013 which strives for a 'Society free of HIV'. Today, WOFAK is visible in the Coast, Nyanza, Western, Rift Valley and Nairobi.

World Starts with Me Alumni Youth Advocacy Network (WAYAN): WSWM Alumni Youth Advocacy Network (WAYAN) is a youth-led advocacy network of youth from the regions of Nairobi, Nyanza and Central and Coast Kenya focusing on SRHR. WAYAN was the outcome of the successful implementation of the computer-based sexuality education program WSWM in secondary schools. Through advocacy and raising awareness, WAYAN aims to improve the SRHR situation of youth in Kenya.

The Anglican Development Services (ADS) Nyanza is a Faith Based organization serving vulnerable communities in Nyanza province. Its goal is to increase access to secure and sustainable livelihood and economic opportunities through integrated and participatory community development, capacity building and economic empowerment programs.

Kisumu Medical and Educational Trust (KMET) is an indigenous NGO formed in Kenya in 1995 and dedicated to provision of quality Reproductive Health and Educational Services. KMET also advocates for sexual and reproductive health rights.

Table 1.1: Partners Involved per County

National	Nairobi	Kisumu	Kakamega	Mombasa	Kwale	Bungoma	Siaya	Kisii	Trans-Nzoia	Migori	Uasin-Gishu	Busia	Homabay
CHAI	AFRICA ALIVE	CSA	GLUK	AFRICA ALIVE	NEPHAK	NEPHAK	GLUK	CSA	GLUK	NAYA	FHOK	GLUK	ADS Nyanza
UNESCO	NAIROBITS	GLUK	NEPHAK	NEPHAK	MAXFACTA	GLUK	WOFAK	GLUK		GLUK			GLUK
Child Line Kenya	NEPHAK	WAYAN	FHOK	WOFAK		MAXFACTA	NAYA			KMET			
	FHOK	FHOK	MAXFACTA	MAXFACTA			ADS Nyanza						
	WOFAK	KMET					KMET						
	MAXFACTA												

Characteristics of the target groups

Table 1.2: Characteristics of the target groups of the SRHR programme in Kenya

		Characteristics of the target group		
Target groups (n = 738)	*Females (n = 366)*	*Males (n=372)*	*Currently in school (n = 513)*	*Currently out of school (n = 225)*
Young people aged 10-14 (n = 161)	86 (53.4%)	*75 (46.6%)*	*156 (96.9%)*	*5 (3.1%)*
young people aged 15-19 (n=395)	214 (54.2%)	181 (55.8%)	350 (88.6%)	45 (21.4 %%)
young people aged 20-24 (n=177)	66 (37.3%)	111 (62.7%)	7 (4.0%)	170 (86.0%)

CHAPTER 2: METHODOLOGY

Sampling Methodology

To aid in sampling, a sampling list of all facilities, schools and community centers that each partner was working with at the time of the baseline survey was developed. This was compiled and selection was performed randomly as below:

- The counties were selected on the basis of the regions where the Youth Empowerment Alliance partners were working. A list of all YEA partners working regions was generated and used as a sampling frame for the counties. Counties representing all the partners were selected.
- For the Health Facility Observation and the Safe Abortion tool: 45 facilities were selected randomly from the respective sampling frame developed from the list of all facilities that the partner organizations currently work with.
- For school, out of school and facility based Interviews; a random sample was obtained for each cadre of school/centre (Primary, Secondary and Out of School Centers) that partner organizations work with. From this sampling frame, 9 Primary, 30 Secondary, 15 Out of School Centers, and 45 health facilities were sampled. The participants for the Primary School and Secondary School Interviews were then systematically sampled from the attendance registers in each class. For Out-of-school and Health Facility Exit Interviews, participants were randomly selected as the participants completed their activities at each of the respective centers.
- Participants for the Focused Group Discussions for which 4 were done in each of the 5 participating counties, were selected by the team leaders and target group leaders based on key actor mapping and considering their availability for the sessions.

Further details on sampling are outlined in the sampling procedures annex.

Description of tools/ instruments

The baseline survey utilized both primary and secondary data sources. The indicators were computed from these data sources as below outlined in Table 2.1. The response rate for each of these tools is outlined in Table 2.2.

a) School Based and Out of School Survey Tool
b) Focused Group Discussion Tool for Young People
c) Focused Group Discussion Tool for community leaders
d) Client Exit
e) Evaluation of Safe Abortion Practices Tool
f) Health Facility Direct Observation Form for Youth Friendly Services
g) Self - Assessment Tool for Youth Organisations (CBOs)
h) Self assessment tool for Alliance Partner Organizations
i) SRH Policies implementation Assessment tool

The secondary data sources that were used in the survey were extracted from the following reports:

a) The Kenya demographic and Health Survey 2003, and 2007 reports
b) The Kenya AIDS Indicator Survey 2008/9 report, and 2012 (preliminary report)
c) The Kenya AIDS Epidemic Update 2012 report
d) The UNGASS 2010 Country Report, Kenya

Table 2.1: Tools used to measure indicators, by indicator

	Indicator	Tool
1.1	*Outcome indicator 1.1 – % of young people with comprehensive/correct knowledge on SRHR/HIV*	*School Based and Out of School Survey Tool* *Focused Group Discussion Tool for Young People*
1.2	% of young people with increased capacity in health seeking behaviour	*School Based and Out of School Survey Tool* *Focused Group Discussion Tool for Young People*
2.1	Contraceptive prevalence rate – modern methods – to women under 25	*secondary data (KDHS)*
2.2	Proportion of population with HIV with access to ARVs	*secondary data (UNGASS report, KAIS)*
3.1	% of HIV-positive pregnant women receiving treatment to prevent mother to child transmission	*secondary data (UNGASS report, KAIS)*
3.2	Proportion of births attended by skilled health personal	*secondary data (KDHS)*
3.3	Antenatal coverage (at least one visit and at least four visits) in targeted area of implementation	*secondary data (KDHS)*
3.4	Young people express satisfaction with the quality and youth friendliness of health services	*Exit Interviews*
3.5	Nr. of government health facilities that adopt and implement youth friendly SRH services	*Health Facility Direct Observation Form for Youth Friendly Services*
3.6	Nr. of private / for profit facilities that adopt and implement youth friendly SRHR services	*Health Facility Direct Observation Form for Youth Friendly Services*
3.7	Nr. of health clinics that adopt and implement youth friendly SRHR services.	*Health Facility Direct Observation Form for Youth Friendly Services*
3.8	Nr. of clinics that comply with the most	*Evaluation of Safe Abortion Practices Tool*

	recent safe abortion guidelines	
4.1	Acceptance/support of young people's right to access SRH services at community/local level	*Focused Group Discussion Tool for community leaders*
4.2	Parents/care takers give support to young people in SRHR	*Focused Group Discussion Tool for Young People*
4.3	Nr. of youth led organisations with organisational capacity in SRH service programming and advocacy	*Self - Assessment Tool for Youth Organisations (CBOs)*
4.4	Nr. of partner organisations with functional structures for the involvement of young people in program design, planning, implementation, monitoring, evaluation, research and advocacy	*Self - Assessment Tool for Alliance partner organizations*
4.5	Development and enforcement of implementation of SRHR policies promoting access to youth SRHR and access to YFS, including hard to reach	*SRH policies implementation assessment tool*

Description of the baseline sample

The Table 2.2 below shows the numbers of respondents and health facilities for each tool that was completed.

Table 2.2: Number of respondents in the sample in Kenya per tool used

Tool Target group	Tool 1 School and Out of School Survey results	Tool 2 Client Exit Tool	Tool 3 Evaluation Safe Abortion Services results	Tool 4 Assessment Tools For Youth Organizations (CBOs) tool	Tool 5 Direct Observation Form - Youth Friendly Services	Tool 6 self assessment tool for partner organizations
Girls 10-14	86	15	N/A	N/A	N/A	N/A
Girls 15-19	214	59	N/A	N/A	N/A	N/A
Girls 20-24	66	213	N/A	N/A	N/A	N/A
Boys 10-14	75	7	N/A	N/A	N/A	N/A
Boys 15-19	180	21	N/A	N/A	N/A	N/A
Boys 20-24	111	41	N/A	N/A	N/A	N/A
Facilities / partner Org	45	34	35	31	36	4

Assessed						
Total	738[1]	356	35	31	36	4

Ethical aspects

Consent, confidentiality and anonymity in the tools and data collection procedures

Informed consent was granted by the interviewee in the form of a signed consent form. Each of the questionnaires issued had a consent form cover page that detailed the purpose of the study, and interviewees were informed that they were free to opt in to fill the questionnaire.

To ensure confidentiality of the data collected, no respondents' name or other personal identifiers were included in reports from this study. The unique individual identifiers used in analysis were generated at the time of filling in of questionnaire.

Ethical clearance

The study proposal was approved by the relevant ministry of education and ministry of health departments in addition to undergoing independent ethical review by the AMREF Ethical Review Committee.

Data collection procedures

Selection and training of data collectors

Twenty nine research assistants (RAs) were selected for the study (to make up data collection teams consisting of a team leader and data collectors for each of the 5 study sites selected)

The team leaders were social scientists who had prior experience conducting qualitative and/or mixed method surveys in Kenya. The rest of the data collectors were selected on the basis of their previous experience in quantitative data collection, administering of household surveys, and familiarity with the area of research.

The data collection teams underwent an intensive four-day training, which involved plenary and group sessions in which the content of the tools and the rationale behind each question were discussed.

Translation, contextualization, adaptation, pretesting of tools

During the training, the teams evaluated the questions on the tools and provided feedback that improved the questions in view of the Kenyan context. Most of the quantitative

[1] Note – for the school survey, 5 records did not have complete age or gender data but are included in the analysis.

section's questions were close ended, and the respective questionnaires were designed to be administered via hand held devices for immediate transcription. The questions were not translated to local languages and data collectors were empowered to translate the questions to interviewees on need basis.

On the last day of the training, a pilot data collection exercise was conducted in 1 facility in Huruma; 1 group of community leaders in Kayole, 1 CBO in Kayole; and 1 out of school centre in Nairobi that had not been selected as sample facilities. The pilot exercise provided a chance for the data collectors and research teams to learn vital lessons ahead of the actual data collection exercise. Prior to undertaking the pretest in the selected facilities, a courtesy call was made to the facility managers.

Data entry, cleaning and analysis

Data entry

Quantitative Data was input into hand held PDAs during the administration of the questionnaires. The completed questionnaire was checked for inaccuracies and inconsistencies at the end of the interview, before being uploaded. This data was then stored in an Ms Access© 2007 (Microsoft Inc., Seattle, Washington, USA) database. The database had been preprogrammed with inbuilt checks to detect inconsistent data and linkages.

Focus Group Discussions were recorded via digital voice recorders, translated into English on transcribing, and typed into Ms Word 2007 (Microsoft Inc., Seattle, Washington, USA) software. Initial charting of the transcripts was conducted by 4 social scientists and a thematic framework was developed. This thematic framework was then applied on all the transcripts. The data transcribed was sorted and managed using NVivo 10 (QSR International, USA)

Cleaning and Data Analysis

The stored quantitative data was imported into Stata© Version 11 (Stata Corp, College Station, Texas, USA). The data was cleaned, recoded and formatted ready for analysis. All steps taken in cleaning, recoding and reformatting were programmed onto a Stata Do File for reproducibility. The data was then analyzed by use of proportions and differences between counties, sectors and levels of care.

Preliminary analysis of the qualitative data was conducted through open coding and thematic categorization based on previously determined and emerging analytical categories. Iterative categorization and refinement of themes was done as more interviews were

examined. A reflexive approach was taken where team members were regularly consulted and feedback provided to refine the findings.

List all datasets used, including the data collected and the secondary data sets

- School Based dataset
- Out of School Survey dataset
- Focused Group Discussion with Young People data
- Secondary data (KDHS, UNGASS Report, KAIS Report, UNGASS report, KDHS report)
- Health Facility Direct Observation for Youth Friendly Services data
- Evaluation of Safe Abortion Practices data
- Self - Assessment Tool for Youth Organisations (CBOs) dataset
- Client exit dataset
- SRH policy implementation qualitative data
- Self-assessment for Alliance Partners organisation data
- FGD for community leaders and parents qualitative data

Description of the acknowledged limitations and strengths of the baseline

Strengths

- Direct Entry and Data Management using Personal Digital Assistants and data collection tablets. This limits on incomplete data, and provides an excellent check on data quality assurance and filed work processes through provision of GPS coordinates.

Limitations

- The program works in twelve counties but the counties selected for the baseline were only five. We understand that is a limitation. The counties selected were the most populous counties, and where all the implementing organizations work and therefore are best representative of the overall work conducted by the project partners. The sampled counties are well representative of the other counties as well.
- Not all facilities that had been sampled were visited due to logistical challenges. The study design was however robust to this and the individual response rate was adequate to perform analysis

Evaluation of the methodology and tools

What can be improved with regard to methodology (sampling, training, data collection, instructions)?

- All the health facilities selected will be selected to work or are already working with the Youth Alliance partners within the ASK program or other programs. To

strengthen impact evaluation there is a need to include comparative facilities that are not under the YEA interventions to detect whether there is any significant changes in the selected indicators or not.

- In terms of data collection, efforts should be made to recruit research assistants not already involved in the project. This involvement introduces research bias and may compromise quality of data in many different aspects. In the course of this study however, mitigating measures were put in place to ensure data quality, including intensive training and testing of the data collection tools and inbuilt data quality checks in the electronic data collection devices.

What can be improved with regard to all the tools?

- The tools may benefit from translation to local language, to ensure the respondents fully understand the questions despite the poor level of familiarity with English that is evident in some rural facilities. This is required especially for the qualitative tools but was not possible in this study due to constraints on time.

CHAPTER 3: RESULTS

3.1: Result Area 1:

Young people (including LGBTIQ, YPLWH, young adolescents (10-16), young people in remote areas and disabled young people) are better informed and thus able to make healthier choices regarding their sexuality

3.1.1 Background information respondents

Table 3.1A: Demographic Characteristics of school and out of school sample

	Demographic Characteristics of the target group[2]					County distribution				
Target groups (n = 738*)	*Mean Age (y)*	*Females (n = 366)*	*Males (n = 367)*	*Currently in school (n = 513)*	*Currently out of school (n = 220)*	*Kisumu*	*Kakamega*	*Nairobi*	*Siaya*	*Mombasa*
Young people aged 10-14 (n = 161)	12.4 (12.2 – 12.6)	86 (53.4%)	*75 (46.6%)*	*156 (96.9%)*	*5 (3.1%)*	*100 (62.1%)*	*2 (1.2%)*	*55 (34.2%)*	-	*2 (1.2%)*
young people aged 15-19 (n=395)	16.8 (16.7 – 17.0)	214 (54.2%)	181 (55.8%)	350 (88.6%)	45 (21.4%)	159 (40.3%)	11 (2.8%)	120 (30.4%)	13 (3.3%)	90 (22.8%)
young people aged 20-24 (n=177)	22.0 (21.8 – 22.2)	66 (37.3%)	111 (62.7%)	7 (4.0%)	170 (86.0%)	34 (19.21%)	37 (20.9%)	54 (30.5%)	47 (26.6%)	2 (1.1%)
5 records did not have Age group or Gender information.										

[2] Age data for 5 people was missing, Gender data for 3 people was missing, School Status data for 7 people was missing, and County data for 7 people was missing.

3.1.2 Knowledge Scores among target group

3.1.2.1 Knowledge on HIV transmission.

We sought to find out the knowledge levels of the targeted youth on various Key HIV transmission questions. The results, as shown in Figure 3.1.1 show that a majority (98.6%) of the youth interviewed had heard about HIV. The figure further shows the performance on all the other questions. The percentage value represents those who gave a correct response in each of the questions. For example, only 73% of the surveyed youth know that one can get HIV infection on the first sexual encounter.

Figure 1:Youth's Knowledge level on HIV Transmission

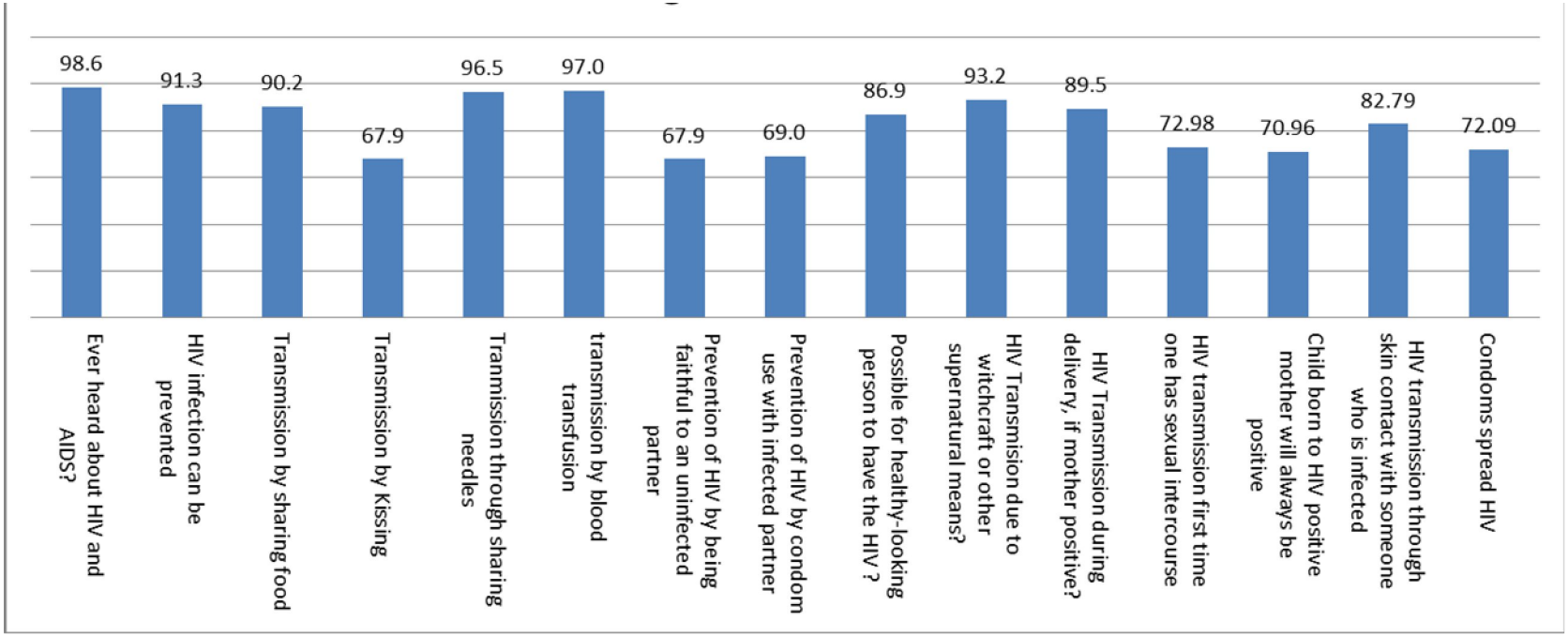


Figure 3.1.1: Youth's Knowledge level on HIV Transmission

For the complete analysis with data aggregated by gender and region, see annex 1

Knowledge levels of other STIs

The Knowledge of other STIs among the youth was also assessed and a majority was aware of Syphilis and Gonorrhea while only 27.6% and 18.3% knew of Herpes and Chlamydia respectively, as shown in the figure 3.1.2 below.

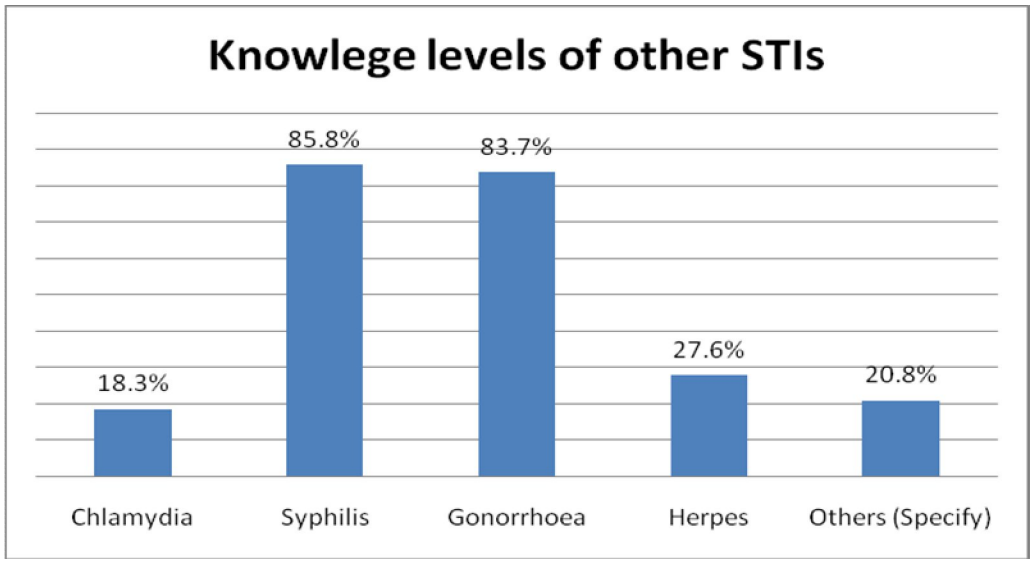


Figure 3.1.2 Youth's Knowledge of other STIs

The majority of those who gave a response of "other" mentioned Chancroid. For the complete analysis with data aggregated by gender and region, see annex 2

3.1.3 Knowledge of symptoms of STIs

We asked the youth to name the symptoms of STIs that they were aware of in both men and women. Figure 3.1.3 below shows that more than half of the youth recognized Discharge from either the penis or the vagina, Pain during urination and Ulcers or Sores in the genital areas as signs and symptoms of STIs.

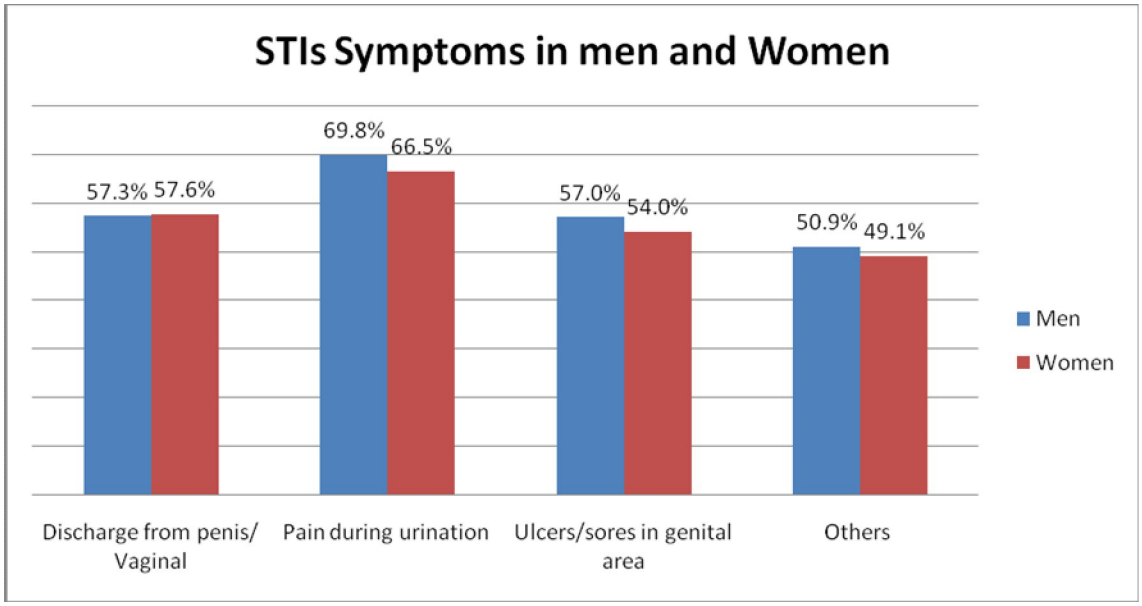


Figure 3.1.3: Knowledge concerning common Symptoms of STIs

For the complete analysis with data aggregated by gender and region, see annex 3.

3.1.4 Prevention of Unwanted Pregnancies:

We asked the respondents what are some of the ways of preventing unwanted pregnancy, or which contraceptives they were aware of. The figure 3.1.4 below summarizes the findings. The male condom was the most widely known method of contraception among the youth with about 80% of them mentioning it during the survey. Non penetrative sex was cited by only 9.6% of the respondents as a method of contraception.

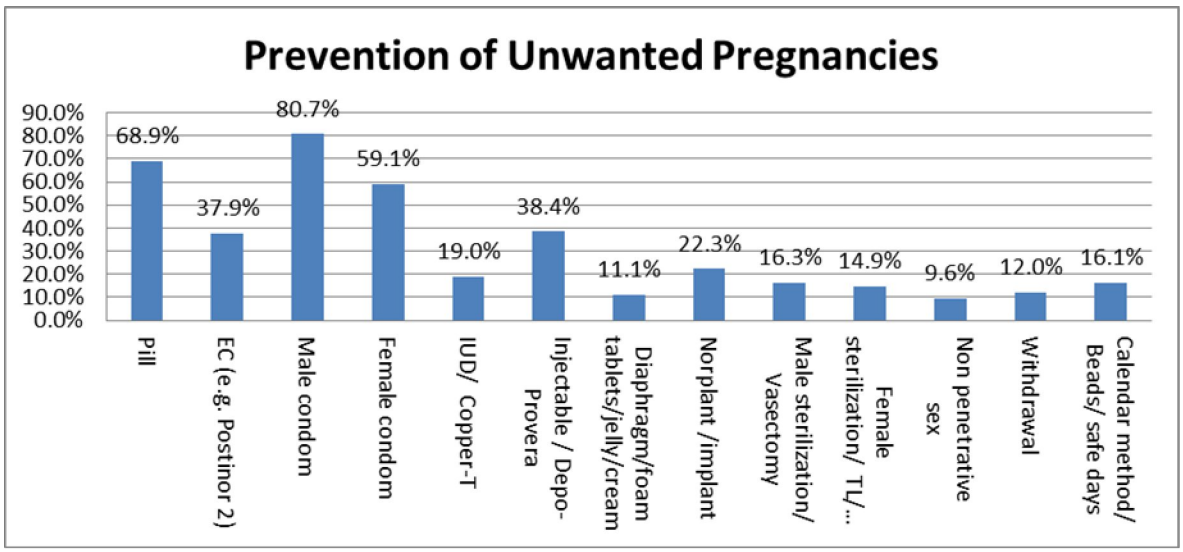
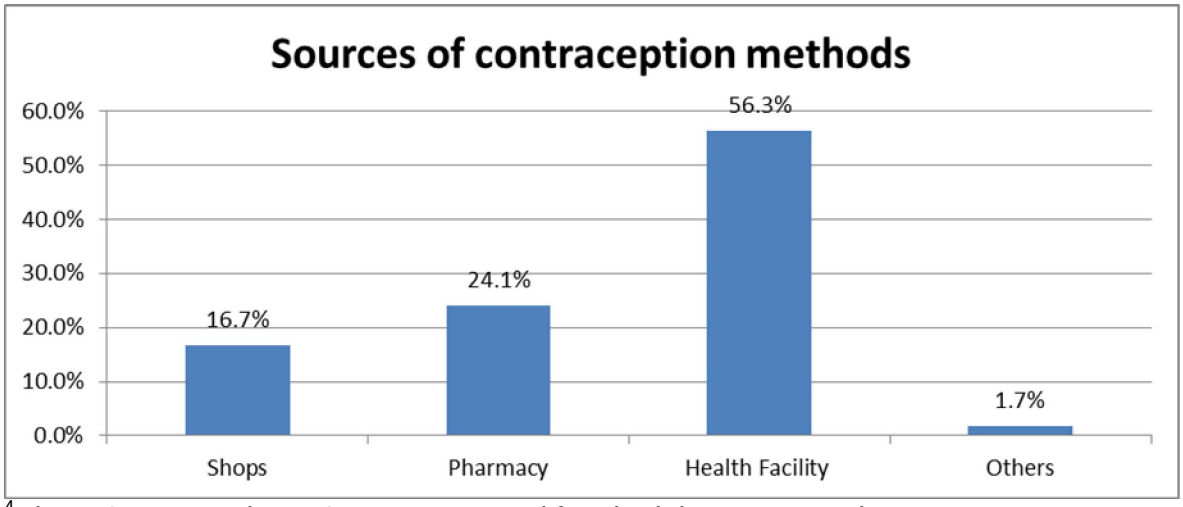


Figure 3.1.4: Knowledge of methods of avoiding unwanted pregnancies

We also sought to know if the respondents had ever used any contraception method. 25% [3]of them answered in the affirmative with 77.1% of these reporting having used a male condom and only 3% reporting the use of a female condom.

The main source of contraception methods was reported to be the health facility with 57% of the respondents reporting having received their methods from there, compared to 24.2% and 16.9% who received their method of choice from the chemist and shops respectively as shown in Figure 3.1.5 below.



[4] Figure 3.1.5: Practices – Sources ever used for obtaining contraception;

3.1.3 Attitude Scores among target groups:

We assessed the attitude of the respondents regarding various reproductive health patterns to determine their capability to make decisions that would enhance their own rights and health. Table 3.1B summarizes the findings on the youth's attitude towards sex and condom use, sexual rights and sexual diversity.

[3] This question was asked to all respondents above 14 years of age. It is likely that the performance would have higher among youth who had had previous sexual experience.

4 Other sources mentioned were CBO and from bar dispenser

Table 3.1B: Responses from the school and out of school questionnaire

		Yes	No	Don't Know
		%	%	%
ATTITUDES ON SEX	Do you think that if someone dresses sexy, the person wants to have sex?	14.3	82.4	3.3
		Agree	Disagree	Don't know
	It is acceptable for young people to have sex when they are not married	11.4	88.4	0.1
ATTITUDES ON CONDIOM USE	It is acceptable for young unmarried people to use a condom	60.6	37.9	1.5
	A girl can suggest to her boyfriend that he uses a condom	83.8	15.4	0.8
	Condoms are suitable for casual relationships	67.3	29.3	3.4
	Condoms are suitable for steady, loving relationships	63.1	33.9	3.0
	If a girl suggests using condoms to her partner, it would mean that she doesn't trust him	18.7	79.7	1.6
	A person who carries a condom is looking for sex	22	73.7	4.4
RIGHTS BASED ATTITUDES	I think it is sometimes acceptable for a boy to force a girl to have sex	10.6	87.65	1.8
	It is sometimes justifiable for a boy to hit his girlfriend	10	88.6	1.4
	A man is allowed to beat his wife if she makes mistakes	12.6	86.7	0.7
	It is mainly the woman's responsibility to ensure that she does not get pregnant	25.6	71.4	3.0
	Girls are as important as boys	87.9	11.8	0.3
	When money is scarce, boys should be send to school before girls	9.3	90	0.7
	Women's most important role is to take care of her home and cook	28.9	70.7	0.4
	Changing diapers, bathing children and feeding the children are mother's responsibility	42.9	56.8	0.3
	A man should have the final word about decisions in his home	35.8	63.4	0.8
	The participation of the father is important in raising children	93.2	6.3	0.4
	Girls should have the same freedom as boys	81.5	17.8	0.7
	It is the man who should decide on using contraception	12.9	81.8	5.4
	When it comes to sex, men should have the final word	13.7	81.5	4.8

	It is correct for parents to choose the husband or wife for their children, even if their child does not want to marry this person	5.5	94	0.6
	A boy is not allowed to touch a girl if she does not want him to	82.9	15.5	1.5
SEXUAL DIVERSITY	People who have a sexual relationship with the same sex should be accepted	8.4	88.2	3.4
	I would never have a homosexual friend	65.1	32.19	2.7

For the complete analysis with data aggregated by gender and region, see annex 4

3.1.4 Behaviour/intention scores among target groups:

The table 3.1 C below summarizes the behavioural practices among the youth we interviewed. It is notable that only 56.9% of the respondents said that they would be able to obtain a condom if they wanted to use one. 30% of the respondents said that it would be embarrassing to obtain or buy a condom.

Table 3.1C: Summary of behavioral Practices among the respondents

Do you agree with the following statements			
	Agree	Disagree	Don't Know
	%	%	%
You know where to get support if you have sexual health problems	87.3	7.5	4.5
I would prefer/my partner to give birth in a health facility when pregnant	96.3	1.8	1.5
If you had daughters, would you have them circumcised?	4.2	94.0	1.5
It would be too embarrassing for someone like me to buy or obtain condoms	30.6	52.1	0.8
I am confident that I can insist on condom use every time I have sex (Now and in future)	65.5	14.6	3.1
I feel that I know how to use a condom properly	41.5	36.8	5.1
I am able to get/buy a condom if I want to use one	56.9	23.7	2.1
If someone touches me in a way I do not like, I find it difficult to say I don't want it	24.1	73.9	1.6
I would refuse to have sex with someone who is not prepared to use a condom	72.8	7.9	2.5
I will not have sex in exchange for money or gifts	92.2	9.0	1.2
I feel confident that I will be able to refuse sex if I do not want to have sex	94.3	3.6	1.5
I feel confident to make the decision myself when (in the future) I want to have sex or not	92.7	3.0	3.1
I feel confident I will be able to reduce the risk of getting infected by HIV	93.8	3.7	1.8

Do you feel any pressure from others to have sexual intercourse?	25.3	72.4	1.6

For the complete analysis with data aggregated by gender and region, see annex 5

Among those who said that they feel pressure from other to have sexual intercourse, 96.4% of them said that the pressure came from friends, 54.6% from relatives and 67.2% from partners or special friends. Other sources of pressure mentioned includes Internet, Media, Neighbours, Out of school friends, Peer groups, People and the Social environment.

We asked the respondents what their reaction would be if someone wanted to have sex with them. 90% of them said they would be able to tell them that they would not want sex even if they got angry and regardless of whether gifts were offered. 80% of the respondents would felt confident enough that they would be able to convince their partner to use a condom. These findings are summarized in the figure 3.1.7 below

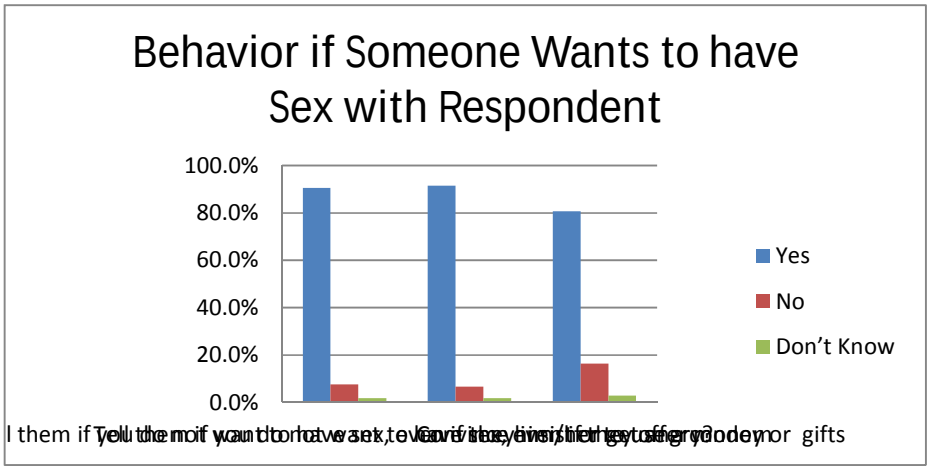


Figure 3.1.7: Behaviour if someone wants to have sex with respondent.
For the complete analysis with data aggregated by gender and region, see annex 6

Table 3.1D below summarizes the knowledge on reproductive health issues among school and out of school youth in the target counties. The younger age groups demonstrated significantly lower aggregate knowledge scores than the older groups as expected. There appeared to be no significant variation in knowledge scores across gender.

Table 3.1D: Comprehensive Knowledge among school and out of school youth

Segment	F % (C.I.*) *[n – 368]*	M % (C.I.*) *[n – 367]*	Aggregated % (C.I.*) *[n – 738]*	10 – 14 % (C.I.*) *[n – 161]*	15 – 19 % (C.I.*) *[n – 395]*	20 – 24 % (C.I.*) *[n – 177]*
% Comprehensive knowledge on HIV/AIDS (minimum 9 out of 15 questions answered correctly)	88.0 (84.3 – 91.0)	87.2 (83.3 – 90.2)	87.4 (84.8 – 89.6)	73.9 (66.6 - 80.1)	89.6 (86.2 – 92.3)	95.5 (91.3 – 97.7)
% Comprehensive knowledge on STIs (minimum 4 out of 7 points)	62.2 (57.1 – 67.0)	65.7 (60.7 – 70.3)	63.8 (60.2 – 67.2)	39.1 (31.9 – 46.8)	73.7 (69.1 – 77.8)	65.0 (57.7 – 71.6)
% Comprehensive knowledge on contraceptives (minimum 3 methods mentioned correctly)	67.4 (62.4 – 72.0)	66.5 (61.5 – 71.1)	66.8 (63.3 – 70.1)	29.8 (23.3 – 37.3)	73.9 (69.4 – 78.0)	84.7 (78.7 – 89.3)
% of young people with comprehensive/correct knowledge on SRHR/HIV (Respondents with comprehensive knowledge on all 3 above segments)	48.1 (43.0 – 53.2)	48.0 (42.9 – 53.1)	48.0 (44.3 – 51.5)	20.5 (15.0 – 27.4)	55.2 (50.3 – 60.0)	57.1 (49.7 – 64.1)
*C.I. - Wilson Binomial Confidence Interval						

Table 3.1E below summarizes the attitudes and intent to behaviour on reproductive health issues among school and out of school youth in the target counties. The younger age group demonstrated significantly lower aggregate scores than the older groups

Table 3.1E: Attitudes and Intent to Behaviour among school and out of school youth

Segment	F % (C.I.*) *[n – 368]*	M % (C.I.*) *[n – 367]*	Aggregated % (C.I.*) *[n – 738]*	10 – 14 % (C.I.*) *[n – 161]*	15 – 19 % (C.I.*) *[n – 395]*	20 – 24 % (C.I.*) *[n – 177]*
% with Right Attitudes regarding sex and condom use (minimum 5 out of 8 points[5])	71.7 (66.9 – 76.1))	59.4 (54.3 – 64.3)	65.4 (61.9 – 68.8)	36.0 (29.0 – 43.7)	68.9 (64.1 – 73.2)	86.4 (80.6 – 90.7)
% with Right Attitudes regarding sexual rights and sexual diversity (minimum 11 out of 17 points)	77.7 (73.2 – 81.7)	80.7 (76.3 – 84.4)	79.0 (75.9 – 81.8)	62.7 (55.0 – 69.8)	84.8 (80.9 – 88.0)	81.3 (75.0 – 86.4)
% Intention to healthy behaviour (minimum 9 out of 14 points[6])	88.3 (84.6 – 91.2)	86.6 (82.8 – 89.8)	87.3 (84.7 – 89.5)	84.5 (78.1 – 89.3)	85.1 (81.2 – 88.2)	96.6 (92.8 – 98.4)
% portraying Confidence to refuse sex. (minimum 3 out of 5 points)	93.8 (90.8 – 95.8)	93.7 (90.8 – 95.8)	93.5 (91.4 – 95.1)	80.7 (73.9 – 86.1)	97.2 (95.1 – 98.4)	98.3 (95.1 – 99.4)
% of young people with increased capacity in health seeking behaviour (Respondents with Positive Attitude / Intent on all 4 above segments)	56.7 (51.7 – 61.8)	48.2 (43.2 – 53.3)	52.4 – (48.8 – 56.0)	23.6 (17.7 – 30.7)	57.7 (52.8 – 62.5)	68.4 (61.1 – 74.7)
*C.I. - Wilson Binomial Confidence Interval						

[5] Because 4 questions in this section of the questionnaire were designed to be skipped for the age group 10 – 14 years, this score reflects the percentage with a minimum 3 out of 4 points in that age group

[6] Because 7 questions in this section of the questionnaire were designed to be skipped for the age group 10 – 14 years, this score reflects the percentage with a minimum 5 out of 7 points in that age group

3.2: Result Area 2:

Increased access to SRH commodities, including ARV and contraceptives for young people (including LGBTIQ, YPLWH, young adolescents (10-16), young people in remote areas and disabled young people)

3.2.1 Contraceptive prevalence Rate (CPR)

The contraceptive prevalence rate (CPR) has been on an upward trend in Kenya. In 2003, the CPR for the age group 15-19 years among sexually active women was at 19.7%. In 2008/09, this rose to 24.7% as shown in table 3.2A below

Table 3.2A: Contraceptive prevalence rate (%) – any modern methods[7] – for all women (disaggregated by age for those < 35y).

Kenya	KDHS 2003[8] %	KDHS 2008/09[9] %
Group 15- 19 yrs	4.8 (n = 1856)	4.9 (n = 1771)]
Group 20- 24 yrs	16.8 (n= 1691)	23.6 (n= 1715)
Group 25-29 Yrs	29.5 (n= 1382)	36.7 (n=1454)
Group 30-34 Yrs	34.0 (n= 1086)	45.0 (n-1209)
All women	22.7 (n = 8195)	28.0 (n= 8444)

For the women between 20 and 24 years, a similar trend was observed with the CPR increasing from 28.5% in 2003 to 23.6% in 2008/09. Among all women, the CPR increased from 38.0% to 28.0% in the same period. Figure 3.2.1 below shows the trends over the period between the two demographic surveys.

No Data for CPR for all women disaggregated by region was available from secondary data sources.

[7] Modern Method includes [Female Sterilisation, Pill, IUD, injectables, Implants, Condoms and (in 2009 only) Lactational Amenorrhoea method] and excludes Traditional methods such as rhythm, withdrawal or Folk methods.

[8] Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH, and ORC Macro. Pp 67

[9] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro. pp 63

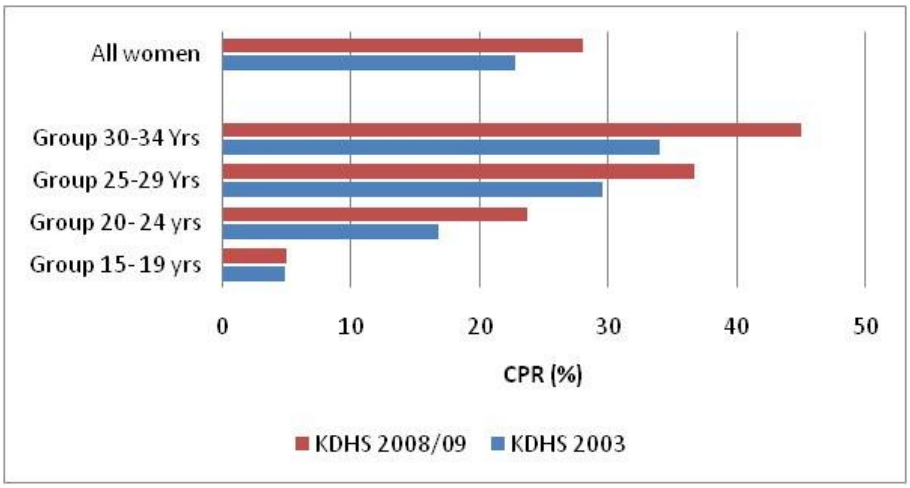


Figure 3.2.1: Chart of Contraceptive Prevalence Rates among target groups in 2003 and 2008/09

3.2.2: ARV Access

Table 3.2B: Proportion (%) of (adult and adolescent) population with HIV infection and eligible[10] for ART, who are currently on ARVs

Kenya	2009 % (via NACC 2010 report[11])	Jan 2011 % (via NASCOP 2012report[12])	Kenya Aids Indicator Survey, 2012 %[13]
ARV Coverage among eligible (adult and adolescent)	70.4 (308610 out of 438000)	71.3 (441993 out of estimated 620000)	63

Data from the National Aids Control Council (NACC) shows that the proportion of adult and adolescent population with HIV infection and who are eligible to receive Anti-Retroviral Therapy as per national guidelines increased marginally from 70.4% in 2009 to 71.3 % in January 2011 as shown in the table 3.2B above. The Kenya Aids Indicator Survey conducted in 2012, whose preliminary report was released in Sept 2013 showed that among HIV-infected persons aged 15-64 years who had CD4+ T-cell counts done as part of KAIS 2012, 58% met the CD4+ T-cell count threshold for ART initiation , and of those, 63% reported current use of ART.

[10] Eligibility is based on the criteria CD4 count < 250 for adults and adolescents between 2007 and June 2010, and < 350 after June 2010 based on national guidelines' recommendations.

[11] National AIDS Control Council (NACC), Office of the President, Kenya. 2010. *UNGASS 2010: Country Report - Kenya.* Nairobi, Kenya. Pp 3

[12] NACC and NASCOP. May 2012. *Kenya AIDS Epidemic update 2012.* Nairobi, Kenya. Pp 72

[13] National AIDS and STI Control Programme, Ministry of Health, Kenya. September 2013. *Kenya AIDS Indicator Survey 2012: Preliminary Report*. Nairobi, Kenya.

Qualitative findings explored access to SRH commodities, including ARV and contraceptives for young people and factors where young people seek SRH commodities. The factors determining where young people seek SRH commodities were mainly (i) attitude of service providers (ii) perceived knowledge of service provider (iii) perceived privacy and confidentially when commodities are given (iv) affordability of commodities (v) ongoing sensitization programs. The privacy and confidentiality of the medical interaction was perceived as very key by both gatekeepers and the young persons.

The younger health providers were described as more friendly and more understanding of young person's SRH needs. The older were described by the adolescents as judgmental rather than providing required commodities and services.

> *"Through sensitization, youth have been enlightened on condoms use and they are in a position to request for condoms, the services and the services providers are friendly; that helps them to get assistance" FGD Gatekeepers Men-Kakamega*

> *"They get the services but I want to add that early on they used to go to traditional birth attendants for right and consistent information. Otherwise they would go to the formal health facilities for right information and services. But these days some shy away from going to these facilities because they think that somebody will see them going for such services, they thus end up getting scanty information from the peers and also use condoms. But I want to quickly say that condom use depends heavily on its availability; if there could be some groups distributing them, then there may be success. Condoms are available in the health facilities but people fear picking them up because they say that it will appear as though they are prostitutes. So if there could be more decentralizing of condoms even up to villages, we would be happy." FGD Men gatekeepers Siaya*

> *"There are some factors that make them choose where to get the services and commodities, like they want to hide themselves some think that if they get the commodities from the shops then they will be seen by others but when they go to the hospitals they know that there are places that the commodities are hidden, and there is privacy..." FGD female Gatekeepers Kakamega*

> *"I can say confidentiality of an institution or facility; whether they are going for services like circumcision if they can keep it secret they would not be afraid to go for the services" FGD Gate keepers Men –Kisumu*

> *"Also there is lack of trust in these facilities. Because when [the pharmacy staff] say don't trust this one because it is for free they will prefer that you use the one that is costing Kshs300* [approximately $3.75]. *And you will find them telling you I don't trust this one, use this one….so where is all this information coming from and yet they are all condoms? Then you'll get others telling you that even if you are injected or use this you will still get pregnant so you find they will prefer to go without the*

contraceptives. So lack of trust is also an issue. Also the quality of services provided; in some facilities there is nice welcome, good consultation and so they tend to attract more clients." FGD young persons, Mombasa

3.3 Result Area 3:

Public and private clinics provide better SRH services, which more young people are using (including LGBTIQ, YPLWH, young adolescents (10-16), young people in remote areas and disabled young people)

3.3.1 Reproductive Health (Indicators 3.1 - 3.3)

We interviewed a total of 356 respondents of whom, over 55% of them were never married and a majority had completed secondary education (Figure 3.3.1 below).

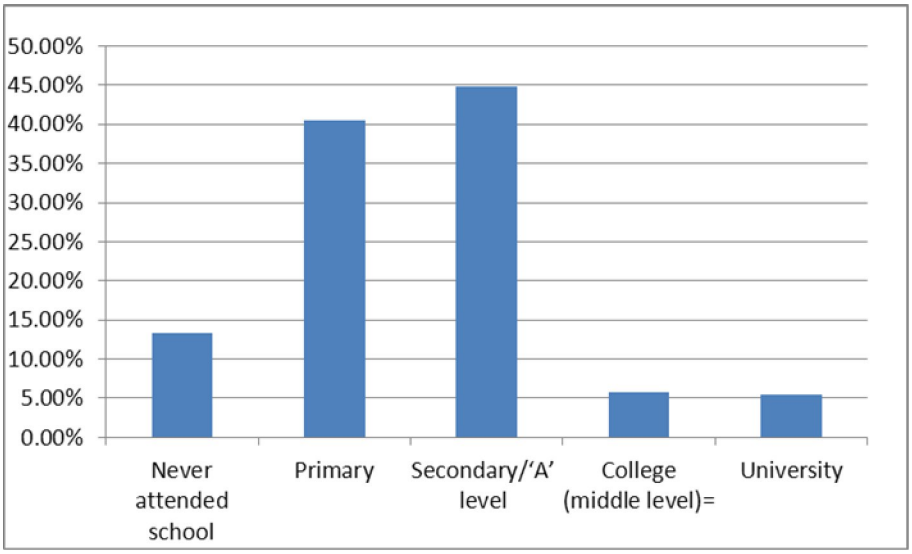


Figure 3.3.1: Level of education for exit clients

The table 3.3A below provides a summary of the prevalence of services sought by young people on the day of the interview.

Table 3.3A: Summary of Services sought on the day of the interview

Services sought on the day of the interview	%
Contraceptives	12.04%
Family planning advice	21.47%
VCT	23.04%
STI testing or treatment	6.54%
Services related to experiences of sexual , physical or emotional violence	4.71%
Maternal services (Post and antenatal care)	28.27%

Delivery	0.52%[14]

Results from the exit survey demonstrate that the most sought services by the young people were maternal services (Post and Antenatal Care), VCT and family planning. The first point of contact for obtaining SRH services was reported as health centers (51.37%) and dispensaries (15.57%).

Table 3.3B: % of HIV-Positive pregnant women receiving ART for PMTCT

Kenya	2009 (via NACC 2010report[15])	Jan 2011 (via NASCOP 2012 report[16])	Kenya Aids Indicator Survey, 2012[17]
% of HIV-Positive pregnant women receiving ART for PMTCT	72.3%	69.2%	90%

The Prevention of Mother-To-Child Transmission (PMTCT) program in Kenya was launched in 2000 and has undergone a substantial scale-up since 2003, with significant gains being recorded in the last five years. A total of 89.6% of women between age's 15-54 years who were pregnant between 2003 and 2007 reported attending an ANC at least once during their pregnancy. This increased to 96% for those women in the same age group who were pregnant between 2007 and 2012. In 2007, 78.6% of women who reported attending an ANC received a HIV test at the ANC compared to 92% in 2012.

The KAIS 2012, reports that of the women who reported testing for HIV at ANC in KAIS 2012, 3% self-reported HIV positive, and of those, 90% received a PMTCT intervention, either maternal or child prophylaxis or both. These estimates, we recognise, do not have associated confidence intervals.

[14] Of the respondents who answered "others", a majority said they had come for general observation

[15] National AIDS Control Council (NACC), Office of the President, Kenya. 2010. *UNGASS 2010: Country Report - Kenya.* Nairobi, Kenya. Pp 3

[16] NACC and NASCOP. May 2012. *Kenya AIDS Epidemic update 2012.* Nairobi, Kenya. Pp 49

[17] National AIDS and STI Control Programme, Ministry of Health, Kenya. September 2013. *Kenya AIDS Indicator Survey 2012: Preliminary Report*. Nairobi, Kenya.

Table 3.3C: Proportion (%) of Births attended by skilled[18] health personnel

	KDHS 2003 % (0.95 C.I.) [19]	KDHS 2008/09 % (0.95 C.I.) [20]
Urban	72.0 (68.0 – 75.9)	74.8 (68.8 – 80.8)
Rural	34.5 (31.8 – 37.3)	36.8 (33.3 – 40.2)
Total (Kenya)	41.6 (39.0 – 44.1)	43.8 (40.4 – 47.1)
Nairobi Province	79.1 (73.8 – 84.3)	88.9 (83.0 – 94.7)
Coast Province	33.8 (25.5 - 42.1)	45.6 (37.9 – 53.4)
Nyanza Province	38.6 (32.1 – 45.2)	45.5 (39.6 – 51.4)
Western Province	29.3 (22.0 – 36.6)	25.8 (19.6 – 32.0)

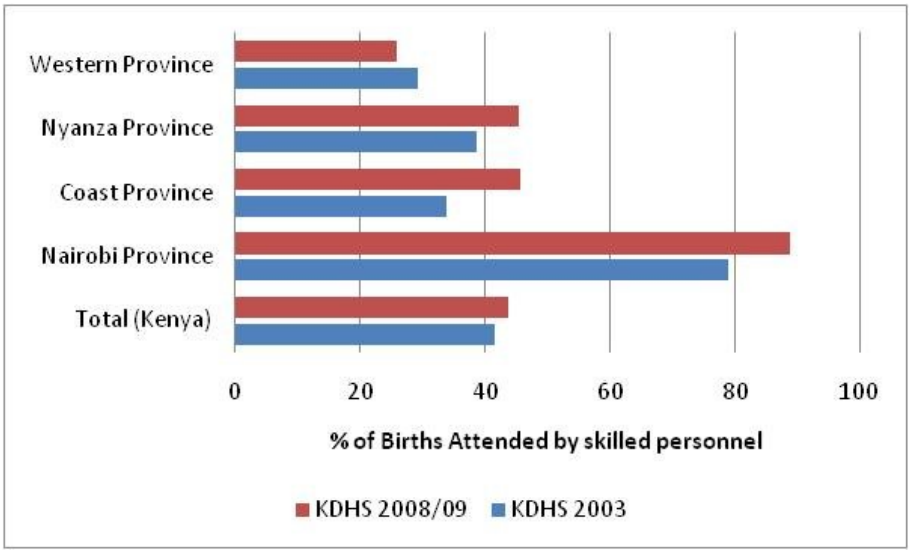


Figure 3.3.2: Chart of Proportion of Births attended by skilled health personnel in specific regions in Kenya, 2003 and 2008-09

The proportion of births attended by skilled health personnel has been increasing over time. Data from the Demographic and Health Surveys of 2003 and 2008/09 shows a marginal increase on this indicator for both individual regions and in Kenya in general as shown in table 3.3C and figure 3.3.2 above.

Table 3.3D: ANC coverage (One Visit, and Four Visits)

Kenya	KDHS 2003[21]	KDHS 2008/09[22]

[18] Note: Skilled health personnel includes doctor, nurse, or midwife. Period of assessment is the 5 years preceding the date of interview

[19] Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH, and ORC Macro. Pp 132

[20] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro. pp 122

Urban	1+ visits 91.3% 4+ visits 66.7% (n = 835)	1+ visits 93.3% 4+ visits 59.9% (n = 823)
Rural	1+ visits 87.0% 4+ visits 48.6% (n = 3217)	1+ visits 90.0% 4+ visits 43.8% (n = 3150)
Total	1+ visits 87.8% 4+ visits 52.3% (n=4052)	1+ visits 90.6% 4+ visits 47.1% (n=3973)

Data from the Kenya Demographic Health Surveys in 2003 and 2008/9 gives the trend of coverage ANC services among pregnant women. As shown in the table 3.3D above, the proportion of women who attended at least one ANC visit was 87.8 % and 90.6% between the two surveys while those who attended at least 4 ANC visits decreased from 52.3% to 47.1% from 2003 and 2008.

There was no region specific disaggregated data available for this particular indicator from these secondary data sets. There is disaggregated data on percentage receiving ANC from a skilled provider, as follows: Nairobi 96.4, Coast 94.5, Nyanza 93.6, and Western 91.5

3.3.2 Satisfaction with services (Indicator 3.4)

The study sought to assess the level of satisfaction of young people with the quality and youth friendliness of health services. We used exit interviews and qualitative interviews to measure this indicator. Over 89% of the young people who sought SRH services on the interview date reported to have received the services. For those 10.5% who did not receive SRH service sought, the main challenges reported were lack of drugs/commodities, while some clients felt they were not yet ready to receive SRH services. The table 3.3E below summarizes the reason provided by young people for not obtaining SRH series at the facilities they had visited.

Table 3.3E: Young People's reasons for not obtaining SRH Services at facility visited

Reasons for not obtaining SRH services at facilities visited	% giving this reason
Do not feel ready to start services/treatment now	10.50 %
Drugs/commodities were not available	24.82%
Provider was not available	6.52%
Lack of equipment to administer drugs	7.41%
Provider was too busy	7.80%
Did not have money to pay for services	6.67%
Services are given on a different date	6.72%
I was given referral to another facility	6.06%
I came for observation/consultation only	22.63 %

[21] Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH, and ORC Macro. Pp 126

[22] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro. pp 116

Further the study sought to understand the perception of the clients on the health facilities. One key finding was that although over 86% of the clients felt providers were responsive, understanding and friendly, only 2.4% of the young people felt the providers are knowledgeable on SRH services. The table 3.3F below summarises the perception of the clients.

Overall, the level of satisfaction with SRH services provided was average, and did not differ greatly across the youth's age group or marital status (table 3.3G). An overall score of 6.8 out of 10 was accorded for general satisfaction with SRH services sought (table 3.3H)

Table 3.3G: mean score on satisfaction with SRH services of married and unmarried young people for all clinics and health facilities Covered in the Study

	UNMARRIED GIRLS			UNMARRIED BOYS			MARRIED GIRLS			MARRIED BOYS			OVERALL MEAN
SATISFACTION WITH:	*10-14*	*15-19*	*20-24*	*10-14*	*15-19*	*20-24*	*10-14*	*15-19*	*20-24*	*10-14*	*15-19*	*20-24*	*ALL*
MEDICAL TREATMENT RECEIVED	2.0	2.5	2.5	2.7	2.5	2.6	NA	2.7	2.5	NA	0	2.7	2.3
LEVEL OF SKILLS OF SERVICE PROVIDER	1.2	1.0	1.2	1.0	1.0	1.2	NA	1.2	1.1	NA	1	1.3	1.1
OPENING HOURS	1.9	2.1	2.2	2.1	2.0	2.2	NA	2.1	2.1	NA	2.2	2.6	2.2
WAITING TIME	1.7	1.8	2.0	1.9	1.7	2.0	NA	2	1.8	NA	1	1.8	1.8
PRICE	2.0	2.2	2.0	1.0	1.9	1.7	NA	2.0	1.7	NA	NA	NA	1.5
PRIVACY AND CONFIDENTIALITY	2.2	2.5	2.6	2.7	2.5	2.6	NA	2.5	3	NA	3	2.6	2.6
TIME FOR THE CONSULTATION	2.2	2.1	2.2	2.1	2.2	1.9	NA	2.2	2.1	NA	2.0	2.0	1.9
WILL RETURN OR NOT	2.3	2.3	2.2	2.1	2.1	2.2	NA	2.3	2.3	NA	2.0	2.5	2.2
MEAN SATISFACTION	1.9	2.1	1.8	2.0	2.0	2.1	NA	2.1	2.1	NA	1.4	1.9	1.8

During the client exit interviews, we asked the respondents to rate the facility on the level of satisfaction on SRH services on a scale of 1-3, with one being the lowest and 3 the highest score.

The mean score for the satisfaction index stood at 1.9 With a minimum score of 1 and a maximum of 3 reported as shown in table 3.3H below. The detailed scoring is as shown in table 3.3 I below.

Table 3.3H: Mean score on satisfaction with SRHR services for young people aged 10-24 in Kenya

Mean score for all clinics together in Kenya	1.8
Range of the score)	*1– 3*

Table 3.3 I: Level of Satisfaction with the service received from the health facility:

3.3.3 Youth Friendly Services (Indicators 3.5 through 3.7)

A summary of findings from the Health Facility Direct Observation Assessment is presented in tables 3.3I – 3.3K outlining the individual findings across facilities. Notably, none of the facilities assessed had a score of >4.0 on compliance with Youth Friendly Services requirements (Table 3.3J)

Table 3.3J Scores on Youth Friendly Services per facility

Name of health facility	Questions						
	Training of the service provider (Most of the service providers received adequate training on working with young people)	Privacy (Privacy is always guaranteed)	Opening hours (The opening hours are convenient)	Accessibility of SRHR services	Referral (Referral system is Present and effective)	Community and parental support (Health facility is actively advocating to create support for adolescents to access SRHR services)	Mean score for the health facility (out of 4)
Kakamega County							
Kakamega General Hospital Urban: Government	1	3	3	4	4	2	2.8
Butere District hospital: Urban: Government	2	4	4	3	4	3	3.3
Prisons Dispensary: Urban: Government	1	3	2	4	4	3	2.8

Masaba Dispensary Rural: Government	2	3	2	3	4	2	2.7
Shimkoko Health Center Rural: Government	1	4	3	4	4	2	3.0
Mabole Health Centre Rural: Government	1	2	2	4	4	3	2.7
Shiraha Health Centre Rural: Government	1	2	3	4	3	2	2.5
Shitsitswi Health Centre Rural: Government	1	4	3	4	4	2	3.0
Lushea Health Center Rural: Government	1	3	3	3	4	3	2.8
Malaha Dispensary Rural: Government	1	3	3	2	4	2	2.5
Shikunga Health Center Rural: Government	2	4	3	4	4	4	3.5
Nabongo Health Centre Urban: Government	1	3	3	4	4	3	3.0
Masinde Muliro University Dispensary Urban: Government	3	3	3	3	4	3	3.2
FHOK Kakamega Health Centre Rural: Partner	3	4	4	2	4	4	3.5

Kisumu County							
Nyahera Sub District urban: Government	3	4	3	4	4	3	3.5
Rabuor Health Centre Rural: Government	1	4	3	4	4	4	3.3
Chulaimbo Rural: Government	3	4	3	4	4	4	3.7
AP Line	-	-	-	1	-	4	0.8
Magina Rural/urban: Private	3	1	3	4	4	3	3.0
Mombasa county							
Mlaleo CDF HC urban: Government	3	1	1	4	4	4	2.8
Nairobi county							
safe ways urban: Government	1	1	3	3	1	1	1.7
Kayole 1 Health centre urban: Government	1	4	1	3	4	3	2.7
Kibera D.O Health Centre Urban: Government	3	4	3	4	4	1	3.2
Lungalunga Rural/urban: Government	3	4	3	4	4	4	3.7
NCCK Huruma	3	4	3	4	4	4	3.2

urban: FAITH-BASED/MISSION/CHURCH							
Marie Stoppes urban: Private	3	4	3	4	-	1	2.5
Salama Health Centre urban: Private	1	1	3	4	1	1	1.8
IOM urban: Private	3	4	3	4	4	4	3.2
FHOK Nairobi Youth Centre urban: Partner	1	4	3	4	1	3	2.7
Siaya							
Mahaya Rural: Government	1	1	3	4	4	3	2.7
Kambajo Rural: Government	1	1	3	4	1	4	2.3
Matayos HC Rural: Government	1	1	3	3	4	4	2.7
Pap-kodero Rural: Government	1	1	3	3	4	4	2.7

Table 3.3K: Compliance with youth friendly services

Compliance	Total number of health facilities targeted in the ASK programme	Total number of health facilities assessed in the study	Number of facilities with score of 2.5 or higher 2013 (baseline)
Total number of compliant government health facilities (score of 2.5)	*36*	*27*	*21*
Total number of compliant private health facilities (score of 2.5)	*2*	*4*	*2*
Total number of compliant NGO-owned health facilities (score of 2.5)	*7*	*3*	*2*
Totals	*45*	*34*	*25*

Table 3.3L: Overview of the mean scores on youth friendliness and the mean scores on satisfaction of young people with the SRHR services provided

Name clinic/health facility	Mean score on youth friendliness (out of 10)	Mean score on satisfaction	
		Girls 10-24	Boys 10-24
KAKAMEGA			
Kakamega General Hospital	7.3	6.9	8.5
Manyala SDH	6.6	6.6	-
Butere district hospital	6.9	6.7	8
Masaba	8	8	8
Shimkoko	6.7	6.5	7
Mabole	7.4	7.3	7.5
Lunza	-	-	-
Shiraha	6.9	6.9	7
Shitsitswi	8.1	8	8.5
Lushea	6.9	7.1	5
Malaha	6.1	6.1	-
Shikunga	8.4	8.5	8
Nabongo Health Center	7.6	7.6	-
Masinde Muliro University Tunza clinic	6.7	6.7	-
FHOK Kakamega	8.7	8.8	8.7
KISUMU			

AP Line Dispensary	7.6	7.7	7.5
Ober kamoth	-	-	-
Magina Dispensary	4.7	5.6	1
Rabuor	7	6.8	7.7
Omiro	-	-	-
Nyahera	6.5	6.8	7
FHOK Kisumu	6.2	6.7	4
MOMBASA			
muleleo CDF HCH	5.9	5.5	9
NAIROBI			
Safe ways	6.1	6.6	9
Kayole 1 Health centre	6.1	6.1	-
Kibera D.O Health Centre	6.5	6.7	5.5
Ungalunga	6.1	6	6.3
NCCK Huruma	7.8	7.8	8
Marie Stoppes	8	7.9	9
Salama Health Center	6.3	6.5	6
IOM	6.9	6.6	7.3
FHOK Nairobi Youth	7.7	7.9	7.3
SIAYA			
Mahaya	5.7	5.8	5.7
Kambajo	5.6	5.6	6
Matayos HC	5.6	6.1	5.5
Pap-kodero	6.6	6.1	6.1

3.3.4 Safe Abortion Guidelines

Table 3.3M below provides a summary of the findings from the Safe Abortion Services Assessment conducted in the health facilities surveyed.

Table 3.3M: Safe Abortion Services offered in Health Facilities

Indicator	n = 35	% Yes Responses
Which of the following health services are provided at the health centre?		
Confirmation of pregnancy	26	74.3%
Estimation of gestational age	23	65.7%
Pre-abortion counselling	22	62.9%
Surgical abortion	7	20.0%
Medical abortion	13	37.1%
Post-abortion counselling	23	65.7%

Family planning	27	77.1%
Referral	23	65.7%
What are the grounds for the provision of induced abortion in this health facility		
On request	5	14.3%
Socioeconomic reasons	3	8.6%
Health(unspecified; as defined by WHO; or with specific conditions)	11	31.0%
Mental health (unspecified or with specific conditions	5	14.3%
Physical health (unspecified or with specific conditions	6	17.1%
Foetal impairment	4	11.4%
Rape	5	14.3%
Incest	2	5.7%
Preservation of life	2	5.7%
Which permissions from third parties does the health facility require before performing abortion? For pregnancies of gestational age up to12–14 weeks		
Parental/guardian authorization;	11	31.4%
Spousal/partner authorization;	9	25.7%
Authorization of medical commissions;	6	17.1%
Police report in case of rape	3	8.6%
Authorization by more than one specialist or physician	5	14.3%
What abortion methods are available and utilized at your health facility? For pregnancies of gestational age up to12–14 weeks		
Vacuum aspiration	12	34.3%
Mifepristone and Misoprostol	6	17.1%
Misoprostol alone	4	11.4%
Referral	3	8.6%
On which of the topics below was your staff trained on(in service / on service) in regards to safe abortion		
Legal framework for the provision of comprehensive abortion care	3	8.6%
Values clarification on abortion	7	20.0%
Technical skills	14	40.0%
Counselling	19	54.3%
Medical abortion	6	17.1%
Which of these services do you provide at your health facility		
Confirmation of pregnancy	25	71.4%
Estimation of gestational age	22	62.9%
Appropriate surgical procedure technique	9	25.7%
Appropriate counselling skills	24	68.6%
Appropriate pain management	22	62.9%
Appropriate medical abortion regimen	10	28.6%
Appropriate follow-up	17	48.6%
What infection-prevention practices do you routinely follow at your health facility		
Standard precautions routinely followed	21	60.0%
Initial soaking of used instruments	19	54.3%

Instrument cleaning	23	65.7%
High-level disinfection or sterilization of medical instruments	19	54.3%
Prophylactic antibiotics administered for surgical methods	13	37.1%
What contraceptive methods are available and routinely provided?		
Male condoms	32	91.43%
Female condoms	19	54.3%
Cervical barriers	3	8.6%
Fertility-based awareness methods	13	37.1%
Iuds (Intra-Uterine Devices	20	57.1%
Sterilization	8	22.9%
Emergency contraceptives	18	51.4%
Are there adequate referral systems in place for		
Induced abortion	18	51.4%
Management of complications	22	62.9%
Contraception;	22	62.9%
Reproductive tract infections	19	54.3%
Gender-based violence	18	51.4%
Which of the measures below does your facility implement before providing induced abortion		
HIV and other tests that are not clinically indicated	9	25.7%
Counselling beyond provision of adequate information relevant to the woman's abortion care	11	31.4%
Mandatory ultrasound prior to abortion	2	5.7%
Requirement for women to listen to foetal heartbeat prior to abortion	3	8.6%

The facilities also undertook a self-assessment on their own compliance with the most recent safe abortion guidelines. A majority of the health facilities (42%) reported that they were not following the most recent guidelines while only 18% rated themselves as fully compliant. The results are as summarized in the table 3.3N below.

Table 3.3 N: Health Facilities' self-assessment on following the latest safe abortion guidelines

	Frequency (n)	Percent %
Fully Compliant with the most recent safe abortion guidelines	6	18.2
Satisfied with compliance but there is still room for improvement	9	27.3
Introduced some measures to follow the guidelines, but not yet satisfied	4	12.1
Not yet following the most recent guidelines	14	42.4
Total	33	100.0

We sought to explore qualitatively the challenges that young people face when accessing SRH services. Overall, young person aged 10-14 and 15-24 reported key SRH concerns as (i)

Lack of resource centers and counselors (ii) Lack of youth dialogues forums (iii) lack of parental guidance and support (iv) confidence, self-esteem issues and (v) tradition and beliefs as a barriers to accessing SRH services. However the older adolescents 15-24 years specifically reported the key issues as (i) Lack of youth friendly services (Absence of heath workers in facilities (ii) stigma associated with STIs and related illness and (III) Gender of service provider. The youth reported that health workers often were not available to provide some services such as long term contraceptive for females. It was reported that often the gender of the service provider influences the health facility the youth seek SRH services. Men providers were perceived as more friendly and, embraced confidentiality and privacy and often provided counseling without being judgmental. The study demonstrated that young persons aged 10-14 and those aged 15-24 have unique concerns regarding access to SRH issues. This was mainly influenced by the type of services sought.

> *"They usually hide and this makes them more prone to get the STIs and other diseases simply because they are not open in sharing. The youths just fear, they fear their own bodies especially in knowing their statuses" FGD Kakamega women Gatekeepers*

> *"Some may not get access to SRH services because some parents refuse and some rely on some cultural customs" FGD young persons, 10-14 Kisumu*

> *"Fear; if they have HIV/AIDS they can't go there they are going to be laughed at" FGD young persons, 15-24 Kisumu*

> *"I think, as she said, lack of confidence and self esteem. Some may be confident but when they reach the facilities they may be rejected by the doctors. You know some doctors are very cruel. One may have confidence and when he/ she reaches the facility the doctor will need a good reason for wanting to get those services" FGD Young people 10-14 years, Kisumu*

> *"The way they treat us when offering the services: like my friend heard the doctor saying those that came for HIV drugs should stay on this side* so one may fear*." FGD Young people 15-24 years Nairobi*

In general, the satisfaction with SRH services provided at the facilities is wanting. The process of service provision (interactions with health workers, provision of services and commodities, lack of counseling / youth friendly services) is seen by the youth as inadequate and exposes them to the community. Health system barriers were mainly reported as the major barriers to access to SRH services and commodities.

Result Area 4:

The sources of SRH information did not vary by county and by age of the adolescents. Overall the main sources of information were reported as (i) schools (ii) peers and friends (iii) social media (iv) health facilities and (v) community health workers. Teachers in schools provide counseling and health talks; the educational curriculum was reported to provide information in school based subjects. Friends and peers were often referred to when the young people felt their parents were not supportive. Social media such as Face book and in general the internet were mentioned by young people mainly in the urban areas as key source of information. Mobile phones are mainly used to access social media.

> *"When someone wants to get information, I think that the person should go to the parent but if the parent if cruel, then I think the person will find the information from the friends" FGD Kisumu young people 10-14 years*

> *"If you are a[n] adolescent you get the information from peers. We get most information from our fellow youth. About our parents, most parents are caught off-guard when they realize their children are already pregnant. The time my mum talked to me was when I was already pregnant but most parents don't talk. " FGD Kisumu Youths 15-24 years*

> *"Lucky few like my son will get information from parents. You don't know where the child or what kind of information they will get from third party e.g. a girl being given information from a boy with the wrong information." FGD Nairobi Gatekeepers Men*

Greater respect for the sexual and reproductive rights of young people and young people from marginalized groups

4.1 Support from parents/caretakers and at community level

We sought to explore the extent to which greater respect for the sexual and reproductive rights of young people and young people is felt in the community using focused discussions. Our findings demonstrate that discussion on SRH for young people across all the counties are discouraged by the community. For adolescents above 18 years, parents get involved in counseling and discussing their sexuality. However below 18 years parents and the community do not engage in such discussion, community norms dictate they should not engage in sex at such ages. However in incidences such as rape, emergency contraception, and post exposure prophylaxis is encouraged. In Kakamega it was reported that after male circumcision, the boys are allowed by the society to seek SRH services. The services sought also dictated if the society will accept, for example abortion is not allowed while testing for

HIV was largely accepted for young people 15-24 years. Further analysis revealed a trend where young people living in urban areas (Living in towns) reported more to discuss SRH issues and seeking counseling from their parents compared to those in rural areas.

> *"When a girl is raped or someone is raped the person should go to the hospital within 72hours because he will be injected with some medicine to prevent the diseases that may be transmitted through sex." FGD young people 10-14 years Kisumu*

> *"Yes they are but it depends on which services they want because let's say like abortion is illegal. If you want an HIV test that one you are allowed".*

We sought to explore differences of the topic between men and women. Overall we found no differences between men and women. The cultural norms and values of the communities dictate the attitudes of the parents and general community to SRH issues.

There were differences among parents and gatekeepers on issues of young people and sexuality. Some parents felt that they had a role in guiding the youth while others felt the society had set proper norms and values that should be followed. The cultural values and norms largely influence attitudes on SRH for adolescents in all counties. Mentorship by same sex parents, sexuality education done by teachers, cultural festivals such as dances and clubbing were mentioned as key determinants for adolescent SRH behaviours.

Overall very few young people and parents acknowledged talking to each other on SRH issues. There appears to be a social distance on the SRH discussions between young people and parents. The teachers have been left to provide this information. Our findings demonstrate the distance is due to the perception that sex and sexuality of young people in the society should not be discussed before they attain the legal adult age of 18 years.

Lack of mentorship from parents in the society was mentioned as a factor influencing SRH attitudes and behaviours as demonstrated by the quote below.

> *"I think that even as parents we need to set good example to our children; if the man is going for the woman who is not his wife, what will the children do or how will the children perceive that act? You do it so openly that even the villagers speak about it, and remember this is a married man doing this as he is sneaking out from his wife. So the children end up aping what the elders are doing in the society." FGD Community Leaders Siaya*

> *"Below the age of 18yrs you are supposed to talk to them tell them it's not allowed and its bad manners" FGD Community Leaders Kakamega*

> *"A girl is supposed to be taught and nurtured by the mother and a boy by the dad hence not by misleading them" FGD Community Leaders Kakamega*

> *"Before they were taught by their grandmothers nowadays they don't go to their grandmas' they stay in their houses and with parents they are ashamed of talking." FGD Community Leaders Siaya*

4.2 Youth Leadership and participation

We assessed the extent to which there was meaningful youth participation in the management and decision making in four of five CSOs working in the target counties. These are, Africa Alive, Nairobits Trust, World Starts with Me Youth Advocacy Network (WAYAN) and the Network for Adolescent and Youth of Africa.

We found of the four CSOs who responded to this self-assessment, three rated themselves 100% on all the aspects of meaningful youth participation and leadership. WAYAN's self-assessment brought out three areas on youth participation that need improvement over the implementation phase as shown in table 4.1 below.

Table 4.1 Meaningful Youth Participation and Leadership

The organisation has policies/guidelines in place which refer to involving young people in the management of projects/programs			
	No	%	
Yes	3	75%	
No	1	25%	WAYAN
The organisation has policies/guidelines in place which refer to involving young people in planning of new activities, projects and programs			
	No	%	
Yes	4	100%	ALL
No	0	0%	
The organisation has policies/guidelines in place which refer to involving young people in implementation of activities, projects and program			
	No	%	
Yes	4	100%	ALL
No	0	0%	
The organisation has policies/guidelines in place which refer to involving young people in monitoring and evaluation of programs (i.e. conducting baseline, midterm or end line measurements or defining targets and results			
	No	%	
Yes	4	100%	ALL
No	0	0%	
The organisation has policies/guidelines in place which refer to involving young people in analysing the context of a targeted area and assessing the needs of a targeted community where activities will soon be started by the organisation			
	No	%	

Yes	3	75%	
No	1	25%	WAYAN
The organisation has policies/guidelines in place which refer to involving young people in research			
	No	%	
Yes	3	75%	
No	1	25%	WAYAN
The organisation has policies/guidelines in place which refer to involving young people in advocacy efforts			
	No	%	
Yes	4	100%	ALL
No	0	0%	

4.4 Advocacy

The advocacy issues being addressed within the Youth Alliance members are mainly (i) increase to access to services and knowledge on SRH among young people living with HIV. (ii) financing framework for sexual and reproductive health and rights(iii) intergration of comprehensive sexuality education in the ministry of education curriculum (iv) Adolescent Reproductive Health and Development Policy (v) budget advocacy

This has involved holding meetings with policy makers who are concerned with SRH. For SRH advocacy the players are involved in supporting and providing technical input on policies including new policy on HIV and Aids developed by UNESCO in conjunction with the ministry of education. Advocacy efforts have involved international, national, health systems and community level health rights dialogues

> *"We were involved in the constitution making and a policy addressing the youth was adopted for needs of women and young people so that was a step forward. Also consultations on adolescent reproductive health and rights. Also there's a new policy on HIV and Aids developed by UNESCO in conjunction with the ministry of education which articulates issues of people living with HIV"*

At the national level, advocacy efforts include holding national conferences on SRH, participating in technical working groups and meetings with donors and government to consult and lobby for increased attention of SRH issues. At the international level, Advocacy efforts have included working with the post 2015 development goal agenda for young people and the SRH, by getting involved with different consultations and international meetings

> *"We are involved, For example we are following the post 2015 development goal agenda for young people and the SRH is an agenda that is strongly highlighted and something that should be addressed. So we have been involved in different consultations and international meetings and there are papers that are coming out on SRH and we are happy. We were also involved in various declaration papers for example the Colombo Declaration that was done last month that states that health is a need that the world needs to come together and address."*

In terms on SRH budget allocation, advocacy has been successful in getting more budgetary allocation however the challenge has been information on SRH issues among influential leaders on key SRH issues. The devolved structure of government has provided a better environment for advocacy of SRH issues and the leadership is supportive of the policies in place or being recommended. However some felt that budget allocation for SRH has not been successful and needs more advocacy at national and sub national levels.

> *"In the devolved structure i can say the governor for Migori Awiti is really passionate about youth issues. Also the governor of Kisumu and the first ladies of these counties are really supportive of these issues."*

> *"The budgetary framework in this country does not provide for SRH as a budgetary item and indeed at national level health budget is just that. So at the ministry level we have to make sure we advocate that some resources are directed towards SRH services and education. This is yet to happen both at national and at county levels"*

> *"At the local level now it's the members of the county assembly who also play a very key role in terms of the budgetary allocation, in terms of looking at the policy framework at the county level but also we have other policy makers who work for example in the members of the county health team where we also ensure we work with members of the local administration because issues such as family planning....one of the things that hinders uptake is low male involvement and even the lack of supportive environment from local administration so then it's very key that we involve them right from that level, so we work with as low as the village elders to the level of the members of the county assembly and the governors, we take that entire framework but we also work with other like-minded individuals and civil society who are also pro sexual and reproductive health and rights"*

The religious leaders and some politicians are reported as opposing advocacy efforts for SRH. It was reported that there are still reservations amongst mainstream churches on contraceptive use and a push from politicians for non-use of family planning to increase the voting population

> *"Yes some like Catholics and Muslims are opposed to the use of condoms and they still have misconceptions which act as barriers but once they get to understand they come on board and support us."*

> *"Of course when it comes to religious leaders some of the issues are very sensitive to certain processes. Certain politicians at times make comments that take processes steps back especially when they touch on populations and numbers these are comments that take certain processes way back."*

Overall the advocacy efforts entail working closely with all partners' especially the ministry of Education and health and also work directly with adolescents and youth. The important stepping-stones in advocacy programme regarding SRH are mainly the constitution, mainly the children's act. The children's act has helped in protecting children where adolescents fall in case they are sexually abused the act takes it up seriously. The biggest barriers/challenges to providing adolescent reproductive health and development information and services are

mainly age, role of parents, health systems issues such as lack of confidentiality, unfriendly services and stock out of SRH/HIV commodities.

> *"When providing information, there have been barriers of age issues because sometimes we cannot access the adolescents due to their age. Also consent. Some parents feel that some of the content we have in our information booklets are still heavy for the youth. Also the fact that most of the information that the youth have is wrong from other peers. Parents are not able to talk to their children about the situation as it is some react by caning the children after they are asked some questions so children are afraid to ask questions any more. Another one is that the term young person has a lot of definitions. As an alliance when we talk of youths we are referring to people below the age of 24 years. So separating them from the ages of 10 to fifteen you find that they are not the same, they come from different social backgrounds and others are LGBTI, within this age groups you find a girl who is considered a woman and she is already married and probably already a mother"*

> *"In budgeting and dealing with the policy framework. If you look at the policy, we have very good policies on paper but we lack personnel to implement. Another case is like we have the national guidelines for the provision of youth friendly services that was issued by the ministry of health some years ago but then if you look at the Kenya service provision assessment report, I think only 7% of these public health centres are youth friendly and that is not very exclusive that means the threshold has even been reduced but they try to show those indications of being youth friendly and when you have a population that is heavily youthful like Kenya, that means there is disconnect between policy makers and the reality in terms of sexual reproductive health and rights indicators."*

In terms of coordination among policymakers in SRH policy, there is a need to strengthen the coordination and communication. The youth should also own the process. It was felt that the youth waited much for the NGOs and civil society to own the process. The government was also noted as not owning the process. Overall, it was felt by all respondents that there need to have a clear lead institution for implementing the SRH policy, which was felt as lacking.

> *"Yes there is coordination so far but they still need to work on communication. They are trying but more needs to be done. When called to meetings both ministries take part then they present their perspectives, but they could coordinate better...."*

> *"I think it's more of the framework that we have, this is the lead agency and will take lead in everything then we leave that to one agency and then we have personnel who are fully in charge of the process and they can be held accountable as one of their performance indicators, but also sometimes at the policy makers don't understand this issues so there needs to be kind of like a civic education for them and they need to look at these issues as key impediments to development and realisation of even vision 2030 that sexual reproductive health is very integral for the young sectors of development."*

> *"I can say that they try though when you look at certain policies that cut across certain ministries there is usually a divide so it's not well coordinated inter ministries so you find policy discourse in various ministries. There should also be more*

involvement from key actors including civil society being part and parcel of these processes."

The suggestions provided to improve the process of influencing policy to respond to local needs were (i) making consultations with the youth (ii) revision of the adolescent reproductive health and right, (iii) fast track the comprehensive sexuality education curriculum (iv) improve policy implementation (v) implement the comprehensive Sexual education

CONCLUSIONS & RECOMMENDATIONS

5.1 Recommendations

Knowledge levels on Sexual and Reproductive Health among adolescents within the ASK implementation sites.

About 50% of young people have correct knowledge on SRHR/HIV. Although this demonstrates an increase knowledge and access information there is need to increase knowledge and access to SRHR/HIV information. Barriers identified in the study to increased knowledge and access to SRHR/HIV information were mainly culturally driven such as sex and sexuality discussion is still considered taboo in the community participating in the study. There is a need to capacitate the community structures to indentify and mobilise champions for SRHR/HIV in the community and built youth leadership structures that can inform the design and development of community based SRHR/HIV. At the policy level there is a need to link the SRH and HIV policies and programmes. Our results demonstrate that with the YEA, 75% of partner organisations have functional structures for the involvement of young people in program design, planning, implementation, monitoring, evaluation, research and advocacy. There is need to strengthen working of the community structures to improve knowledge and access to SRHR/HIV information. Our study demonstrates that the main sources of SRHR/HIV information were reported as (i) schools (ii) peers and friends (iii) social media (iv) health facilities and (v) community health workers respectively with parents and institutions such as religious institutions cited as least involved.

Access of reproductive health commodities for adequate SRH services provision.

In terms of access to HIV services over 63% of the youth with HIV access ARVs with majority of HIV positive pregnant women (90%) receiving treatment for to prevent mother to child transmission. Overall over 90% of pregnant women received at least once ANC visit with only 47% attending at least 4 ANC clinic visits.

There is need to strengthen HIV interventions/programs to increase the proportion of youth population receiving ARVs and accessing proper antenatal care when they require it. There is need for example to address the socio-cultural and health system barriers (e.g. Stock outs of contraceptives and community stigma related to SRHR/HIV). Health workers need to be trained on all aspects of commodity management such as proper quantification and record keeping.

Programs need to address concerns the young people on the access of SRHR/HIV services such as Absence of heath workers in facilities, stigma associated with STIs and related illness, attitudes of service provider and the lack of youth dialogues forums on SRHR/HIV related issues.

Quality of SRH services sought by young people within the public and private sector at baseline.

Overall 68% of young people expressed satisfaction with the quality of youth friendliness of the health services. There is a need to set up programs or strengthen existing programs focusing on quality assurance of SRHR/HIV services. Health facilities need to increasingly focus and prioritize on offering quality Youth Friendly Services, actively addressing the fears of lack of confidentiality resident among the youth and the attitudes of health workers.

Level of support for young people's SRH:

The study findings demonstrate a gap in the support provided to young people at the community level regarding the SRHR/HIV services. There is need to create sexually education and mentorship programs that strengthen the parents, religious and community leader's involvement in SRHR/HIV related issues. Discussions around SRHR/HIV in the community begin at the age of 18 years and above, this lead to a missed opportunity for sexuality education among younger youths. The YEA members have initiated international, national and sub national advocacy efforts of SRHR/HIV related issues including SRH budget allocation. However there have been challenges that need to be addressed such as policy revisions for SRHR/HIV, coordination and implementation of national and sub national SRH programs and have clear frameworks for resources for SRH/HIV programs.

Partner programs need to enhance their activities focusing on the above mentioned areas of weaknesses as revealed by the baseline survey, if the target indicators are to be met in the end term evaluation. In addition to this, further routine or survey data from health facilities and sample households may need to be collected to detect with adequate sensitivity the changes anticipated in the indicators currently being monitored through secondary data.

5.2 Conclusions

The survey reveals that there is still a need for SRH advocacy and public education among the youth in the areas of focus. A greater focus is also required targeting the gatekeepers to change perceptions on sexual and reproductive health and rights of the youth. Parents and Gatekeepers should be targeted to provide the much needed guidance to the youth and to break down the social barriers impeding discussions on sexual and reproductive health. Health facilities need to prioritise and upscale the quality of their Youth Friendly Services to meet the minimum quality criteria, and health system barriers such as perceived lack of confidentiality and poor access to contraceptives / health commodities should be addressed in a wholesome manner.

ANNEXES

Annex 1: Youth's Knowledge level on HIV Transmission

SECTION 200: KNOWLEDGE					
Indicator	Totals	Gender		school status	
		Male	*Female*	*in school*	*out of school*
Q201. Have you ever heard about HIV and AIDS? (n= 734)	No = 10 (1.36%) Yes = 724 (98.64%)	No = 3 (0.82%) Yes = 364 (99.14%)	No = 7 (1.91%) Yes = 359 (98.09%)	No =8 (1.56%) Yes = 505 (98.44%)	No = 2 (0.93%) Yes = 212 (99.07%)
Q202 Can HIV infection be prevented? (n= 734)	No = 54 (7.36%) Yes = 67 (91.28%) Don't Know = 10 (1.36%)	No = 32 (8.72%) Yes = 332 (90.46%) Don't Know = 3(0.82%)	No =22 (6.01% Yes = 337 (92.08%) Don't Know = 7(1.91%)	No = 48 (9.38%) Yes = 454 (91.28%) Don't Know = 10 (1.95%)	No = 6 (2.79%) Yes = 209 (97.21%) Don't Know = 0 (0%)
Q203 Can sharing food with someone who is infected transmit HIV infection (n= 733)	No = 661 (90.18 %) Yes = 63 (8.59%) Don't Know = 9 (1.23%)	No = 329 (89.65 %) Yes = 34 (9.26%) Don't Know = 4 (1.09%)	No = 331 (90.68 %) Yes = 29 (7.95%) Don't Know = 5 (1.37%)	No = 464 (90.63%) Yes = 43 (8.40%) Don't Know = 5 (0.98%)	No = 191(89.2%) Yes = 19 (8.88 %) Don't Know = 4 (1.87%)
Q204 Can HIV infection be transmitted by kissing with someone who is HIV infected? (n= 735)	No = 209 (28.44 %) Yes = 499 (67.89%) Don't Know = 27 (3.67%)	No = 106(28.88 %) Yes = 245 (66.76%) Don't Know = 16 (4.36%)	No = 103 (28.07 %) Yes = 253 (68.94%) Don't Know = 11 (3.00%)	No = 122 (23.78 %) Yes = 371 (72.32%) Don't Know = 20 (3.90%)	No = 85 (39.53 %) Yes = 123 (57.21 %) Don't Know = 7 (3.26%)
Q205 Can HIV be transmitted through sharing needles? (n= 733)	No = 24 (3.27%) Yes = 707 (96.45%) Don't Know = 2 (0.27%)	No = 14 (3.83%) Yes = 351 (95.90 %) Don't Know = 1 (0.27%)	No = 10 (2.73%) Yes = 355(96.99%) Don't Know = 1 (0.27 %)	No = 122 (23.78 %) Yes = 371 (72.32%) Don't Know = 20 (3.90%)	No = 85 (39.53%) Yes = 123 (57.21%) Don't Know = 7 (3.26%)
Q206 Can HIV be transmitted by blood transfusion? (n= 731)	No = 16(2.19%) Yes = 709 (96.95%) Don't Know = 6 (0.82%)	No = 10(2.73 9%) Yes = 351 (95.905%) Don't Know = 5 (1.37%)	No = 6(1.65%) Yes = 357 (98.08%) Don't Know = 1(0.27%)	No = 12(2.35%) Yes =492 (96.47%) Don't Know = 6 (1.18%)	No = 4(1.87%) Yes =210 (98.13%) Don't Know = 0 (0.00%)
Q207 Can being faithful to an uninfected partner prevent HIV infection? (n= 734)	No = 198(26.9%) Yes = 498 (67.85%) Don't Know = 38 (5.18%)	No = 109 (29.78%) Yes = 236 (64.48 %) Don't Know = 21 (5.74%)	No = 88 (23.98%) Yes = 262 (71.39%) Don't Know = 17 (4.63%)	No = 148 (28.91%) Yes = 329 (64.26%) Don't Know = 35 (6.84%)	No = 49 (22.79%) Yes = 163 (75.81%) Don't Know = 3 (1.40%)
Q208 Can using a condom when having sexual intercourse with someone who is HIV infected prevent HIV infection? (n= 732)	No = 170 (23.22%) Yes =505(68.99%) Don't Know = 57 (7.79%)	No = 71 (19.45%) Yes =267 (73.15 %) Don't Know = 27(7.40%)	No = 99 (27.05%) Yes =238 (65.03%) Don't Know = 29 (7.92%)	No = 142 (27.79%) Yes =319 (62.43%) Don't Know = 50 (9.78%)	No = 25 (11.68%) Yes = 182 (85.05%) Don't Know = 7 (3.27%)

Q209 Is it possible for a healthy-looking person to have the HIV virus? N= 735	No = 87(11.84%) Yes =639(86.94%) Don't Know =9 (1.22%)	No = 50 (13.62%) Yes =312 (85.01%) Don't Know = 5 (1.36%)	No = 37(10.08 %) Yes =326 (88.834%) Don't Know = 4 (1.09%)	No = 61(11.89%) Yes =444 (86.55%) Don't Know = 8 (1.56%)	No = 26(12.09%) Yes = 188 9(87.44%) Don't Know = 1 (0.47%)
Q210. Can people get the HIV virus because of witchcraft or other supernatural means? N=733	No = 683(93.18%) Yes =37(5.05%) Don't Know =13 (1.77%)	No = 338 (92.35%) Yes =23 (6.28%) Don't Know = 5 (1.37%)	No = 344 (93.99%) Yes =14 (3.83%) Don't Know = 8 (2.19%)	No = 478 (93.36 %) Yes =22 (4.30%) Don't Know =12 (2.34%)	No = 199 (92.56%) Yes =15 (6.98%) Don't Know =1 (0.47%)
Q211. Can HIV be transmitted during delivery, if the mother is HIV positive? N=734	No = 61(8.31%) Yes =657(89.51%) Don't Know =16 (2.18%)	No = 27 (7.36%) Yes =332 (90.46%) Don't Know = 8 (2.18%)	No = 34 (9.29%) Yes =324 (88.52%) Don't Know =8 (2.19%)	No = 43 (8.40%) Yes =456 (89.06%) Don't Know = 13 (2.54%)	No = 18 (8.37%) Yes =194 (90.23%) Don't Know = 3 (1.40%)
Q213. A person can get HIV the first time he/she has sexual intercourse n=729	True=532(72.98%) False = 175(24.01%) Don't Know =22(3.02%)	True = 259 (72.98%) False = 98 (26.92%) Don't Know = 7 (1.92%)	True = 272 (74.73%) False =77 (21.15%) Don't Know = 15(4.12%)	True = 362 (70.70%) Disagree =131 (25.59%) Don't Know =19 (3.71%)	True = 164 (78.10%) Agree Disagree=43 (20.48%) Don't Know = 3 (1.43%)
Q214 A child born to a HIV positive mother will always be HIV positive as well n=730	True = 187(25.62%) False=518(70.96%) Don't Know = 25 (3.42%)	True = 87 (23.84%) False = 268(73.42%) Don't Know = 10 (2.74%)	True = 100 (27.47%) False =2497(68.41%) Don't Know = 15 (4.12%)	True = 145 (28.43%) False =345 (67.65%) Don't Know = 20 (3.92%)	True = 41 (19.25%) Agree =167 (78.40%) Don't Know = 5 (2.35%)
Q215 HIV can be transmitted through skin contact with someone who is infected n=732	True = 110(15.03%) False =606(82.79%) Don't Know =16(2.19%)	True = 50 (13.62%) False =309 (84.20%) Don't Know = 8 (2.18%)	True = 60 (16.48%) False = 296 (81.32%) Don't Know = 8 (2.20%)	True = 74 (427 %) False =427 (83.40%) Don't Know = 11 (2.15%)	True = 35 (16.36 %) Agree =174 (81.319%) Don't Know = 5 (2.34%)
Q216 Condoms spread HIV n=731	False = 527(72.09%) True = 145(19.84%) Don't Know =59(8.07%)	False = 281 76.78% True =64 17.49% Don't Know =21 5.74%	FALSE =245 (67.31%) True = 81 (22.25%) Don't Know= 38 (10.44%)	False = 348 68.10% True = 110 21.53% Don't Know = 53 10.37%	False = 174 81.31% True = 34 15.89% Don't Know =6 2.80%

Q212. What treatments are effective for HIV and AIDS			
	Total	Male	Female
Having sex with a virgin	No = 13(100%) Yes =0(0%)	No = 3 (100%) Yes =0 (0%)	No = 10 (100%) Yes =0 (0%)
Anti Retroviral (ARVs)	Yes= 627 (100.00 %) No =0 (0%)	Yes = 312 (100.00%)	Yes = 315 100.00% No = 0 (0%)

Herbal Medicines	No = 22 (100.00%) Yes =0 (0%)	No = 13 (100.00%) Yes =0 (0%)	No = 9 (100.00%) Yes =0 (0%)
Others (Specify	Majority responded not knowing (Open ended question)	Majority responded not knowing (Open ended question)	Majority responded not knowing (Open ended question)

Annex 2: Youth's Knowledge of other STIs

Q217 Which Sexually Transmitted Infections (STIs) do you know?			
	Total	Male	Female
Chlamydia	No = 0(0%) Yes = 134(100%)	Yes=66 100.00%	Yes= 68 100.00%
Syphilis	No = 0(0%) Yes =627(100%)	Yes= 311 100.00%	Yes =315 100.00%
Gonorrhoea	No = 00(0%) Yes = 612(100%)	Yes= 308 100.00%	Yes =302 100.00%
HIV and AIDs	No = 0(0%) Yes =437(100%)	Yes= 215 100.00%	Yes =222 100.00%
Herpes	No = 0(0%) Yes =202(100%)	Yes= 84 100.00%	Yes =117 100.00%
Others (Specify	Yes= 152 100.00% No = 0(0%)	Yes= 71 100.00%	yes= 81 100.00%

	Total	Male	Female
Q407 If a friend of yours needed treatment for a sexually transmitted infection, where could he or she obtain such treatment?	Shop = 5 (0.69%) Pharmacy =19(2.64%) Health Facility =672(93.20%) Other (Specify)= 5 (0.69%) Don't Know=20(2.77%)	Shop = 4 (1.10%) Pharmacy =10(2.75%) Health Facility =338(93.11%) Other (Specify)= 2 (0.55 %) Don't Know=9 (2.48%)	Shop = 1 (0.28%) Pharmacy = 9 (2.52%) Health Facility =333(93.28%) Other (Specify)= 3 (0.84 %) Don't Know=11(3.08%)

Annex 3: Knowledge concerning common Symptoms of STIs

Q218 What are the signs and symptoms of a sexually transmitted Infections (STIs) for a man? (tick all that apply)			
	Total	Male	Female
Discharge from penis	No = 0 (0%) Yes = 419 (100%) Don't Know = 0 (0%)	Yes = 215 100.00%	Yes =203 100.00%
Pain during urination	No = 0 (0%) Yes = 510 (100%) Don't Know = 0(0%)	Yes = 256 100.00%	Yes= 253 100.00 %
Ulcers/sores in genital area	No = 0 (06%) Yes = 417 (100%) Don't Know = 0(0%)	Yes = 213 100.00%	Yes= 203 100.00 %
Q219 What are the signs and symptoms of a sexually transmitted Infections (STIs) for a woman? (tick all that apply)			
	Total	Male	Female
Vaginal Discharge	No = 0 (06%) Yes = 421 (100%) Don't Know = 0(0%)	Yes = 207 100.00%	Yes= 213 100.00 %
Pain during urination	No = 0 (06%) Yes = 486 (100%) Don't Know = 0(0%)	Yes = 232 100.00%	Yes= 253 100.00 %
Ulcers/sores in genital area	No = 0 (06%) Yes = 395 (100%) Don't Know = 0(0%)	Yes = 207 100.00%	Yes= 188 100.00 %
others	Yes = 159	Yes = 81 100.00%	Yes = 78 100.00%
FGM allowed in Kenyan law	Yes= 29 (3.96%) No= 635 (86.75%) Don't Know =68 (9.29%)	No= 316 (86.10%) Yes = 21 (5.72%) Dont Know = 30 (8.17%)	No=318 (87.36%) Yes= 8 (2.20%) Don't Know= 38 (10.44%)
A woman is most likely to get pregnant if she has sexual intercourse half way in her cycle	No= 212 (29.12%) Yes =347 (47.66%) Dont Know= 169 (23.21%)	No= 110 (30.14%) Yes =168 (46.03%) Dont Know= 87 (23.84%)	N0= 102 (28.18%) Yes=178 (49.17%) Dont Know=82 (22.65%)
It is safe for girls who have not yet been pregnant to use the pill. There is no long-term risk for infertility.	No= 405 (55.48%) Yes =216 (29.59%) Dont Know= 109 (14.93%)	No =190 (51.91%) Yes = 121 (33.06%) Dont Know= 55 (15.03%)	No= 214 (58.95%) Yes=95 (26.17%) Dont Know= 54 (14.88%)

Annex 4: Responses from the school and out of school questionnaire

SECTION 300 : ATTITUDE			
	Total	Male	Female
Q301 Do you think that if someone dresses sexy, the person wants to have sex?	No = 601 (82.44%) Yes = 104 (14.27 %) Don't Know = 24(3.29%)	No = 302 (82.51%) Yes = 104 (15.03%) Don't Know = 9(2.46%)	No = 298 (82.32%) Yes = 49 (13.54 %) Don't Know = 15 (4.14%)
Q302 It is acceptable for young people to have sex when they are not married	No = 645 (88.4 %) Yes = 83 (11.39%) Don't Know = 1(0.14%)	No = 319(87.16%) Yes = 47 (12.84%) Don't Know = 0(0.14%)	No =325 (89.78%) Yes = 36 (9.94%) Don't Know = 1 (0.28%)
Q303 It is acceptable for young unmarried people to use a condom?	No = 216 (37.86 %) Yes = 442 (60.63%) Don't Know = 11(1.51%)	No = 120 (32.88%) Yes = 243 (66.58 %) Don't Know = 2 (0.55%)	No = 156 (42.98%) Yes = 198 (54.55 %) Don't Know = 9(2.48%)
Q304 . A girl can suggest to her boyfriend that he uses a condom	No = 94 (15.36%) Yes = 513 (83.82%) Don't Know = 5(0.82%)	No = 34 (11.04%) Yes = 272 (88.31%) Don't Know = 2 (0.65%)	No = 60 (19.80%) Yes = 240 (79.21%) Don't Know = 3 (0.99%)
Q305 Condoms are suitable for casual relationships	No = 179 (29.30%) Yes = 411 (67.27 %) Don't Know = 21(3.44%)	No = 231 (75.00%) Yes = 69 (29.30 %) Don't Know = 8 (2.60%)	No = 110 (36.42%) Yes = 179 (59.27%) Don't Know = 13(4.30%)
Q306 Condoms are suitable for steady, loving relationships	No = 207(33.93 %) Yes = 385 (63.11%) Don't Know = 18(2.95%)	No = 84 (27.27%) Yes = 214 (69.48%) Don't Know = 18(2.95%)	No = 123 (40.86%) Yes = 170 (56.48 %) Don't Know = 8(2.66%)
Q307 If a girl suggests using condoms to her partner, it would mean that she doesn't trust him	No = 487 (79.71 %) Yes = 114 (18.66%) Don't Know = 10(1.64%)	No = 249 (80.84%) Yes = 55 (17.86 %) Don't Know = 4(1.30%)	No = 237 (78.48%) Yes = 59 (19.54 %) Don't Know = 6(1.99 %)
Q308 I think it is sometimes acceptable for a boy to force a girl to have sex	No = 639 (87.65 %) Yes = 77 (10.56%) Don't Know = 13(1.78%)	No = 321 (87.95%) Yes = 37(10.14 %) Don't Know = 13(1.78%)	No = 317 (87.33%) Yes = 40 (11.02 %) Don't Know = 6 (1.65 %)
Q309 It is sometimes justifiable for a boy to hit his girlfriend	No = 644 (88.58 %) Yes = 73 (10.04%) Don't Know = 10(1.38%)	No = 321 (88.19%) Yes = 39 (10.71%) Don't Know = 3 (0.82%)	No =322(88.95 %) Yes = 34 (9.39 %) Don't Know = 6 (1.66 %)
Q310 A man is allowed to beat his wife if she makes mistakes	No = 633 (86.71%) Yes = 92 (12.60%) Don't Know = 5(0.68%)	No = 319 (87.16%) Yes = 44 (12.02%) Don't Know = 3 (0.82%)	No = 313 (86.23%) Yes = 48 (13.22%) Don't Know = 2 (0.55%)
Q311 . It is mainly the woman's responsibility to ensure that she does not get pregnant	No = 521 (71.37 %) Yes = 187 (25.62%) Don't Know =22(3.01%)	No = 267 (72.95%) Yes = 91(24.86 %) Don't Know =8 (2.19%)	No = 254 (69.97%) Yes = 95 (26.17 %) Don't Know =214 (3.86 %)
Q312 Girls are as important as boys	No = 86 (11.81 %) Yes = 640 (87.918%) Don't Know = 2(0.27%)	No = 52 (14.21%) Yes =313 (85.52%) Don't Know = 1	No = 34(9.42%) Yes =326(90.30%) Don't Know = 1

		(0.27%)	(0.28 %)
Q313 When money is scarce, boys should be send to school before girls	No = 655 (89.97 %) Yes = 68 (9.34%) Don't Know = 5(0.69%)	No = 319 (87.16%) Yes = 45 (12.30%) Don't Know = 2 (0.55%)	No = 335(92.80%) Yes = 23 (6.37%) Don't Know = 3 (0.83%)
Q314 Women's most important role is to take care of her home and cook	No = 516 (70.68 %) Yes =11 (28.90%) Don't Know = 3(0.413%)	No = 261(71.31%) Yes = 105 (28.69 %) Don't Know = 0 (0%)	No = 255 (70.25%) Yes = 105 (28.93%) Don't Know = 3 (0.83%)
Q315 Changing diapers, bathing children and feeding the children are mother's responsibility	No =414 (56.79 %) Yes =313 (42.94%) Don't Know = 2(0.27%)	No =203 (55.46%) Yes = 163 (44.54%) Don't Know = 0(0%)	No =211 (58.29%) Yes = 149 (41.16%) Don't Know =2 (0.55%)
Q316 A man should have the final word about decisions in his home	No = 261 (35.80%) Yes = 462 (63.37 %) Don't Know = 6(0.82%)	No = 261 (35.80%) Yes = 462 (63.37 %) Don't Know = 6(0.82%)	No = 244(67.22%) Yes = 116 (31.96%) Don't Know =3 (0.83%)
Q317 The participation of the father is important in raising children	No = 46 (6.33%) Yes = 678 (93.2 %) Don't Know = 3(0.41%)	No = 21 (5.77%) Yes = 34 (93.68%) Don't Know = 2 (0.55 1%)	No = 25 (6.91%) Yes = (336 92.82%) Don't Know = 1(0.28%)
Q318 Girls should have the same freedom as boys	No = 130 (17.83 %) Yes = 594 (81.48%) Don't Know = 5 (0.69%)	No = 67 (18.31%) Yes = 297(81.15%) Don't Know = 2 (0.55 %)	No = 63 (17.40%) Yes = 296 (81.77 %) Don't Know = 3 (0.83%)
Q319 It is the man who should decide on using contraception	No = 94 (12.89%) Yes = 596 (81.76 %) Don't Know = 39(5.35%)	No = 285 (77.87%) Yes = 64 (17.49%) Don't Know = 17 (4.64%)	No = 310 (85.64%) Yes = 30(8.29%) Don't Know = 22(6.085%)
Q320 When it comes to sex, men should have the final word	No = 593 (81.46%) Yes = 100 (13.74%) Don't Know = 35(4.81%)	No = 282 (77.47%) Yes =67 (18.41 6%) Don't Know = 15 (4.12%)	No = 100(13.74%) Yes = 310 (85.40%) Don't Know = 20 (5.51%)
Q321 It is correct for parents to choose the husband or wife for their children, even if their child does not want to marry this person	No = 686 (93.97 %) Yes =40 (5.48%) Don't Know = 4(0.55%)	No = 336 (91.80%) Yes = 28 (7.65%) Don't Know = 2 (0.55%)	No = 349 (96.14%) Yes = 12 (3.31%) Don't Know = 2 (0.55%)
Q322 People who have a sexual relationship with the same sex should be accepted	No = 61(8.36%) Yes = 644 (88.22 %) Don't Know = 25(3.42%)	No = 316 (86.34 %) Yes = 39 (10.66%) Don't Know = 11 (3.01%)	No = 327 (90.08%) Yes = 22 (6.06 %) Don't Know = 14 (3.86%)
Q323 I would never have a homosexual friend	Agree = 475 (65.07%) Disagree = 235 (32.19%) Don't Know = 20(2.74%)	Disagree = 128 (34.97%) Agree = 230 (62.84%) Don't Know = 8 (2.19%)	Disagree = 106 (29.20%) Agree = 245 (67.49%) Don't Know = 12 (3.31%)
Q324 A person who carries a condom is looking for sex	Yes=160 (21.95%) No= 537 (73.66%) Don't Know= 32 (4.39%)	Yes= 78(21.37%) No= 271 (74.25%) Dont know=16 (4.38%)	Yes=82 (22.59%) No= 265 (73.00%)

			Dont Know= 16 (4.41%)
Q325 A boy is not allowed to touch a girl if she does not want him to	Yes = 605 (82.99%) No= 113 (15.50%) Dont know =11 (1.51%)	Yes =291 (79.51%) No =70 (19.13%) Dont Know=5 (1.37%)	Yes =313 (86.46%) No = 43(11.88%) Dont know= 6 (1.66%)

Annex 5: Summary of behavioral Practices among the respondents

Q 408: Do you agree with the following statements			
a You know where to get support if you have sexual health problems	Agree=638 (87.88%) Disagree= 55 (7.58 %) Don't know =33 (4.55%)	Agree=314 (86.03%) Disagree= 36 (9.86%) Don't know =15 (4.11%)	Agree=323 (89.72%) Disagree= 19 (5.28%) Don't know =18 (5.00%)
b I would prefer/my partner to give birth in a health facility when pregnant	Agree=704(96.70%) Disagree= 13 (1.79 %) Don't know =11 (1.51%)	Agree=352 (96.17%) Disagree= 8 (2.19%) Don't know =16 (1.64%)	Agree=351 (97.23%) Disagree= 5 (1.39%) Don't know =5 (1.39%)
c If you had daughters, would you have them circumcised?	Agree=31 (4.25%) Disagree= 687 (94.24%) Don't know = 11 (1.51%)	Agree=21 (5.74%) Disagree= 339 (92.62%) Don't know = 6 (1.64%)	Agree=10 (2.76%) Disagree= 347 (95.86%) Don't know = 5 (1.38%)
d It would be too embarrassing for someone like me to buy or obtain condoms	Agree=224 (36.66%) Disagree= 381 (62.36%) Don't know=6 (0.98%)	Agree=91 (29.35%) Disagree= 216 (69.68%) Don't know=3 (0.97%)	Agree=133 (44.33%) Disagree= 164 (54.67%) Don't know=3 (1.00%)
e I am confident that I can insist on condom use every time I have sex (Now and in future)	Agree=479 (78.65%) Disagree= 107 (17.57 %) Don't know =23 (3.78%)	Agree=253 (82.41%) Disagree= 47 (15.31%) Don't know =7 (2.28%)	Agree=226 (75.08%) Disagree= 59 (19.60 %) Don't know =16 (5.32%)
f I feel that I know how to use a condom properly	Agree=303 (49.75%) Disagree= 269 (44.17 %) Don't know =37 (6.08%)	Agree= 194 (63.19%) Disagree= 103 (33.55 %) Don't know = 10 (3.26%)	Agree=108 (35.88%) Disagree= 166 (55.15%) Don't know =27 (8.97%)
g I am able to get/buy a condom if I want to use one	Agree=416 (68.87%) Disagree= 173 (28.64%) Don't know =15 (2.48%)	Agree=229 (75.08%) Disagree= 68 (22.30%) Don't know =8 (2.62%)	Agree=186 (62.42%) Disagree= 105 (35.23%) Don't know =7 (2.35%)
h If someone touches me in a way I do not like, I find it difficult to say I don't want it	Agree=176 (24.18%) Disagree= 540 (74.18 %) Don't know =12 (1.65%)	Agree=100 (27.40%) Disagree= 258 (70.68%) Don't know =7 (1.92%)	Agree=75 (20.72%) Disagree= 282 (77.90%) Don't know =5 (1.38%)
i I would refuse to have sex with someone who is not prepared to use a condom	Agree=532 (87.50%) Disagree= 58 (9.54 %) Don't know =18 (2.96%)	Agree= 269 (87.62%) Disagree= 29 (9.45%) Don't know = 9 (2.93%)	Agree=262 (87.33%) Disagree= 29 (9.67%) Don't know =9 (3.00%)
j I will not have sex in exchange for money or gifts	Agree=654 (89.71%) Disagree= 66 (9.05 %) Don't know =9 (1.23%)	Agree= 329 (89.89%) Disagree= 31 (8.47%) Don't know =6 (1.64%)	Agree=324 (89.50%) Disagree= 35 (9.67%) Don't know = 3 (0.83%)

k I feel confident that I will be able to refuse sex if I do not want to have sex	Agree=689 (94.90%) Disagree= 26 (3.58 %) Don't know =11 (1.52%)	Agree= 346 (94.54%) Disagree= 13 (3.55%) Don't know = 7 (1.91%)	Agree=342 (95.26%) Disagree= 13 (3.62%) Don't know =4 (1.11%)
l I feel confident to make the decision myself when (in the future) I want to have sex or not	Agree=678 (93.78 %) Disagree= 22 (3.04 %) Don't know =23(3.18%)	Agree= 337 (92.58%) Disagree= 14 (3.85%) Don't know =13 (3.57%)	Agree=340 (94.97 %) Disagree= 8 (2.23%) Don't know =10 (2.79%)
m I feel confident I will be able to reduce the risk of getting infected by HIV	Agree=686 (94.49%) Disagree= 27 (3.72 %) Don't know =13 (1.79%)	Agree=337 (92.08%) Disagree= 21 (5.74%) Don't know =8 (2.19%)	Agree=348 (96.94%) Disagree= 6 (1.67%) Don't know =5 (1.39%)
n Do you feel any pressure from others to have sexual intercourse?	Agree= 185 (25.48%) Disagree= 529 (72.87%) Don't know =12 (1.65%)	Agree= 95 (25.96%) Disagree= 266 (72.68%) Don't know =5 (1.37%)	Agree= 190 (25.07%) Disagree= 262 (72.98%) Don't know = 7 (1.95%)

Annex 6: Behaviour if someone wants to have sex with respondent.

Q 409 : Say a boy/girl wants to have sex with you. Do you think you can			
	Total	*Male*	*Female*
a Tell him/her if you do not want to have sex, even if he/she insists or gets angry?	No =52 (7.48%) Yes= 630 (90.65%) DON'T KNOW =13 (1.87%)	No =23 (6.59%) Yes= 323 (92.55%) DON'T KNOW =3 (0.86%)	No =29 (8.41%) Yes= 306 (88.70%) DON'T KNOW =10 (2.90%)
b Tell him/her if you do not want to have sex, even if he/she offers you money or nice gifts	No =46 (6.66%) Yes= 632 (91.46%) DON'T KNOW =13 (1.88%)	No =26 (7.58%) Yes= 308 (89.80%) DON'T KNOW =9 (2.62%)	No =20 (5.76%) Yes= 323 (93.08%) DON'T KNOW =4 (1.15%)
c Convince him/her to use a condom	No =91 (16.37%) Yes= 449 (80.76%) DON'T KNOW =16 (2.88%)	No =36 (13.04%) Yes= 233 (84.42%) DON'T KNOW =7 (2.54%)	No =55 (19.71%) Yes= 215 (77.06%) DON'T KNOW =9 (3.23%)

Annex 7: Sampled Primary Schools

The following 9 Primary Schools were randomly sampled from a sample frame of all schools within which the partners work.

SAMPLED PRIMARY SCHOOLS	
KISUMU COUNTY (6)	NAIROBI COUNTY (3)
Bar Union	Njiru community
Sinyolo	KAG Olympic
St Alloys Ojolla	Jack&Jill
St. Alloys	
Rae	
Migingo	

From each Primary School Sampled, at least 15 youth between age 10 – 14 (attending class 4 – 8) were selected using the respective class registers. Systematic sampling was used to pick at least 3 individuals from each of the classes, i.e. the first, middle and last pupil in each class register.

Annex 8: sampled secondary schools

The following 30 Secondary Schools were randomly sampled from a sample frame of all schools within which the partners work.

KISUMU COUNTY (15)	MOMBASA COUNTY (6)	NAIROBI COUNTY (9)

Okok Mixed	silver spring high	st alyosius ngonzaga
Wachara	bamburi community	utawala mixed
Bar Union Mixed	nyali international	embakasi girls
Sinyolo Girls	st michaels high	ushirika
Lions	changamwe high	eastleigh secondary
Kisumu Girls	Brainsworth	ndururuno sec
Nyakach Girls		ourlady of Fatima
Dago Kokore Mixed		state house girls
Migingo Girls		Lavington High
Sinyolo		
Ogada		
Ojolla		
Eluhobe Mixed		
Ahero		
Ojola Grils		

From each Secondary School Sampled, at least 15 youth between age 14 – 20 (attending Form 1 to 4) were selected using the respective class registers. Systematic sampling was used to pick at least 4 individuals from each of the classes, i.e. each next $k/4$th pupil in the class register (where k was the class register's count).

Annex 9: Sampled Out of school Centres

The following 15 Centres were randomly sampled from a sample frame of all out of school centres within which the partners work.

Region	Out of school centres
Kakamega	Bulanda
Kakamega	Eshienjera
Kakamega	Koloo
Kakamega	Shibembe
Kakamega	Mutoma
Kisumu	Nyahera
Kisumu	Moro
Kisumu	Anyweyo
Nairobi	Eastleigh (FHOK Centre)
Nairobi	Mathare (Maji Mazuri)
Nairobi	Kibera (SHOFCO)
Nairobi	Mukuru (Mukuru kwa Reuben Centre)
Siaya	Momnetum
Siaya	Home and away
Siaya	Tembea na majira

15 Interviews were conducted targeting 15 persons of age 15 – 24 per each centre. The youth were selected as they randomly arrived at the centre.

Annex 10: Sampled health facilities

The following 45 Health Facilities were randomly sampled from a sample frame of all health facilities within which the partners work.

SAMPLED HEALTH FACILITIES				
KAKAMEGA COUNTY (17)	KISUMU COUNTY (12)	MOMBASA COUNTY (1)	NAIROBI COUNTY (10)	SIAYA COUNTY (5)
General Hospital	Pap-Onditi D.H	muleleo CDF HC	Eastleigh Health care	Mahaya
Manyala SDH	Chulaimbo Hospital		Kayole 1 Health centre	Kambajo
Butere district hospital	Nduru		Kibera D.O Health Centre	Matayos HC
Prisons Health Centre	Ober		Lungalunga	Pap-kodero
Masaba	Ober kamoth		Dandora Health care	Kaluo
Shimkoko	Lambwe		Marie Stoppes	
Mabole	Katito		MSF	
Lunza	Rabuor		St. Vincent	
Shiraha	Omiro		Maisha House care	
Shitsitswi	Nyahera		FHOK Nairobi Youth Centre	
Lushea	Youth Empowerment Centre			
Malaha	FHOK Kisumu			
Shikunga				
Nabongo Health Centre				
Masinde Muliro University				
Tunza clinic				
FHOK Kakamega				

From each Health Facility Sampled, at least 20 client exit interviews were conducted in Tier 3 facilities (Hospitals) and at least 10 interviews in the Tier 2 health facilities (Dispensaries and health Centres).

In addition to this, the Facility Observation Tool and the Safe Abortion Tool were filled in each facility.

Annex 11: Sampled community based organizations/organized community groups (CBO assessment)

The following 31 Community Based Organisations and Groups were randomly sampled from a sample frame of all health facilities within which the partners work.

CBOs /Organized groups				
NAIROBI (10)	MOMBASA (9)	KISUMU (4)	SIAYA (5)	KAKAMEGA (3)
Dream achivers	Nzumari youth groups	Faith Against AIDS&TB in Kisumu (FAATIK)	SEGA Youth advocates	Tuungane Support Group; ;
youth led organizations from Kariobangi	Smart and responsible teens	Jiu Pachi	Siaya/Busia (4CBOs: Bwicha YG;	Pamoja Positive Voices Network
youth led organizations from Mathare	Mopusen	Hope for Kisumu Youth Achievers	Bwambani SHG;	Best ladies Support Group
youth led organizations from Mukuru	Kenya Network of Post Test Clubs	Men Against Aids in Kenya	Sigwata YG;	
youth led organizations from Eastleigh	Mikindani Youth Support Group		Nangoma YG	
youth led organizations from Kibera)	Planet Protectors Youth Group			
Kibera Youth Group,	Mbuguni Youth Support Group			
Baba Dogo Youth Group,	Mlaleo Epic;			
Jipange Youth Group	Young Fishers			
Utena Youth Group				

Notes on conducting self-assessment forms:

For all the above Groups, administer a CBO self-assessment form with the senior most member of the management

Annex 12: Sampling for focused group discussions

The following 53 community centres were randomly sampled from a sample frame of all centres where the partners work in.

SAMPLING OF FGDs				
NAIROBI (10)	MOMBASA (8)	KISUMU (11)	SIAYA (11)	KAKAMAEGA (13)
Eastleigh	kisauni	Kisumu Area	Sega Community	Shirembe
Mathare North	mwandoni	Nyamaji East	Usire	Mahala
Mathare	Shanzu	God Jope	Kapiyo	Lushea
East leigh	bangladesh	East Kamagak	Bar Kanyango	Shaitsala
baba ndogo,	bamburi	Kakelo Kamroth	Hawinga	Mabole
kariobangi	Likoni	Ober	Mahaya	Shihara
Huruma,	majengo	Nyalenda A	Memba	Lunza
Soweto;	mshomoroni	Kanyawegi	Kobong	Lukohe
Kayole		Moro; Ayueyo	Ojwando B	Bulanda
Tassia;		Magina	Pala	Shikunga
		Bar A	Omia- Malo	Masaba
				Emunuku
				Mutoma

The centres were stratified by county, and 4 FGDs were conducted in each county as below:

a) FDG with young people 10-14
b) FGD with young people 15-24
c) FGD with gatekeeper's women
d) FGD with gatekeeper's men

All FGD participants were selected from the centres above, for each county. The target was to have 8 – 13 participants per FGD.