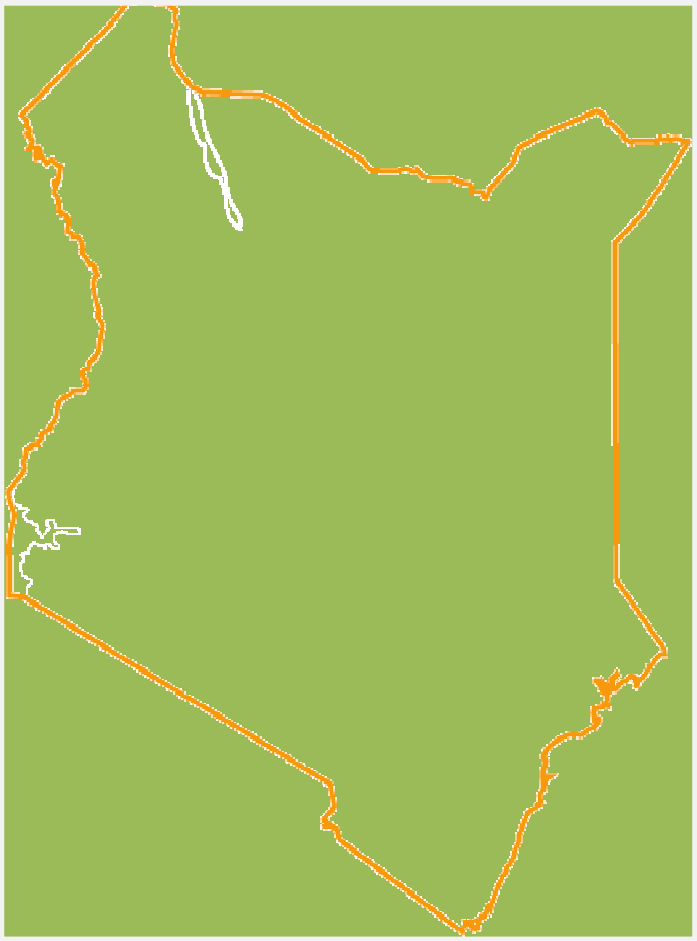
SR HR Alliance

KENYA

Sexual Reproductive Health and Rights Alliance



A baseline study report

UFBR baseline report

Centre for the Study of Adolescence (CSA)
The African Medical and Research Foundation (AMREF)
Africa Alive! (AA)
Great Lakes University of Kisumu (GLUK)
Nairobits Trust
Support Activities In Poverty Eradication and Health (SAIPEH),

November 2011

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LIST OF ACRONYMS

AA	Africa Alive
AIDS	Acquired Immune Deficiency Syndrome
AMREF	Africa Medical and Research Foundation
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
CBHMIS	Community Based Health management information systems
CHW	Community health workers
CSA	Centre for the Study of Adolescence
CSE	Comprehensive Sexuality Education
FGD	Focus Group Discussion
FP	Family Planning
GLUK	Great Lakes University of Kisumu
HC	Health Centre
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUCD	Intra Uterine Contraceptive Devices
KAP	Knowledge Attitude and Practice
KDHS	Kenya demographic and Health Survey
LGBT	Lesbian, Gay, Bisexual, Transgender
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MFS	Ministry of Foreign Services Netherlands
NGO	Non-Governmental Organization
OVC	Orphaned and Vulnerable Children
PAC	Post Abortion Care
RWPF	Rutgers World Population Foundation
SAIPEH	Support Activities In Poverty Eradication and Health
SGBV	Sexual and Gender Based Violence
SPSS	Software Package for Social Sciences
SRHR	Sexual Reproductive Health and Rights
STI/STD	Sexually transmitted Infection
TBA	Traditional Birth Attendant
UFBR	Unite for Body Rights
VCT	Voluntary Counseling and Testing
WSWM	World Starts With Me
YFS	Youth Friendly Services
YWLI	Young Women Leadership Institute

1.0 INTRODUCTION

In 2010, a sexual and reproductive health alliance was established in the Netherlands by 5 Dutch organizations namely Rutgers WPF, AMREF Netherlands, Simavi, Dance4life and Choice. The aim of the SRHR Alliance is to work towards a society free of poverty in which all women and men, girls and boys, and marginalized groups have sexual and reproductive rights irrespective of their background. The Alliance, in collaboration with partner organizations in developing countries – developed the 'Unite for Body Rights (UFBR)' programme, which is funded by the Dutch Ministry of Foreign Affairs.

The 5 year (2011 – 2015) UFBR programme is being implemented in nine countries, five in Africa and four in Asia: Ethiopia, Kenya, Malawi, Tanzania, Uganda, Bangladesh, India, Indonesia and Pakistan. In each country, the SRHR Alliance works through local partner organizations of the members of the Alliance. The SRHR alliance mainly targets women and young people. Other marginalised groups include survivors of violence, Lesbians, Gays, Bisexuals and Transgender (LGBT), people with disabilities, people living with HIV/AIDS and people with traditional lifestyles in remote areas to enhance meaningful participation development.

A 2010 context analysis conducted in each country identified four priority areas that require attention of MDGs 3, and 4-6, the International Conference on Population and Development (ICPD) Programme of Action and other international agreements for promoting sustainable development are to be met. These four priority areas are:

(1) improved sexual and reproductive health services
(2) comprehensive sexuality education
(3) combating sexual and gender-based violence, and
(4) Freedom of expression of sexual diversity and gender identity.

In line with these priority areas, the following are the objectives:

1. Increased utilization and quality of comprehensive Sexual and Reproductive Health (SRH) services
2. Increased quality and delivery of Comprehensive Sexuality Education (CSE)
3. Reduction of Sexual and Gender Based Violence (SGBV)
4. Increased acceptance of Sexual Diversity and Gender Identity

1.1 Introduction of the baseline

1.1.1 Workshops (baseline workshop, planning workshop June-Aug, target setting)

Three planning workshops for the UFBR program were held by Southern and Northern partners in 2009 and 2010. The first workshop hosted by SRH alliance and Hivos discussed country specific context analysis report laying the foundation for the UFBR program. The second workshop (April 2010) discussed the MFS funding framework, SRH situation including stakeholders analysis in Kenya and the focus of the Kenyan UFBR programme. A third workshop in November 2010 was held to develop the Kenyan programme in more detail.

A fourth planning workshop was held in March 2011 to review progress made and plan for a baseline study that would inform intervention development. The meeting brought together northern partners and Kenyan partner organization. Among the key highlights were a review of Kenya country specific indicators and adaptation of the baseline study tools. The meeting resolved to conduct the Kenyan baseline study in the months of April and May with the Centre for Study of Adolescence providing leadership.

1.1.2 Short introduction of the country program

Kenya has six local partners implementing the UFBR programme; AMREF Kenya, CSA, Nairobits, Africa Alive, GLUK and SAIPEH. Each of these organisations are reaching an important group of marginalised young people and women in urban and rural areas. These organisations blend SRHR service delivery, comprehensive sexuality education, advocacy with research. Through the alliance, the organisations complement each other in implementing the UFBR program. The UFBR programme is being implemented by the local partners in four regions-Coast, Nairobi, Western, and Central regions of Kenya as described below. The table below shows the implementing organisation and its affiliated alliance member:

Table 1: Organizations in the UFBR alliance

Implementing organization	Affiliated Alliance member
AMREF Kenya	AMREF Netherlands
CSA	Rutgers-WPF and Simavi
Nairobits	Rutgers-WPF
Africa Alive	Dance4life
SAIPEH	Simavi
GLUK	Simavi

1.1.3 Objectives of program

The UFBR programme in Kenya is aimed at meeting the following objectives:

1. Increased utilization and quality of comprehensive Sexual and Reproductive Health (SRH) services
2. Increased quality and delivery of Comprehensive Sexuality Education (CSE)
3. Reduction of Sexual and Gender Based Violence (SGBV)
4. Increased acceptance of Sexual Diversity and Gender Identity

1.1.4 Description of the project areas

The UFBR program will be implemented in three clustered regions: Western region (this includes the Western and Nyanza Provinces); Central region (Nairobi and South Rift Valley, Lower Eastern, and the Central Provinces); and Coastal Province. Consensus on the geographic focus and target groups was reached at in consultative workshops by the SRHR Alliance.

Western region is largely rural and agricultural with communities around Lake Victoria also engaging in fishing. The region has poor RH and maternal health indicators. Nyanza province has the highest HIV prevalence rate in the country standing at 7.1. The UFBR program is being implemented in four districts of Kisumu, Kisii, Bungoma, Busia, Teso and Mumias districts by CSA, SAIPEH and GLUK.

Nairobi region covers Nairobi city and province. With an estimated cosmopolitan population size of 3.2 million people, Nairobi region has eight administrative districts (Kamukunji, Dagoretti, Embakasi, Kasarani, Kibera, Makadara, Starehe and Westlands). The region has the largest concentration of social, health and educational amenities in the country provided by the City council of Nairobi, Central government and the private sector. The region has large informal settlements with very poor RH indicators for women, adolescents and children. The UFBR programme will be implemented in seven out of the eight districts by CSA, Nairobits and Africa Alive.

Under the UFBR programme, the Central region covers Kajiado and Loitokitok Districts in the southern part of Rift valley province. Rift Valley province presents a mix of good and poor performing districts as far as social, health and educational amenities are concerned. The two districts covered by the UFBR programme are immensely dry with local population only practicing pastoral nomadism. The UFBR program will be implemented in these districts mainly by AMREF Kenya.

The Coastal region covers Coast province over an area of 83,603 km² and a population of 3,325,307 inhabitants. The province has 15 administrative districts with poor RH outcomes, low access to health services and poor school enrollment. *Africa Alive!* will partner with CSA to implement the UFBR programme in Mombasa, Kwale, Kilifi and Malindi districts.

1.1.5 Description of the target groups

The UFBR-Programme in Kenya targets two main groups: the youth (10-24 years); and women of reproductive age (15- 49 years). Young people experience negative consequences of restricted or limited access to sexual and reproductive health and rights (SRHR)-services and information. They are affected more strongly by the adverse effects of unsafe abortion and pregnancy. About 43% of the Kenyan population is below the age of 15 years; and over 60% of all Kenyans – about 25 million people – is below 25 years. Kenyan women run a high risk of maternal mortality, HIV-infection and

experiencing sexual and gender-based violence, and have a high unmet need for family planning. They are considered a target group, because their good sexual and reproductive health will have a long-term effect on society.

Table 2: Characteristics of the target groups of the UFBR programme in Kenya

Target groups	Characteristics of the target group	Community
Young people aged 10-14	Urban/Rural/ in and out of school	Rift Valley province : Loitokitok District, Magadi District Western province: Mumias, Bungoma, Kisumu. Kisii Districts Nairobi province: Kamukunji, Kasarani, Starehe, Embakasi, Makadara
young people aged 15-19	Urban/Rural/ in and out of school	Rift Valley province : Loitokitok Districts Western province: Mumias District Nairobi province: Kamukunji, Kasarani, Starehe Nyanza province : Kisumu and Kisii Districts
young people aged 20-24	Urban/Rural/in and out of school	Rift valley- Loitokitok Western: Mumias, Kisumu. Kisii Districts Nairobi: Kamukunji, Kasarani, Starehe
Women	Rural	Western province: Mumias, Kisumu. Kisii Districts Rift valley province: Loitokitok Magadi District

1.1.6 Short description of UFBR implementing organisations in Kenya

AMREF-Kenya: The African Medical and Research Foundation (AMREF) is an independent non-profit, non-governmental organization (NGO) founded in 1957. AMREF Kenya works to improving health and health care in Africa by partnering with local communities, building their capacity, strengthening health systems, research and advocacy. AMREF-Kenya's major targets are the vulnerable groups including women, children, the elderly, people with disabilities and the poor in rural and urban underserved areas.

From 2007, AMREF Kenya has been implementing a regional multi-site Nomadic youth (10-24years) reproductive health project which covers Kenya, Ethiopia, and Tanzania with funding from the Dutch Ministry of Foreign Affairs through AMREF Netherlands. The project covers Kajiado district (Magadi division) and Loitokitok district targeting to reach at least 50,000 Kenyan youth with SRH information and services.

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). Under the SRHR alliance *Africa Alive*! is working in Nairobi and Coast regions targeting youth in and out of school youth.

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. GLUK will support the implementation of UFBR in the Western region through the community health strategy

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. Under the UFBR program, Nairobits will work in Nairobi region

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 grassroot 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. In the UFBR program, CSA will be working in three of the four UFBR regions of Western, Coast and Nairobi.

SAIPEH: Support Activities In Poverty Eradication and Health [SAIPEH], is a registered Non-governmental organization [NGO] based in Western province of Kenya. SAIPEH works to provide structural and sustainable support services to alleviate poverty and increase ways of bettering living standards of all members of the community, especially the orphans and vulnerable children, youth, women and the marginalized through development of strategies and initiatives at grass root level in the community that will enable this groups, be self supportive and independent. The Organisation runs a reproductive health and rights programme supporting HIV/AIDS outreach, performing arts and community peer education. SAIPEH has a strong community background and will contribute immensely in supporting CSE implementation in Western region.

2.0 METHODOLOGY

This section describes the sampling procedures and data collection tools for the baseline study on UFBR programme in Kenya. This baseline study was conducted in selected districts expected to implement the UFBR programme. Priority consideration in selecting the division, locations, schools and health facilities for this baseline study was for those that are not yet implementing the UFBR program but will be incorporated into the program within the five year project life. The description of the total population to be reached by the UFBR programme was made with specific focus on the targeted sub groups. The UFBR programme primarily targets women, out of school and in school young people. Similarly, the baseline study targeted in and out of school young people aged 10 years to 24 years and married and un-married women 25 years to 49 years.

2.1 Data collection methods & tools

Representative, random sampling

The UFBR survey used multistage sampling drawing from the three UFBR program regions by first selecting targeted districts where the program will be implemented over the next five years. In each of the selected districts, divisions/constituencies were identified and locations and sub-locations in each division/constituency sampled. This followed the government administrative structures. In selecting participating divisions, a list of divisions to be covered by the programme was prepared with the help of SRHR alliance partners. All the names of the division were then written on equally cuts pieces of paper of the same size. The small pieces of paper were then rolled in into equal sizes and share and a staff member at CSA office requested to randomly pick three pieces, one each at a time.

In each of the selected divisions, a list of all locations covered by the programme was prepared. The names of the locations were then written on equally cut pieces of paper of the same size which were then rolled and placed in a bowl and only one picked by a staff member. Selection of two sub-locations in each of the selected locations also followed a similar sampling strategy. In cases where the sub locations could not provide sufficient numbers required another sub-location was picked using same random selection until number required is attained.

Variability at the sub-location level considered among other variables place of residence (rural or urban). In each of the locations, a representative sample of schools and health facilities was selected. A representative number of people and facilities were randomly selected from study site population. Random selection is important as it decreases bias in data making it more reliable and comparable to follow on midterm and end term evaluation in 2013 and 2015. In this study, drawing of individuals in the baseline study sample was completed at three levels: the community level; the school level and the heath facility level. This was stratified based on unique characteristics such as age, sex, exit clients at health facilities, in-and out-of school young people, married/unmarried women with /without children. In randomly selecting eligible participants for this study, each individual had an equal opportunity of being included only.

The sampling of subgroups of the target population the UFBR baseline study in Kenya was guided by the Central Limit Theorem in analysis that requires at least 25-30 respondents in each population sub group.[1] The sampling method for each of the selected study population is described below.

i. Sampling of respondents for KAP surveys in communities

The 2011 UFBR baseline study program targeted women in Mumias and Loitokitok districts. In the two districts, none of the selected study locations had an existing listing of households that would have formed the sample frame. Constrained by time to undertake a household listing in the two locations, the study team used sampled health facilities (Mumias) and or chief's offices (Loitokitok) as reference points in randomly selecting

[1] For example, if you like to analyse data both for boys and girls, you need at least 50-60 respondents. This number increases when you also want to analyse data for different age groups and at the same time also for boys and girls

households to be included in the study. In Mumias, which is densely populated, every fifth household was included in the study sample. In Loitokitok, which are sparsely populated due to the nomadic life, households are kilometres apart. For this reason, each household that the data clerks came across was selected and a household listing done to establish if there were any eligible respondents.

Data clerks approached the household head or any other responsible adult in the household at the time of the survey for consent. The inclusion criteria was based on: Age (3 groups: 15-19, 20-24, 25-49); Marital status (married vs. not married); and Motherhood (with vs. no child(ren)).If a household was found to have more than one eligible member for each of the study categories; one member was included per responsive category. Only one eligible respondent was selected in each of the sampled household per category where households had more than one member in each category. In total 30 respondents were selected per study site for each category.

ii. Sampling of out of school youth for KAP survey

Sample selection of young people out of school drew from existing Youth groups in each study location. A listing of all registered youth groups was obtained from the Ministry of Youth affairs officer at the divisional level. Youth groups were used as a means of mobilizing young people out of school and this was done using the snowballing method where a young person selected from a youth group was responsible to bring in other young people. The names of all the youth groups were written on pieces of paper equally cut to size. The small pieces of paper were then rolled in into equal sizes and a staff member at CSA office requested to randomly pick five, one at a time. Five youth groups were selected in each location and a listing of members obtained from whom six were randomly selected. Inclusion criteria for young people were based on the following:

i. Age (3 groups: 10-14, 15-19 and 20-24),
ii. Gender (boys vs. girls), and
iii. out of school

Due to cultural differences, care was taken to accommodate older adolescents especially those aged 20-24 who may still be in school especially in Loitokitok district where boys and girls start schooling late. This is also attributed to the nomadic lifestyle of the community which disrupts school during certain seasons delaying entry and completions.

iii. Sampling of in school youth for KAP survey

A listing of all schools targeted by the programme in the selected locations was obtained from the local education offices. The names were listed on equally cut pieces of paper and three schools randomly picked from the list. Selection of young people in each of the schools drew from the class register which lists all students. In each of the schools covered, care was taken to select students from upper primary and secondary schools following the list of names in each class. A sampling interval was determined for each class and students randomly selected from the registers.

Most boys and girls aged 10-14 years in Kenya are likely to be in primary schools while those aged 15-19 are most likely to be in secondary schools. Both Primary and secondary schools were included in the study. Selection from the register was equally split among boys and girls with each sub group producing 15 respondents for the study.

All the students selected in the sample were then assembled in a common area- in most cases a classroom where the self administered interview was given. Three research assistants facilitated the interviews, with one interviewer reading each question at a time and allowing the students to complete the questionnaire before moving to the next questions. Two other research assistants were available to assist students who did not understand the questions or required clarification. This was done until the data clerks completed reading all the questions. After the interview, the students were asked to cross check their questionnaires for any skipped questions and they were accordingly guided. Caution was taken in each of the schools to keep teachers away from the interview area/class to enhance confidentiality. Consent was requested before the interviews begun.

Selection of secondary schools also followed the same procedure where 2 secondary schools in each district (for 15-19 year old students) from a list of schools where partners plan to implement the programme. Once a list of

students in class register was obtained from the head teacher, 15 students each from among boys and girls were selected from the two schools. A self administered KAP tool was then administered following the self administered questionnaire procedures outlined for primary schools above.

iv. Sampling of exit clients at health facilities

Sampling for health facilities drew from a list of all targeted health facilities in each of the sampled UFBR baseline locations. In each region, at least six health facilities were required for the study. In locations with fewer health facilities, additional facilities were drawn from the nearest location as long as they are in the intervention area for UFBR alliance members.

At the health facilities, data collection clerks positioned themselves at the exit gate of the facility and randomly approached all potential respondents who they thought likely fell within the study age brackets. They were introduced to the study and asked if they would be willing to participate in the study. The potential respondents had to be patients or guardians leaving the health facility after receiving services. If agreeable, the data clerks confirmed their ages to determine if they fell within the target age ranges. Formal consent to participate was then obtained. This continued until two respondents in each sub group (women-married and unmarried 15-24 and 25-49; young people- boys and girls 10-14, 15-19 and 20-24) were interviewed. Each health facility targeted a total of 20 exit interviews with both young people and women.

2.2 Description of tools/ instruments

The UFBR baseline study used 7 data collection tools for interviews in the community, schools and at health facilities. The table below describes each of the tools used for the study**.**

Table 3: Tools used to measure indicators, by indicator

Indicator	Tool	Short Explanation of the Tool
Outcome indicator 2.1a – exposed target groups has an increased capacity to make safe and informed decisions (on SRHR)	KAP survey	Administered among women and young people both in and out of schools. It covered knowledge attitudes and behaviour practices of young people and women relating to reproductive health.
Outcome indicator 2.2a – targeted (youth friendly) services increasingly comply with IPPF standards for youth friendly services	Checklist – tool number 2	This tool was used at health facilities to establish capacity and ability to provide youth friendly service ASRH services
Outcome indicator 2.2b – Increase in the number of young people satisfied with SRHR services	Exit interview (structured questionnaire) – tool number 3	This tool was used to asses satisfaction levels with services received at health facilities by clients. Open ended questions were used in the tool
Outcome indicator 2.2c - targeted maternal health services increase their compliance to the (national) quality standard	Checklist – Tool number 4	This tool was used to assess the provision of maternal health services especially as relates to available supplies and services
Outcome indicator 2.2d – Increase in the number of women satisfied with SRHR services	Exit interview (structured questionnaire) – Tool number 5	This tool was used to asses satisfaction levels with services received at health facilities by clients. Open ended questions were used in the tool
Outcome indicator 2.3a - increase in young people and women using SRHR services	Secondary data collection –Tool number 6	This tool collected data from health facilities by interviewing health providers
Outcome indicator 2.3b - Number of births attended by a skilled birth attendant is increased	Secondary data collection – Tool number 6	Using facility records and interviewing health providers
Outcome 2.3c – increase in pregnant women who have 1-4 antenatal check-ups	Secondary data collection –Tool number 6	
Output indicator 2.3.1a - targeted facilities have increased availability of contraceptives, ART, ACT & antibiotics	Secondary data collection – Tool number 6	

Outcome indicator 2.4b - Increased acceptance of SRHR at community level	FGD's	Topics in the interview guide for FGD
Outcome indicator 2.4c – Increased involvement of community leaders in realisation of SRHR	Key stakeholder mapping	Topics in the interview guide for FGD

2.3 Description of the baseline sample

In Kenya, the UFBR intervention is slightly different in each region. The target group may be bigger or smaller and the focus on education or services may be differing in intensity. Based on the planned intervention, below is an overview of target groups and tools that were used in each area for the baseline, as well as where sampling was needed: See annex for Number of respondents in the sample in Kenya per tool used.

2.4 Ethical aspects: Consent, confidentiality and anonymity in the tools and data collection procedures

This baseline study was approved by the Kenya National Council for Science and Technology. Entry points in each of the study districts followed the government structures. With the head of the district- District Commissioner- being briefed about the intended baseline study for approval. A copy of the research permit was issues given to each of the district heads together with an introductory letter on the study prepared by CSA that described the study, target groups and expected outputs and usefulness for the community. A list of all data collectors on the study was attached to the introductory letters. The DC then gave permission to the study team to visit the divisional officers, then chiefs from selected locations as part of community entry to seek permission to conduct the study.

Selected study participants were fully informed about the study and permission sought for an interview. A prepared consent statement highlighting the objective of the study, target population, benefits, choice to freely participate, and assurance of confidentiality was read to each respondent before being interviewed. The legal age for consent in Kenya is 18 years. Only individuals aged 18 years and above provided consent to participate in the study. For those aged below 18 years, consent was sought from guardians-provided by teachers for youth in school and parents for those younger than 18 years who were out of school. In addition to parental/guardian consent, the young people aged below 18 years were read an assent form as part of individual willingness to participate. Only those willing to participate in the study were interviewed. (see annex for consent & assent form).

For those who agreed to participate in the survey, all interviews were conducted in privacy-away from other people - to maintain confidentiality. In-school adolescents filled a self administered questionnaire individually after the consent was obtained from the school administration. No personal identifiers were used on the individual questionnaires. All questionnaires were pre- serialized for each region. After interviews, supervisors in each region reviewed the questionnaires for quality and send them by courier to CSA head office in Nairobi where they were entered and stored in the data storage cabinets.

2.5 Data collection procedures - steps in preparation and data collection

Team of 36 research assistants was recruited to participate in this study. Data collection team consisted of staff from participating organization as a measure of strengthening internal capacities for research. The teams of data collectors were trained for one week on research methods, community entry, interviewing techniques and confidentiality. The team also reviewed each data collection tool questioned by question to adapt it to the local cultural settings. The CSA team which trained the data collectors moderated the discussion to maintain comparability f the tool with other countries. As the partners had agreed in the planning workshop, the KAP survey tools were translated in Kiswahili for ease of understanding of the target populations particularly rural out of school groups. The translation of the tools also enhanced the data collectors understanding of the questions.

On the fourth day of data collector's training, the team pre-tested all the tools. After pretest, there was debriefing session where each interviewer reported back on the experience administering the tool, challenges' faced, difficulties questions in understanding and how they resolved challenges. The group discussed the pretest experience and agreed to adopt a common approach addressing the challenges that are likely to emerge from the field based on experience from the pretest.

2.6 Data entry, cleaning and analysis

Data entry clerks were selected from a pool of data clerks that CSA has. They were given a two days training on how to enter data for various tools that were used during data collection. The questionnaires were coded after data collection by the data entry clerks, with each region being given a separate code to enable easy identification of the questionnaires per region. The data was entered using EpiData 3.0 software and after entry the data was merged then exported to SPSS 15.0 for analysis. The lead consultant in consultation with CSA staff conducted data cleaning by running the frequencies and reviewing errors/invalid entries. All the missing data was coded as 9, for single digit response and 99 for double digit response.

The data was analyzed using SPSS to generate frequencies and obtain mean scores, comparing data and significant findings of various variables. On the Likert scale data, the most desirable answer was assigned the highest scorer according to the Likert scale while the least desirable answer was assigned the lowest score. This necessitated reversing and recoding of some of the variables to assign them new value codes for analysis.

2.7 Strengths and limitations of the baseline study

The study was conducted in collaboration with partners in areas where they will implement the UFBR program. This helped the respective partners to already make initial contact with key stakeholders in their respective districts or provinces. The SRHR alliance partners strongly supported the baseline study allowing for smooth coordination and timely completion of data collection.

The logistics arrangements where organizations were providing staff and other logistical support made it easier for CSA to conduct studies in areas where they do not have presence. The KAP survey for young people had to be conducted in two phases due to school holidays, this made the study take a longer time and it was not easy for organizations to commit staff for this study at the expense of other scheduled activities.

Getting service statistics at public health facilities was a challenge given the bureaucracy involved. In Nairobi, the study had to secure additional authorization to be able to access the city council heath facilities. This delayed data collection from sampled health facilities increasing cost for both the permits and data collections. Records for various commodities were not well kept and this made it difficult to calculate number of people accessing services. In some facilities they have condom dispensers and there are no records of the number of condoms distributed in a particular given period.

Translation to Swahili used vocabulary not commonly used by young people and at times posed challenges in understanding. In some schools the teachers did not allow the study team to proceed with data collection after reading the Swahili translation due to difficulties in interpretation. The data collection tools for health facilities, namely the quality of maternal health, YFS standards and availability of supplies, should be adapted in line Ministry of Health data capture tools. This will facilitate ease of collect data from existing ministry records; reduce confusions of which records should be reviewed and save time. The training of data clerks was very critical in enabling the data clerks to follow study procedures, collecting quality data, and accomplish their work within the set time frame.

3.0 BASELINE RESULTS

This chapter presents some of the findings from the baseline survey per indicator. It should be noted that not all indicators from the result chain (logframe) are included particularly those with a 'zero' baseline value

Background characteristics of baseline study respondents

i. KAP out of school young people

A knowledge, attitude and practice (KAP) household survey was conducted in the four regions to provide baseline information as basis for impact measurement and to inform the refinement of appropriate intervention strategies for the UFBR program. A total of 1033 young people aged 10-24 years; over half of them living in rural areas were interviewed in this study. About 13% of young people aged 10-24 years old reported to married. The table below shows the distribution of in and out of school respondents by their background characteristics. The data shows that most of young people 10-24 years are not married though in rural areas the proportion of married adolescents tends to rise.

Table 4: Distribution of in and out of school young people by their background characteristics

Background characteristic		**10-14**	**15-19**	**20-24**	**Missing**	**Total**
Age group (KAP young people)	Boys	142(13.7%)	284(27.5%)	151(14.6%)		577(55.9%)
	Girls	150(14.5%)	266(25.8%)	40(3.9%)		456(44.1%)
Place of Residence (KAP young people)	Rural	242(23.5%)	231(22.4%)	81(7.9%)	0(0%)	554(53.8%)
	Urban	46(4.6%)	317(30.8%)	106(10.3%)	4(0.4%)	473(46.1)
	I don't know	0(0%)	1(0.1%)	1(0.1%)	1(0.1%)	3(0.3%)
	Missing	2(0.2%)	1(0.1%)	2(0.2%)	0(0%)	5(0.5%)
Schooling status and highest levels reached	In-school	174(24.6%)	475(67.1%)	55(5.3%)	4(0.6%)	708(68.4%)
	No-formal-education	23(2.2%)	4(0.4%)	8(0.8%)	0	35(3.4%)
	Primary-school	87(8.4%)	32(3.1%)	30(2.9%)	0	149(14.4%)
	Secondary-school	3(0.3%)	31(3.0%)	67(6.5%)	3(0.3%)	104(10.0%)
	College/university	0(0%)	5(0.5%)	24(2.3%)	0(0%)	29(2.8%)
	Vocational-training	0(0%)	2(0.2%)	3(0.3%)	0	5(0.5%)
	Missing	4(0.4%)	0(0%)	0(0%)	0(0%)	4(0.4%)
Marital status (KAP young people)	Married	6(0.6%)	17(1.7%)	31(3.0%)		54(5.2%)
	Unmarried	275(26.7%)	520(50.2%)	154(14.9%)		949(91.9%)
	Missing	11(1.1%)	13(1.3%)	6(0.6%)		30(2.9%)

ii. KAP women

This study surveyed women in the reproductive health category of 15-49 to determine their SRHR knowledge, attitude and practices including health seeking behaviour. The distribution of respondent across the three age categories for this group was almost the same as shown in table 5 below. As expected, baseline study results show increase in the proportion of those reporting to be married by age. Nearly half (49.4%) of women aged 15-49 who participated in this study had received at least primary school education. Educational attainment is associated with better health outcomes. The KAP women survey was conducted in largely rural districts of Mumias and Loitokitok. Any intervention that addresses sexual and reproductive health and rights issues in

these regions need to be alive to the possible impact from different social-cultural factors such as cultural values and interpretation of circumcision and importance of marriage which might lead to early marriages among girls.

Table 5 Distribution of women and their background characteristics

Background characteristic		15-19	20-24	25-49	Missing	Total
Age group (KAP Women)	15-19	237				
	20-24		244			
	25-49			245		
	Missing				5	
Region	Western	120 (50.6%)	122 (50%)	123 (50.2%)	2 (40%)	367 (50.2%)
	Central	117 (49.4%)	122 (50%)	122 (49.8%)	3 (60%)	364 (49.8%)
Place of Residence (KAP Women)	Rural	226(95.4%)	226(92.6%)	211(86.1%)	5(100%)	668(91.4%)
	Urban	10(4.2%)	18(7.4%)	33(13.5%)	0(0%)	61(8.3%)
	Missing	1(0.4%)	0(0%)	1(0.4%)	0(0%)	2(0.3%)
Educational attainment	No-formal-education	19 (8.1%)	25 (10.3%)	33 (13.5%)	0 (0%)	77 (10.6%)
	Primary-school	147 (62.8%)	106 (43.6%)	104 (42.5%)	2 (40%)	359 (49.4%)
	Secondary-school	63 (26.9%)	100 (41.2%)	70 (28.6%)	3 (60%)	236 (32.5%)
	College/university	2 (0.9%)	11 (4.5%)	36 (14.7%)	0 (0%)	49 (6.7%)
	Vocational-training	2 (0.9%)	0 (0%)	1 (0.4%)	0 (0%)	3 (0.4%)
	Missing	1 (0.4%)	1 (0.4%)	1 (0.4%)	0 (0%)	3 (0.4%)
Marital status (KAP Women)	Married	110 (46.4%)	122 (50%)	128 (52.2%)	4 (80%)	364 (49.8%)
	Unmarried	126 (53.2%)	122 (50%)	116 (47.4%)	1 (20%)	365 (50.0%)
	Missing	1 (0.4%)	0 (0%)	1 (0.4%)	0 (0%)	2 (0.3%)

3.3 Findings on different thematic areas

The 2011 UFBR baseline study covered a range of topics among both young people and women. These thematic areas are being addressed by the interventions implemented by the ASRH alliance partners in the program districts. This study covered the following areas:

i. Knowledge about HIV/AIDS,
ii. Knowledge about contraception,
iii. SRHR related attitudes,
iv. Use of condoms and other contraceptives,
v. Experience with non-consensual sex, and
vi. Perceived social norms on sexuality (for young people only)

i. Knowledge about HIV/AIDS

Previous national studies in Kenya have shown that awareness of HIV/AIDS in near universal. The latest KDHS puts it at 99% of women and 100% of men who have ever heard of HIV/AIDS.[2] The UFBR baseline study investigated the HIV/AIDS knowledge levels among respondents (young people and women) through seven questions:

a) Can HIV infection be prevented?
b) Can HIV infection be transmitted by sharing food with someone who is infected?
c) Can HIV infection be transmitted by kissing with someone who is HIV infected?
d) Can HIV infection be prevented by being faithful to an uninfected partner?
e) Can HIV infection be prevented by using a condom when having sexual intercourse with someone who is HIV infected?
f) Is it possible for a healthy-looking person to have the HIV virus?
g) Can people get the HIV virus because of witchcraft or other supernatural means?

Findings suggest that younger adolescents aged 10-14 had lower knowledge levels on key HIV/AIDS questions in the survey compared to the older ones. Knowledge levels for older adolescents aged 15 years and above stabilize between 5.5 and 5.8.

[2] Kenya National Bureau of Statistics (KNBS), Ministry of Health (MOH) and ORC Macro, 2010. Kenya Demographic and Health Survey 2008-9. Calverton, Maryland.

Table 6: Mean score on Knowledge on HIV transmission and prevention

Age and marital status	Mean score (out of 7 questions asked)	Significance value
Girls 10-14	4.0	0.000
Girls 15-19	5.7	0.051
Girls 20-24	5.8	0.049
Boys 10-14	4.0	0.001
Boys 15-19	5.6	0.512
Boys 20-24	5.8 Significant	0.000
Unmarried women 25+	5.7 not significant	0.759
Married women 25+	5.5 Significant	0.001
Total	5.6	

The table below relates to the questions on HIV knowledge among ins-school girls ages 10-14 years and their significance level.

Table 7: Significance level of knowledge on HIV transmission among in-school girls 10-14 years

Question	Significance (Pearson Chi-squire)
Can HIV infection be prevented?	0.000
Can HIV infection be transmitted by sharing food with someone who is infected?	0.003
Is it possible for a healthy-looking person to have the HIV virus?	0.000
Can people get the HIV virus because of witchcraft or other supernatural means?	0.000

For the out of school girls only the question, is it possible for a healthy-looking person to have the HIV virus? Was significant (0.002) which means that the knowledge levels for the girls out of school was low
Among older women aged 25years and above, the unmarried women reported higher scores compared to their married counterparts though the difference is not significant. The fact that married women are more likely to contract HIV was not related to their knowledge levels **Table** 8 below illustrates the mean scores.

Table 8: Mean scores on HIV/AIDS knowledge among young people (10-24 yrs) and women (25-49yrs)

Age and marital status	Mean score (out of 7 questions asked)
Girls 10-14	4.0
Girls 15-19	5.7
Girls 20-24	5.8
Boys 10-14	4.0
Boys 15-19	5.6
Boys 20-24	5.8
Unmarried women 25+	5.7
Married women 25+	5.5
Total	5.6

***** mean scores are based on correct answers to the seven knowledge questions

ii. Knowledge about contraception

Table 9: Knowledge on contraceptives among young people 10-24 years

Young people were asked which contraceptives they know regardless of if they have ever used any of the contraceptives indicatedContraceptive method	Proportion reporting knowledge among In-school adolescents			Proportion reporting knowledge among women and out of school adolescents							
	10-14	15-19	20-24	Girls 10-14	Girls 15-19	Girls 20-24	Boys 10-14	Boys 15-19	Boys 20-24	Unmarried women 25+	Married women 25+
I have never had sexual intercourse				71.7	54.6	41.0	73.1	36.1	12.5	18.4	1.1
Pill	43.9	67.8	68.6	60.0	95.0	91.9	40.5	61.8	67.7	80.3	84.0
IUD	5.2	14.1	11.8	7.5	40.00	40.5	13.9	20.0	34.4	19.4	21.3
Injectables / Depo-Provera	28.1	38.9	43.1	25.0	50.0	70.3	25.0	47.3	55.9	70.6	79.3
Diaphragm/foam tablets/jelly/cream	3.5	14.9	17.6	0.0	30.0	35.1	2.3	18.2	21.5	7.6	8.9
Male condom	75.4	90.9	98.0	87.5	100.0	94.6	100.0	96.4	98.9	89.7	89.0
Female condom	28..1	73.0	58.8	45.0	80.0	91.9	33.3	49.1	75.3	52.1	54.7
Norplant	0	8.7	13.7	15.0	45.0	40.5	13.9	21.8	26.9	34.7	38.5
Contraceptive (Unspecified)	0.2	9	1.1	5.0	5.0	2.7	0.0	12.7	3.2	6.6	8.8
Traditional method: (specify)	1.8	7.8	7.8	2.5	10.0	8.1	2.8	7.3	6.45	2.4	2.7
Non penetrative sex	3.5	22.1	13.7	5.0	30.0	32.4	2.8	14.6	30.1	8.8	4.4
Safe days/abstinence	8.8	35.6	37.2	15.0	50.0	46.0	13.9	45.5	49.5	27.7	33.1
Emergency contraception	8.8	33.7	31.4	10.0	55.0	89.2	2.7	23.6	35.5	25.9	19.8
Withdrawal	5.3	29.3	27.5	22.5	40.0	54.1	16.7	36.4	57.0	18.8	14.8

The UFBR baseline findings show lower knowledge levels about contraceptives among young adolescents aged 10-14 compared to the older groups. This could be attributed to limited exposure to contraceptive information given that the majority are not sexually active. Over three quarters of younger adolescents 10-14 (both boys and girls) have never had sexual intercourse.

Knowledge levels on the condom and pills are very high compared to other contraceptives. Injectables are more known by women than men especially the married women who prefer to use injectables, results comparable with the latest KDHS. These findings seem to be corroborated by the qualitative data on the restrictive school environment. The Ministry of Education is very clear that young people in primary and secondary schools are not supposed to be taught about condoms.

iii. Rights-based sexuality attitudes

Respondents in this survey were asked rights based questions on sexuality to establish their attitude and perceptions levels. Specifically, respondents were asked if they agree or disagree with statements which were

read to them by the interviewers. The SRHR alliance considers statements that agree with sexual rights to be endorsing (in agreement with; in the direction of) the concept to be measured (i.e. rights-based sexuality attitudes). The following statements were readout to both young people and women in this study:

1. Do you think that if someone dresses sexy, the person wants to have sex?
2. Do you think its okay for someone to use some force or pressure if his/her lover refuses to have sex?
3. Do you think that if someone is sexually excited and wants sex, his/her lover is allowed to refuse?
4. Do you agree with the following statement: A girl should be a virgin at marriage, therefore she does not need any information about sexuality

The analysis shows gender differentials in right based sexuality attitudes with girls and women having more favourable attitudes than boys. Both boys and girls in age group 10-14 years had lower average score of between 2.2 for boys and 2.4 for girls out of a possible 4. This shows that at younger ages young people do not have adequate knowledge on rights issues or tend to follow what is perceived to be socially acceptable. Generally boys scored lower on rights issues than girls. Being strongly patriarchal societies, most violence is perpetrated by boys and men. In some communities such as the Maasai in Loitokitok, boys who are circumcised are allowed to have sex without consent of the girls.

Table 10: Right based sexuality attitude

Statement	Boys (Yes)	Girls (Yes)
Do you think that if someone dresses sexy, the person wants to have sex?	26.7% ***	9.3% ***
Do you think its okay for someone to use some force or pressure if his/her lover refuses to have sex?	6.3%*	3.0%*
Do you think that if someone is sexually excited and wants sex, his/her lover is allowed to refuse?	33.5%**	18.3%**
Do you agree with the following statement: A girl should be a virgin at marriage, therefore she does not need any information about sexuality	12.9%*	6.6%

*** P>0.000, **P>0.001, * P<0.005(not significant)

There were significant differences in attitudes between boys and girls as shown by the above P values meaning that boys had more negative attitudes in regard to dress, use of force in sexual relations and virginity. These attitudes are reinforced by FGD results showing that culturally boys have been socialised to believe that they should not be denied sex when they want especially after circumcision. Specific educational efforts aimed at changing these attitudes need to be directed to the boys.

Table 11: mean scores by age and gender on Rights-based sexuality attitudes

	Mean score
Girls 10-14	2.4
Girls 15-19	**3.3**
Girls 20-24	**3.5**
Boys 10-14	**2.2**
Boys 15-19	**2.7**
Boys 20-24	**3.1**
Unmarried women 25+	**3.1**
Married women 25+	**3.0**
Total	**2.9**

iii. Use of condoms and other contraceptives

The table blow shows baseline findings on contraceptive use among young people and women. It's clear that married respondents are more likely to use long-term contraceptive methods than their unmarried counterparts.

The most utilized contraceptive method among unmarried youth is the condom. On the other hand, injectables seem more popular among married women over the age of 25years.

Table 12 Proportions of in and out of schools youth reporting use of contraceptive method (KAP young people)

Contraceptive method	In-school			Out of school x%							
	10-14	15-19	20-24	Girls 10-14	Girls 15-19	Girls 20-24	Boys 10-14	Boys 15-19	Boys 20-25	Unmarried women 25+	Married women 25+
Never had sexual intercourse	77.1	73.6	32.1	64.3	40.0	51.4	56.8	29.1	11.8	3.5	1.7
Pill	1.9	5.2	9.4	7.3	10.0	16.2	5.6	3.6	11.8	28.4	32.6
IUD	0	0.5	0	0.0	0.0	0.0	0.0	0.0	3.2	2.5	2.8
Injectables / Depo-Provera	0.9	1.3	1.9	4.8	0.0	2.7	0.0	0.0	1.1	24.5	30.0
Diaphragm/foam tablets/jelly/cream	0	0	0.9	0	0	0	0	0	1.1	1.3	1.1
Male condom	3.9	21.7	47.2	16.7	25.0	37.8	24.3	52.7	74.2	54.4	46.4
Female condom	0.9	5.4	15.1	4.8	15.0	8.1	2.7	1.8	4.3	19.2	18.1
Norplant	0	0.2	1.9	0.0	0.0	0.0	2.7	0.0	0.0	5.0	6.9
Contraceptive (Unspecified)	17.5	73.8	8.8	0.0	0.0	0.0	2.7	3.6	1.1	3.5	3.9
Traditional method: (specify):	0	0.4	1.9				0.0	0.0	0.0	0.0	50.0
Non penetrative sex	0	0.4	3.7	0.0	5.0	2.7	0.0	1.8	4.3	1.6	0.6
Safe days/abstinence	0.9	4.3	11.3	2.4	5.0	5.4	2.7	5.5	8.6	12.0	13.3
Emergency contraception	0	2.7	9.4	2.4	5.0	21.6	2.7	7.3	8.6	9.5	7.5
Withdrawal	0.9	3.4	18.8	7.1	10.0	8.1	2.7	14.6	18.3	3.8	3.6

On condom use boys reported more than girls, this is because of the perception by women that condoms are used by men only thus even if their partner used a condom they will not report. The report also takes cognisance that young men over report on sexual issues while younger women and girls under report.

A separate question was asked specifically if they have ever used a condom to those who reported ever having sex, the results are shown below

Table 13 Reported male condom use by young people and women, in percentages

Target group	Condom use, in %
Girls 10-14	21.4
Girls 15-19	35.0
Girls 20-24	37.8
Boys 10-14	24.3
Boys 15-19	52.7
Boys 20-24	74.2
Unmarried women 25+	56
Married women 25	48.1

iv. Experience with non-consensual sex

All respondents in this study were asked if they had ever been forced to have sex when they did not want to. The table below shows the proportion of respondents reporting non consensual sex

Table 14 Proportions of respondents reporting non-consensual sex

Target group	Reported non-consensual sex, in %
Girls 10-14	32.0
Girls 15-19	27.3
Girls 20-24	20.0
Boys 10-14	15.0
Boys 15-19	12.2
Boys 20-24	14.6

Unmarried women 25+	12.7
Married women 25	14.3

The results show clear gender differences with girls more likely to have ever been forced to have sex when they did not want to than boys. Although lower than the girls, the proportions of boys who reported ever being forced to have sex were still high especially among young boys 10-14 years. The proportions reporting non-consensual sex are thrice as higher than the national average of about 8.5% as reported in the 2009-10 Kenya Demographic Health Survey. The proportions among older women of 25 years and above reporting non consensual sex are lower and about 13%and 14% for unmarried and married women aged 25years and above respectively compared to younger women. At older age for women the proportions of non consensual sex are comparable to national statistics of women being forced in having sex at about 14% and 15% of women aged 20-19 and 30-39 respectively reported ever being forced to have sex when they did not want.[3]

3.9 Perceived social norms on sexuality

The survey investigated perceptions of young people on social norms and sexuality by asking the following questions:

1. Is it acceptable in your community for young people to have sex when they are not married? Yes=rights-based=2
2. Is it acceptable in your community to use a condom if you are not married? Yes=rights-based=2
3. (Is it acceptable married people in your community to use a condom?) Yes=rights-based=2

The analysis that marital status for women aged 25years and above does not seem to have any effect on perception of whether the community accepts young people to have premarital sex as shown in the table below.

Table 15 Proportions of young people reporting perception on sexuality issues

% of respondents giving rights-based answers	Question 1 (Is it acceptable in your community for young people to have sex when they are not married?)	Question 2 (Is it acceptable in your community to use a condom if you are not married?)	Question 3 (Is it acceptable married people in your community to use a condom?)	Average %
Girls 10-14	7.8	21.0	56.5	28.4
Girls 15-19	1.7	70.8	83.3	51.4
Girls 20-24	24.4	82.9	77.5	61.6
Boys 10-14	13.0	32.1	50.0	31.7
Boys 15-19	18.0	71.7	62.3	50.7
Boys 20-24	23.2	72.7	69.7	55.2
Married women 25+	34.4	72.3	71.4	59.4
Unmarried women 25+	34.8	67.7	69.6	57.5
Total mean	16.6	57.7	64.5	46.3

In the study majority of the population sampled indicated that young people should abstain until marriage. Similar findings emerged from the qualitative assessment with the argument that the having sex before marriage is unacceptable especially for young girls below 18 years in the communities Data also shows that condom use is less popular among younger people 10-14 years probably due to the majority among this age group are yet to initiate sexual activity.

Condom use for older adolescents (15years and above) seems to gain approval and support. The qualitative data showed that girls should decide on condom use since they are the ones at the risk of pregnancy..

[3] Kenya National Bureau of Statistics (KNBS), Ministry of Health (MOH) and ORC Macro, 2010. Kenya Demographic and Health Survey 2008-9. Calverton, Maryland.

3.10 Checklist for youth friendly services

Provision of youth friendly services is one of the intervention targets for the UFBR program. This study investigated the standards of youth friendly services at heath facilities in participating regions in Kenya. These standards were measure against the IPPF benchmarks for youth friendly services. The UFBR program hopes to achieve compliance with IPPF standards for all youth friendly services offered under the program

Table 16 Scores on issues of youth friendliness of health facilities in Kenya

Questions / Name Of The Clinic	Training of the service provider	Provider confidence	Privacy	Opening hours	Accessibility	Affordability	Referral	Community and parental support	Sum score per health facility	Mean score is:
Bahati Health Centre	2	2	4	4	2	3	4	4	25	25/8= 3.1
Bamburi Health C	3	3	4	1	2	3	4	4	24	3.0
Elwasambi Dispensary	2	2	1	1	2	4	4	1	17	2.1
Entarara Health	3	3	3	4	2	4	4	4	27	3.4
Iltilal Dispensary	3	3	1	2	1	4	2	3	17	2.1
Loitokitok Distr	3	3	4	4	2	4	4	4	28	3.5
Lusheya Health C	1	3	2	2	2	4	4	2	20	2.5
Makunga R.D.H.C.	1	1	1	2	2	4	4	4	19	2.4
Malaha Dispensary	3	3	2	1	2	4	4	2	21	2.6
Mariakani	3	3	3	2	2	3	4	4	24	3
Miritini Health	1	4	4	1	2	4	4	4	20	2.5
Mung'ang'a Dispensary	2	3	3	2	2	4	4	4	24	3
Mwakirunge Health	4	4	4	4	2	4	3	4	29	3.6
Nyaporo Dispensary	1	2	3	2	2	2	2	2	16	2
Ribe Dispensary	2	3	4	2	2	3	4	4	24	3
S.O.S.	3	4	4	3	2	4	4	4	28	3.5
Shimo La Tewa Di	2	2	4	2	2	4	3	4	20	2.5
Special Treatment Centre	3	3	4	2	2	4	4	1	23	2.7
St. Lukes Mission	3	3	4	2	.1	3	4	4	17	2.1
Tudor District H	3	3	3	3	2	4	1	4	23	2.7
Utunge Health Facility	1	1	4	3	2	3	4	4	22	2.7
Mathare North Hc	1	4	1	2	2	4	2	4	20	2.5
Eastliegh PH	3	3	1	2	2	4	2	4	21	2.6
Biafra Disp	2	2	4	2	2	4	3	3	22	2.7
Special Treatment Clinic	2	4	4	1	2	4	4	4	25	3.1
Namelok	2	3	3	2	2	3	3	2	20	2.5
St. Michael	3	4	3	3	2	4	4	4	27	3.4
All Facilities	2.3	2.9	3.0	2.3	2.0	3.7	3.4	3.4	22.3	2.8

***Score of 1 is the lowest. Scores of 4 is the highest**

Findings show that the total score for facilities ranged from 17-29 out of possible 30 the average score was 22.3 for all the facilities, This shows that facilities are considering youth friendliness in line with government health sector strategy. There remains room for improving youth friendly services at these facilities. Mwakirunge health centre in Mombasa and Loitokitok district hospital were the best facilities that embraced youth friendliness. Elwasambi in Mumias and St. Luke Mission hospital in Kilifi were the lowest scorers in terms of their youth friendliness. The mean score for all health facilities that participated in the study was above average at 2.8. The table below illustrates facility scores on each on ten IPPF stand ads for youth friendly service provision.

Table 17 Mean score on youth friendliness for all clinics in Kenya

Mean score for all clinics together in Kenya	2.8
Range of the score (give the lowest individual mean score and the highest)	2.0-3.6

Text box 1 Suggested topics for YFS by youth Young people participating in the exit interviews

1. **Training** on how to deal with young people, communication skills, peer education, OVC mentorship, Provider initiated testing and counseling and integrating YFS within other services at health facilities
2. **Structural changes to ensure privacy is observed during consultations**
   - using youth VCT room
   - have three consultation rooms which are private and confidential
   - There is luck of infrastructure but ensure privacy by locking the door.
   - Special rooms for young people to assure privacy and confidentiality
3. **Opening hours- Flexible opening hours to cater for young people**
   - They want to come in the evening
   - Open on all working days and sometimes weekends
   - School health department caters for all schools in the city.
   - during lunch time and at/after 5.00pm
   - Opening days be also on weekends since youth are in schools
4. **Accessibility.**
   - Not all services offered especially in level one facilities
   - The service is accessible, available and free.
   - But only STI screening, family planning is not offered in mission hospital.
   - need to involve unmarried young people
   - Lower level facilities need laboratory for proper screening
   - Make services affordable for young people

3.11 Satisfaction with SRHR services from Exit interviews

Increased satisfaction with services is one of the key indicators in the UFBR program. The baseline study asked exit clients at health facilities about their satisfaction levels with services received at heath with the lowest score in satisfaction at 1 and the highest at 4. The table below shows mean scores on satisfaction levels per service received by the target groups. Most of the respondents in the study reported satisfaction with the services offered at various facilities. Most facilities in this study were public facilities run by the government and local authorities.

Table 18: Mean score on satisfaction with SRHR services of married and unmarried young people for all clinics and health facilities in Kenya

	Unmarried girls		**Unmarried boys**		**Married girls**		**Married boys**	
Satisfaction with:	**15-19**	**20-24**	**15-19**	**20-24**	**15-19**	**20-24**	**15-19**	**20-24**
Information received	3	2.9	2.8	2.9	2.9	3	3	3
Medical treatment received	3	3.1	2.8	2.9	3	3.3	3	2.9
Level of skills of service provider	3	3.1	2.9	3	2.9	3.2	3	3.1
Opening hours	2.5	2.8	2.7	2.6	2.9	2.9	3	2.8
Waiting time	2.4	2.5	2.3	2.5	2.5	2.7	3	2.2
Price	3.9	3.2	3.1	3.2	3.1	3.4	3	2.6
Privacy and confidentiality	2.9	3.1	2.9	3	2.7	3.3	3	2.8
Treatment as a person	2.8	2.9	3	3	3.1	3.1	3	3
Time for the consultation	2.9	2.9	2.9	3	3.1	3.5	3	2.6
Will return or not	3	2.9	3	2.9	3.2	3.4	3	2.8
Mean satisfaction	**2.94**	**2.94**	**2.84**	**2.90**	**2.94**	**3.18**	**3.0**	**2.78**

Table 19 Mean score on satisfaction with SRHR services for young people aged 10-24 in Kenya

Mean score for all clinics together in Kenya	2.82
Range of the score (give the lowest individual mean score and the highest)	2.36 – 3.39

Table 19 below on utilization of services shows that high utilization on treatment for other illness. Among the females, uptake of maternal health service, family planning advice and contraceptive methods were reportedly to be highly used. Among the males, VCT, contraceptive uptake and STI testing and treatment followed in that order

Table 20 Actual demand of services given by respondents in exit interviews at clinics and health facilities, for girls and boys

Female			Male		
Demand priority	Service	Number of clients	Demand priority	Service	Number of clients
1	Treatment of other illnesses	72	1	Treatment of other illnesses	93
2	Maternal Services	44	2	VCT	13
3	FP advice	21	3	Contraceptives	7
4	Contraceptives	15	4	STI testing or treatment	7
5	Delivery	4	5	Maternal Services	3
6	VCT	3	6	FP advice	2
7	STI testing or treatment	2	7	Delivery	1
8	Counseling for sexual, physical or emotional violence	1	8	Counseling for sexual, physical or emotional violence	1

Text box 2. Young exit Clients comments on improvement of services

14. What suggestions can you make to improve this health facility and the services provided?

- Expand facility -Create an in-patient wing, maternity wing
- They should employ workers to clean the compound
- They should keep the time because we have families behind, like I came in the morning at 9.00am and I was served at 2.00pm
- Increase supply of medicines, the medication should be there promptly and not when you come there is no vaccination medicine
- The facility should provide a waiting bay
- Opening hours should be 24 hours including weekends and public holidays
- Please supply doctors on night shift
- Don't sell syringe
- They should improve on the laboratory services because I am not satisfied with them
- Staff to be social and not to discriminate(2)
- Build resource centre for youths on sexual reproductive health
- The weighing machine should be more than one type to reduce the risk of children falling from the current one

15. Was there anything in particular that you liked about the health facility?

- The staff are good, welcoming and not rude(4)
- Yes, more neat room, the buildings are good
- Enough water supply
- They try to be fast despite the workload
- Reception of nurses was good, some doctors are good to me
- Yes, their treatment and service is good to me
- The staff are good, they listen to you and give you answers without discrimination
- The services are satisfactory
- The ante-natal care is fast and the nurse advice you on anything you ask
- The services are free at the facility
- I was happy to see visitors
- When medicine are in stock they dispense properly

16. Was there anything in particular that you disliked about the health facility?

- Waiting hours are long
- Antenatal Clinic patients were not promptly served with a doctor but by a student nurse
- Waste of time. They do not treat patients well, sometimes they quarrel us
- The staff were slow
- They only give me Panadol; I am a poor lady ,where do I get money for medicines
- Every time you bring the baby for ante-natal care you are attended to by different staff
- The nurse gave me an incomplete service so I don't know what to do next
- When I came in the nurses treated me rudely and told me to go to another hospital

Comments generated from individual clients from different facilities hence providing varying perceptions. However the young clients have provided suggestions for improvement including facility expansion, proper time management, reduction of waiting hours and ensuring availability of drugs and other medical supplies.

Targeted maternal health services increase their compliance to the national quality standard

The average score for quality of maternal health was 21 with scores ranging from 7 to 30, facilities such as Utange do not offer any maternal health care and do not have CBHWs attached to it. The total possible score was 32 in each row while in each category the maximum score is 4. The scoring was based on 8 issues that are

represented in the first row thus to compute the mean score each facility's total score was divided by eight. The table below shows maternal health services provided and the mean scores:

Table 21: Quality of maternal health per facility

Name of facility	CBHMIS	CHW refer to ANC	TBA refer to ANC	CHW refer to delivery	TBA refer to delivery	MCH competent to conduct safe deliveries	MCH competent to conduct PAC services	MCH competent to conduct FP services	Mean quality
Bahati Health Centre	3	4	1	4	.	4	4	2	2.8
Bamburi Health C	3	3	2	1	1	4	4	1	2.4
Eastliegh	4	4	1	4	1	4	4	4	3.3
Elwasambi Dispensary	4	3	1	3	1	3	3	2	2.5
Entarara Dispens	4	4	3	4	3	4	4	4	3.8
Iltilal Dispensary	1	2	2	2	2	4	4	3	2.5
Kimana	2	2	2	4	1	3	3	3	2.5
Loitokitok Distr	.	.	2	4	2	4	4	4	2.5
Lusheya H.C.	1	4	1	2	1	4	4	1	2.2
Makunga R.D.H.C.	3	4	3	3	1	4	2	2	2.8
Malaha H.C.	4	3	2	1	1	4	3	2	2.5
Mariakani	4	4	1	4	2	4	4	3	3.3
Mathare North He	3	3	1	3	1	4	4	3	2.8
SOS	1	2	1	3	1	3	4	3	2.2
Biafra HC	1	4	2	4	2	3	3	2	2.6
Kombeni HC	2	4	4	4	3	4	3	3	3.4
St. Michael	2	4	3	3	3	4	4	4	3.4
Rabai HC	2	4	1	4	2	4	.	4	2.6
Miritini Health	4	4	1	.	.	.	4	.	1.6
Mung'ang'a H.C.	4	3	3	2	2	4	4	3	3.1
Mwakirunge Health Centre	4	4	1	3	1	4	4	4	3.1
Nyaporo Dispensary	1	3	2	3	1	4	4	4	2.8
Ribe Dispensary	2	4	3	4	3	4	4	4	3.5
Shimo La Tewa Di	3	4	1	4	2	4	4	.	2.8
Special Treatment Centre	1	1	1	1	1	4	4	4	2.1
St. Lukes Mission	2	2	2	2	2	3	.	.	1.6
Tudor District H	4	2	2	2	2	4	4	4	3.0
Utunge Health Centre	3	3	1	.	.	.	.	.	0.9
Isinet	4	4	1	4	1	4	4	3	3.2
Namelok	3	3	1	3	1	4	4	4	2.9
Total	2.7	3.3	1.8	3	1.7	3.8	3.7	3.0	2.2

Table 22: Mean score on quality of maternal health services in Kenya

Mean score for all clinics together in [country]	2.2
Range of the score (give the lowest individual mean score and the highest)	0.9 – 3.8

The best performing facility was Entarara in Loitokitok with a mean score of 3.8 out ot the possible 4, while the least was Utange Health Center which does not offer maternal health services. The mean of all targeted facilities was 2.2 implying that opportunities exist for improving maternal health services provision in the targeted facilities.

Under the community strategy the government is trying to use CBHW to reach out to the community and also encourage women to seek maternal health care from certified facilities within the community. In most of the facilities in rural areas such as Loitokitok, Mumias and Kaloleni in the Coast CBHWs use referral slips to send clients to health facilities for services.

Text Box 3 Quality of maternal health services

QUALITY OF MATERNAL HEALTH SERVICES

1. Functioning community
- Newly trained CHW under community strategy
- They have not been provided E tools
- It is not fully functioning in the communities
- Its just been introduced not yet fully functioning (2)

2. CHW'S reference for ANC
    - They refer and the clients leave a copy at the facility
    - They are trained and also refer the clients to the hospital
    - They refer

3. TBA's reference for ANC
- The women are transferred
- Only clients who have had prolonged labour pains
- Only during problems when delivering
- Lack of knowledge

4. CHW'S reference for delivery
- There has been problems delivering at home so they prefer going to the hospital
- Clients with prolonged labour pains
- Not always since not always open on weekends

Increase in the number of women satisfied with SRHR services

Most services utilized by women in the study were treatment of other illnesses, maternal health services and family planning advice. In annex C a table can be found to report on the type of services the respondents came to the clinic or health facility for.

Firstly report on each clinic for each question. There is a table in Annex C.

Secondly report on the mean satisfaction of women for all clinics and the range of scores.

Table 23: Actual demand of services given by female respondents (aged 25+) in exit interviews at clinics and health facilities

Demand priority	Service	Number of clients
1	Treatment of other illnesses	27
2	Maternal services	15
3	FP advice	10
4	Contraceptives	4
5	Delivery	4
6	VCT	2
7	Counseling for sexual, physical or emotional violence	2
8	STI testing or treatment	1

Table 24: Mean score on satisfaction of women aged 25+ with SRHR services in Kenya

Name clinic/health facility	Mean score on satisfaction of women 25+
Elwasambi Dispensary	2.6
Entarara Dispens	2.9
Kimana health centre	2.5
Loitokitok District hospital	2.6
Lusheya H.C.	2.53
Makunga R.D.H.C.	2.4
Malaha H.C.	2.6
Namelok Dispensary	3.0
Isinet Dispensary	3.1
Mung'ang'a H.C.	2.8
Nyaporo Dispensary	2.7
Iltilal	2.6
All Facilities	2.7

Table 25: Total mean score and range of quality of maternal health

Mean score for all clinics together in [Kenya]	2.7
Range of the score (give the lowest individual mean score and the highest)	2.4 – 3.1

Most women in the exit interviews were satisfied with the services that were being offered in the facilities visited. The only problem was on the dispensary side which do not open on weekends and during weekdays they close as early as 3pm making it difficult for them to access the services. This was especially visible in Loitokitok where the distance to health facilities was in the range of 5km on average. The women also raised concerns on inadequate number of service providers in the facilities sampled for the study.
Women were satisfied with the services provided though on quality of maternal health according to service providers were low; the mean score for quality was at 21.3 compared to cumulative satisfaction of women at 30.1 out of a maximum of 40. Entarara health centre which had the highest score on quality of maternal health also scored high on satisfaction by women.

Table 26 Mean scores on quality of maternal health services by women per facility

Name clinic/health facility	Mean score on quality of maternal health	facility	Mean score on satisfaction of women 25+
Bahati Health Centre	2.8	Bahati Hc	
Bamburi Health C	2.4	Bamburi Hc	
Eastliegh	3.3	Eastliegh	
Elwasambi Dispensary	2.5	Elwasambi Disp	2.6
Entarara Dispensary	3.8	Entarara Disp	2.9
Iltilal Dispensary	2.5	Iltilal	2.6
Kimana	2.5	Kimana H C	2.5
Loitokitok Distr	2.5	Loitokitok Dh	2.6
Lusheya H.C.	2.2	Lusheya Hc	2.53
Makunga R.D.H.C.	2.8	Makunga Rdhc	2.4
Malaha H.C.	2.5	Malaha Hc	2.6
Mariakani District Hospital	3.3	Mariakani	
Mathare North He	2.8	Mathare North	
Biafra	2.6	Biafra	
SoS HC	2.2	SoS HC	
Kombeni HC	3.4		
St Michael	3.4		
Rabai HC	2.6		
Miritini Health	1.6	Miritini Hc	
Mung'ang'a H.C.	3.1	Mung'ang'a Disp	2.8
Mwakirunge Health Centre	3.1	Mwakirunge Hc	
Nyaporo Dispensary	2.8	Nyaporo Disp	2.7
Ribe Dispensary	3.5	Ribe Disp	
Shimo La Tewa Di	2.8	Shimo La Tewa	
Special Treatment Centre	2.1	Special Treatment	
St. Lukes Mission	1.6	St. Luke	
Tudor District H	3.0	Tudor Dist H	
Utunge Health Centre	0.9	Utange Hc	
Isinet	3.2	Isinet Disp	3.1
Namelok	2.9	Namelok Hc	2.9
All Facilities	2.2	All Facilities	2.7

3.12 Service utilization

The UFBR program looks to increase the number of young people and women using SRHR services increase the number of births attended by a skilled birth attendant and increase number of women who have 1-4 antenatal check-ups. In this study, hospital records for the previous quarter to the survey (January-march 2011) were reviewed to establish the levels of uptake of these services.
The table below summarises consumption of various services. The tables below show that despite the high number of women reported to have received antenatal services, delivery by skilled attendant was very low among women across the ages. To assess in depth reasons for not being delivered by skilled attendance the research proposed that further qualitative data be collected.

Table 27. Service records for Kenya, for the January-March 2011 period: number of young people and adults using SRHR services, births attended by skilled birth attendants and antenatal check-ups, in numbers

Services	**Young people**						**Total number of young people**	**Range (lowest visitor number – highest visitor number)**	**Adults**		**Total number of adults**	**Range**
	Girls			**Boys**					**Women (24+)**	**Men (24+)**		
	10-14	15-19	20-24	10-14	15-19	20-24						
SRHR services (includes all services)	203	1526	5095	450	727	1785	9786		5329		5329	
Births attended by skilled birth attendant	1	223	687	n.a.	n.a.	n.a.	911	0 - 350	551	n.a.	551	0- 50
1-4 Antenatal check-ups	10	2462	2875	n.a.	n.a	n.a.	5347	0 - 2744	1599	n.a.	1599	0-234
Totals	**203**	**1526**	**5095**	**450**	**727**	**1785**	**9786**	**2964**	**5329**	**0**	**5329**	**1745**

[N = 30 clinics]

Commodity supplies

In order to ensure increased uptake of services, community and drug security at the health facilities require to be enhanced. The UFBR program in collaboration with the MOH seeks to support availability of contraceptives, ACT, ART, and antibiotics at the participating health facilities. The study investigated the supply levels for contraceptives and essential drugs at participating health facilities. Results suggest that contraceptive and dugs supply (ART and antibiotics) are averagely stable. Among all 28 health facilities in the study, half never experience any stock out s for contraceptives and ART. Only one facility reported perpetual stock outs of antibiotics. The table below shows commodity supply in 28 health facilities.

Table 28 out of stock problems for contraceptives, ACT, ART, and antibiotics, for all targeted clinics in Kenya in numbers

	Don't know	Never	Sometimes	Frequently	(Almost) always
Contraceptives	2	14	6	6	
ART	8	14	6		
ACT	6	8	8	4	3
Antibiotics	2	8	8	9	1

N = [28]

4.0 CONCLUSIONS AND RECOMMENDATIONS

1.1 Conclusions

Review of literature has confirmed that young people might poses the knowledge but behave differently. In the study knowledge and practice were different across all age categories. The gap between knowledge and practice may be attributed to the lack of skills on the part of youth to enable them put into practice what they have learnt for their own benefit. Information was collected in two rural areas where traditional beliefs are considered to be the guiding principles on family issues.

Adolescents report engaging in sexual activities at a very early stage as early as 10 years thus exposing themselves to risks associated with unprotected sex. Though the study showed that young people were sexually active, few those who are sexually active reported using any method of contraceptives. Condom was the most utilized contraceptive by the young people, though less than half of those who engaged in any sexual activity reported using the condoms..

During the survey getting the sample of young married adolescents without children was not easy, most of them get into marriage because of pregnancy and their parents cannot take them back to school. Most of the young people had engaged in sex before the age of 18 years. The dangers of unprotected sex are well known to the young people yet few youth take precautions. The survey confirms the early initiation of sexual activity among young people.

Younger adolescents do not have adequate knowledge and skills on sexuality related issues thus making them more vulnerable to adverse sexuality related outcomes. Most programs target older adolescents who have already had sexual experience thus the mitigation in most cases relate to protection using condoms and not delay in sexual debut.

Regarding access and utilization of services, although more women reported to have received antenatal services, delivery by skilled attendants was very low among women across the ages .

The prevalence of sexual violence especially among younger girls of 10-14 years in the study was very high with about one third of those in this age category reporting ever being forced to have sex. In recent times media have reported an increase in rape cases among young people.

In the community strategy that the government put in place dispensaries were the first level of treatment and prevention to ensure that people get essential commodities at the dispensaries that serve the local community. In the study most dispensaries did not have basic contraceptives such as pills or the frequency of stock out was higher compared to other levels. This contributes greatly to unmet needs of women in the said communities that the dispensaries serve.

Even though in most of the facilities visited the staff had some formal training on youth friendly services most of the providers do not apply such skills due to adequate space, supplies and the work load is overwhelming in some areas. Also the training was done long ago and the providers cannot deal with emerging issues on adolescent health and development.

Generally most women were satisfied with the services provided by the facilities visited and cost was not prohibitive to accessing services. In areas such as Loitokitok the distance to facilities was the major hindrance to services. Being a nomadic community most women could not rely on one facility for safe motherhood services. Thus it was not easy for the women to track ANC visits or be able to get adequate supplies.

1.2 Recommendations and implications for programme planning [2 p]

Linkages need to be created to improve access to comprehensive reproductive health services which should not just include clinical services but accurate information that will encourage young people to make responsible decisions. Current services are limited both in terms of scope and quality. Services such as VCT and PMTCT should be designed with youth clients in mind and their needs carefully included to ensure easy access. The survey findings also confirm the need for a programme that boldly looks at sexuality and related issues and promotes dialogue on sexuality and reproductive health.

There is need to target young people with information, in the study younger adolescents especially the ones out of school 10-14 years are never targeted with comprehensive sexuality education. Comprehensive sexuality education should be introduced in primary schools.

Access to services among young people is still very low especially young girls seeking contraceptives and/or maternal health services. There is need to improve on access through strengthening the implementation of youth friendly services.

1.3 Strengths and limitations of the baseline study [1 p]

The study was conducted in collaboration with partners in areas where they will implement the UFBR program. This helped the respective partners to already make initial contact with key stakeholders in their respective districts or provinces.

Being an alliance all the partners knew each other thus conducting the study was made easy and communication among partners enhances more. This allowed smooth participation in data collection which was completed on time according to the work plan for the baseline.

The logistics arrangements where organizations were providing staff and other logistical support made it easier for CSA to conduct studies in areas where they do not have presence. The KAP survey for young people had to be conducted in two phases due to school holidays, this made the study take a longer time and it was not easy for organizations to commit staff for this study at the expense of other scheduled activities.

Records for various commodities were not well kept and this made it difficult to calculate number of people accessing services. In some facilities they have condom dispensers and there are no records of the number of condoms distributed in a particular given period.

Government facilities usually give service statistics at the end of each year thus getting information for services offered between January and March this year was also difficult. In Nairobi there was bureaucracy which made it difficult to access the facilities. Most of the health centers and dispensaries are managed by the city council and the research authorization was provided by the government, this made it difficult to conduct the study in these facilities and CSA had to obtain another research authorization from the City council which had financial implications that were not planned it also took more time to collect data in these facilities.

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APPENDICES

1. Country result chain, highlighting the indicators that are relevant for baseline measurement
2. All baseline tools in English
3. Ethical clearance document (when relevant)
4. Sampling procedures

Annexes with more detailed country information
A1 – Results from the KAP survey for young people
A2 – Results from the KAP survey for women
B - Satisfaction with youth friendly services
C – Increase of number of women satisfied with SRHR services
D – Increase in use of services by young people and women (including skilled birth attendance and antenatal consultations)
E – Stock out problems

Annex A1, reporting on **Indicator 2.1a: exposed target groups have an increased capacity to make safe and informed decisions (on SRHR) FOR YOUNG PEOPLE**

Younger adolescents 10-14 years receive information from their parents compared to the older ones, this is an indication that as they grow communication between the parents and the young people tend to reduce. At older stage peers are the main source of information for the young people

Table 29: From whom have you received information about health topics such as the changes that happen when you grow up, sexuality and how to protect yourself from pregnancy and sexually transmitted infections?

Source of information	Girls 10-14 Girls 10-14		Girls 15-19 Girls 15-19		Girls 20-24 Girls 20-24		Boys 10-14 Boys 10-14		Boys 15-19 Boys 15-19		Boys 20-24 Boys 20-24	
	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school
No information	16.1	25.0	1.2	4.2	0	4.9	23.8	26.0	4.9	1.6	5.7	9.1
Parents/care takers	63.2	54.7	81.6	70.8	0	53.7	49.4	53.7	63.8	54.1	72.2	49.5
Teachers	57.5	39.1	89.2	79.2	0	68.3	60.9	29.6	86.6	60.7	80.4	52.5
Friends	23.0	37.5	65.2	66.7	0	73.2	19.5	44.4	52.7	54.1	50.0	55.6
Peer educators	8.1	32.8	67.2	75.0	0	87.8	8.1	33.3	56.3	49.2	53.7	53.5
Religious leaders	4.6	29.7	62.4	58.3	0	41.5	11.5	24.1	51.8	39.4	61.1	40.4
Magazines, newspapers, posters	8.1	6.3	59.3	45.8	0	63.4	13.8	3.7	38.4	26.2	63.0	38.4
Radio	20.7	21.9	56.4	45.8	0	58.5	25.3	25.9	43.8	36.1	55.6	50.5
TV	18.4	14.1	61.0	58.3	0	58.4	21.8	16.7	48.2	31.2	53.7	50.5
Community meetings, road shows	4.6	4.7	32.5	37.5	0	43.9	6.9	14.8	21.9	18.0	31.5	30.3
Internet	2.3	3.1	35.6	41.7	0	61.0	3.5	0.0	22.9	11.5	31.5	25.3
Other means	1.2	4.7	4.0	20.8	0	7.3	3.5	3.7	3.2	6.6	2.0	11.2

Table 30: From whom do you prefer to get information about health topics such as the changes that happen when you grow up, sexuality and how to protect yourself from pregnancy and sexually transmitted infections (STIs)?

Source of information	Girls 10-14 Girls 10-14		Girls 15-19 Girls 15-19		Girls 20-24 Girls 20-24		Boys 10-14 Boys 10-14		Boys 15-19 Boys 15-19		Boys 20-24 Boys 20-24	
	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school	In school	Out of school
Parents/care takers	58.6	70.3	75.8	70	0	70.7	62.1	63.0	59.4	46.7	61.1	37.8
Teachers	62.1	26.6	81.9	58.3	0	53.7	59.8	29.6	71.0	31.2	77.8	25.3
Friends	11.5	39.1	45.2	58.3	0	58.5	12.6	50.0	43.8	52.5	40.7	54.6
Peer educators	16.1	32.8	64.0	79.2	0	87.8	16.1	37.0	66.5	37.7	61.1	59.6
Religious leaders	10.3	39.1	47.6	54.2	0	43.9	18.4	33.3	48.66	39.3	51.9	37.4
Magazines, newspapers, posters	3.5	15.6	44.8	66.7	0	58.5	4.6	16.7	35.3	31.2	40.7	40.4
Radio	5.8	23.4	34	50.0	0	51.2	10.3	38.9	28.6	39.3	33.3	43.4
TV	8.1	20.3	42.8	58.3	0	58.5	10.3	22.2	35.3	27.9	33.3	38.4
Community meetings, road shows	2.3	9.4	24.8	29.2	0	26.8	2.3	14.8	22.3	19.7	29.6	27.3
Internet	1.2	1.6	27.7	50.0	0	61.0	0	0.0	24.1	11.5	24.1	25.3
Other means	0	9.4	2.8	8.7	0	7.3	2.3	3.7	4.1	21.3	1.9	10.2

Annex A2, reporting on **Indicator 2.1a: exposed target groups have an increased capacity to make safe and informed decisions (on SRHR) FOR WOMEN**

Table x: Characteristics of the married and unmarried young people coming to SRHR services at [name health facility] in the exit interview sample

Annex B, reporting on **indicator 2.2b: increase in the number of young people satisfied with SRHR services**

Table 31: Youth friendliness per clinic and per question

	Information Received	Medical Treatment Received	Level Of Skills Of Service Provider	Opening Hours	Waiting Time	Price	Privacy And Confidentiality	Treatment As A Person	Time For The Consultation	Will Return Or Not	Sum Satisfaction	Mean Satisfaction
Bahati HC	3.7	3.3	3.7	3.0	3.3	6.0	3.8	3.4	3.3	3.3	30.5	3.68
Bamburi HC	2.9	2.9	3.0	2.6	2.5	3.9	3.0	2.9	3.4	2.9	29.8	3.0
Biafra HC	3.6	3.9	3.9	3.0	3.6	4.0	3.9	3.9	3.6	3.5	33.9	3.69
Eastleigh HC	3.0	3.1	3.0	2.8	2.9	3.0	3.0	3.0	3.1	3.1	28.9	3.0
Elwasambi Disp	3.0	3.0	3.0	2.4	2.2	2.7	2.7	3.0	2.9	3.0	27.4	2.79
Entarara HC	3.0	3.1	3.3	3.2	3.2	2.9	3.6	3.3	3.3	4.0	32.9	3.29
Iltilal Disp	3.0	3.0	3.0	2.5	3.5	3.0	3.5	3.5	3.0	3.5	31.5	3.15
Isinet HC	3.0	3.2	3.0	3.1	3.2	3.0	3.6	3.1	3.3	4.0	31.9	3.25
Kimana HC	3.1	3.1	3.1	2.9	2.1	3.6	2.3	2.8	2.8	2.8	28.6	2.86
Kombeni HC	2.8	2.7	2.8	2.7	1.8	3.0	3.1	3.0	2.8	2.8	27.5	2.75
Loitoktok DH	3.0	3.0	3.1	2.8	2.4	3.6	3.2	3.2	3.0	3.4	30.3	3.07
Lusheya HC	2.8	2.8	2.9	2.7	1.8	2.1	2.6	2.9	2.9	2.4	24.2	2.59
Makunga Rdhc	2.9	2.7	2.8	2.8	2.2	2.1	2.2	3.0	2.9	3.0	24.6	2.66
Malaha HC	3.0	2.9	2.8	2.4	2.7	2.7	3.0	3.0	2.8	3.0	26.9	2.83
Mariakani DH	2.9	2.8	2.6	2.2	1.8	4.3	2.8	2.9	2.8	2.8	26.5	2.79
Mathare NorthHC	2.3	3.2	3.3	2.4	1.8	4.1	3.9	2.8	3.4	3.0	28.2	3.02
Miritini HC	2.8	2.8	2.8	3.0	3.0	5.6	3.0	3.0	3.0	3.0	29.2	3.2
Mung'ang'a Disp	3.0	2.9	2.9	3.1	2.7	2.8	3.1	2.9	3.0	3.0	28.5	2.94
Mwakironge HC	2.8	2.9	3.1	2.3	2.3	3.0	3.1	2.9	3.5	2.9	28.4	2.88
Namelok HC	3.3	3.4	3.1	3.4	3.0	3.0	3.4	3.1	3.7	3.8	32.9	3.32
Nyaboro HC	2.9	2.9	2.9	2.5	2.6	2.6	2.8	3.0	2.9	2.9	27.7	2.8
Rabai Rural HC	2.8	2.8	2.8	2.5	2.1	2.5	3.2	3.0	2.8	2.9	26.8	2.74
Ribe Disp	3.0	2.8	3.1	3.2	2.6	3.0	3.1	2.9	3.2	3.3	29.9	3.02
Shimo la Tewa Di	2.9	2.9	3.0	2.5	2.0	3.0	3.1	3.0	3.0	3.0	27.7	2.84
SoS HC	3.2	3.5	3.5	3.2	2.7	2.5	3.2	3.4	3.0	3.1	28.3	3.13
St Luke Mission	2.6	2.8	2.8	2.2	2.1	2.5	2.5	2.8	2.8	2.9	25.5	2.6
St. Michaels Dis	2.8	2.8	2.8	2.2	2.0	2.7	2.0	2.6	2.8	2.6	24.1	2.53
STC-Casino	2.6	2.8	2.8	2.6	2.2	2.8	2.8	2.2	2.1	2.2	23.8	2.51
Tudor DH	2.9	2.9	3.1	3.1	2.8	5.0	2.7	3.0	2.8	3.0	28.7	3.13
Utange	2.9	2.8	3.0	2.9	3.0	3.0	3.0	3.0	3.0	2.9	27.5	2.95
Total	2.9	3.0	3.0	2.7	2.5	3.2	3.0	3.0	3.0	3.0	28.2	2.93

Table 32: youth friendliness of all clinics, per question

Information received	2.9
Medical treatment received	3.0
Level of skills of service provider	3.0
Opening hours	2.7
Waiting time	2.5
Price	3.2
Privacy and confidentiality	3.0
Treatment as a person	3.0
Time for the consultation	3.0
Will return or not	3.0
Mean satisfaction	**2.93**

Annex C, reporting on indicator 2.2d: increase in the number of women satisfied with SRHR services

Table 33: Total score of women satisfaction per clinic and range of scoring per clinic

Name clinic/health facility	Mean score on satisfaction of women 25+
Elwasambi Dispensary	28.8
Entarara Dispens	32.3
Kimana health centre	27
Loitokitok District hospital	28
Lusheya H.C.	27.8
Makunga R.D.H.C.	26.3
Malaha H.C.	28.3
Namelok Dispensary	32.6
Isinet Dispensary	33.5
Mung'ang'a H.C.	30.8
Nyaporo Dispensary	29.5
All Facilities	30.1

Table 34: Mean score of women on satisfaction per clinic and range of scoring per clinic

Name clinic/health facility	Mean score on satisfaction of women 25+
Elwasambi Dispensary	2.6
Entarara Dispens	2.9
Kimana health centre	2.5
Loitokitok District hospital	2.6
Lusheya H.C.	2.53
Makunga R.D.H.C.	2.4
Malaha H.C.	2.6
Namelok Dispensary	3.0
Isinet Dispensary	3.1
Mung'ang'a H.C.	2.8
Nyaporo Dispensary	2.7
Iltilal	2.6
All Facilities	2.7

Annex C, reporting on

Indicator 2.3a: increase in young people and women using SRHR services

Indicator 2.3b: number of births attended by a skilled birth attendant is increased

Indicator 2.3c: increase in pregnant women who have 1-4 antenatal check-ups

Table 35: Service records for [country and clinic], for the January-March 2011 period: number of young people and adults using SRHR services, in numbers, by service

Service	Young people						Total number of young people	Range (lowest visitor number – highest visitor number)	Adults		Total number of adults	Range
	Girls			Boys					Women (24+)	Men (24+)		
	10-14	15-19	20-24	Oct-14	15-19	20-24						
Condom distribution	0	43	176	0	128	345	692	0 -320	278		278	0-224
Antenatal care	10	2462	2875	n.a.	n.a	n.a.	5347	0 - 2744	1599	n.a.	1599	0-234
Pregnancy test	3	70	89	n.a.	n.a.	n.a.	162	0 - 68	38	n.a.	38	3 - 13
Contraceptives: *Please provide details on range of choice provided [add rows to the table]*												
Pills	0	95	645				740	0 - 210	506		506	2 -71
IUCD	0	49	104				153	0 - 48	174		174	0 - 71
Injectables	6	288	1986				2280	0 - 779	1765		1765	5-476
Implants	0	37	46				83	0 - 18	74		74	0 - 27
ECP	0	119	116				235	0 - 125	42		42	0 - 9
Births attended by skilled birth attendant	1	223	687	n.a.	n.a.	n.a.	911	0 - 350	551	n.a.	551	0- 50
VCT for HIV	114	345	1162	386	262	800	3069	0 - 452	1071		1071	0-201
STI screening	6	37	118	14	19	46	240	0 - 90	175		175	0-76
Counselling on safe sex, sexuality and life skills: *Please specify what exactly is provided [add rows to the table]*	72	245	380	49	277	431	1454	0 - 543	571		571	33-200
Referrals for all services not provided (*with follow-up mechanisms in place)*	0	15	31	1	7	30	84	0 - 44	24		24	4 - 15
Psycho-social support for young people living with HIV/Aids	0	15	23	0	14	107	159	0 - 60	246		246	2-140
Support for victims of sexual violence	2	4	3	0	9	10	28	0 - 20	9		9	0-9
Emergency contraception	0	119	116	n.a.	n.a.	n.a.	235	0 - 125	42	n.a	42	0 - 9
Post-abortion care*	0	18	17	n.a.	n.a.	n.a.	35	0 - 12	15	n.a.	15	0-10
Other services: please specify [add rows to the table]	0	27	83	0	11	16	137	0 - 50	299		299	0-222

* Including incomplete abortion care, counselling and post-abortion contraception

Annex E, reporting on Indicator 2.3.1a: targeted facilities have increased availability of contraceptives, ACT, ART, and antibiotics

Table 36: out of stock problems for contraceptives, ACT, ART, and antibiotics, for all targeted clinics in [country]

	Contraceptives	ACT	ART	Antibiotics
Bamburi Health Center	Sometimes	Never	Never	Never
Miritini Health Facility	Sometimes	Don't know	Don't know	Sometimes
Shimo La Tewa Dispensary	Sometimes	Don't know	Never	Frequent
Utunge Health Facility	Never	Sometimes	Never	Never
Mwakirunge Health Center	Never	Never	Don't know	Never
Tudor District Hospital	Never	Never	Never	Never
Mariakani	Never	Never	Don't know	Don't know
SOS clinic	Never	Never	Never	Never
Eastleigh	Never	Don't know	Sometimes	Frequent
Mathare North Health	Never	Never	Sometimes	Missing
Bahati Health Center	Don't-know	Missing	Sometimes	Frequent
Makunga R.D.H.C.	Frequent	Never	Missing	Frequent
Malaha H.C.	Frequent	Sometimes	Never	Frequent
Lusheya H.C.	Never	Frequently	Never	Sometimes
Mung'ang'a H.C.	Frequent	Frequently	Missing	Frequent
Nyaporo Dispensary	Frequent	Sometimes	Never	Almost-a
Elwasambi Dispensary	Frequent	Sometimes	Missing	Frequent
Miritini	Never	Don't know	Never	Sometimes
Ribe Dispensary	Never	Almost always	Never	Frequent
St. Lukes Mission	Sometimes	Frequently	Never	Sometimes
Rabai	Never	Never	Never	Never
Entarara Dispensary	Frequent	Sometimes	Sometimes	Sometimes
Loitokitok District Hosp	Never	Frequently	Sometimes	Sometimes
Kimana	Never	Don't know	Never	Never
St Michael	Sometimes	Almost always	Sometimes	Frequent
Isinet dispensary	Sometimes	Don't know	Don't-know	Never
Iltilal Dispensary	Never	Sometimes	Missing	Sometimes
Special Treatment Center	Don't know	Sometimes	Never	Sometimes

Don't know: The service provider who was interviewed does not know
Never: Stock outs never occur
Sometimes: Stock outs happen approximately once a year
Frequently: Stock outs happen more than once a year
(Almost) always: These medicines are almost always out of stock (for more than nine months per year)

Table 37: Overview of the mean scores on youth friendliness and the mean scores on satisfaction of young people with the SRHR services provided at health facilities

Name of the clinic	Mean score on youth friendliness	Mean score on satisfaction	
		Girls 10-24	Boys 10-24
Bahati Health Centre	25	30.7	27.3
Bamburi Health Centre	24	28.2	27.4
Biafra Health Centre	27	33.9	
Eastleigh Health Centre		29.8	27.3
Elwasambi Dispensary	17	28.2	26.7
Entarara Health Centre	27	32.9	33.0
Iltilal Dispensary	17	32.0	31.0
Isinet Health Centre	20	32.0	31.8
Kimana Health Centre	21	27.5	27.8
Kombeni Health Centre	25	27.5	27.5
Loitokitok District Hospital	28	29.2	29.8
Lusheya Health Centre	20	23.0	24.5
Makunga R.D.H.C.	19	24.0	25.0
Malaha Dispensary	21	27.8	26.3
Mariakani health centre	24	27.0	22.2
Mathare North Hc	20	29.1	25.0
Miritini Health Centre	20	27.5	28.2
Munga'ng'a Dispensary	24	28.0	28.7
Mwakirunge Health centre	29	25.5	28.3
Namelok Health Centre		33.0	32.5
Nyaporo Dispensary	16	29.0	26.7
Rabai Health Centre	22	27.0	26.5
Ribe Dispensary	24	29.3	30.5
Shimo La Tewa District Hospital	20	27.2	28.2
S.O.S. Childrens Home	28	27.6	28.8
St. Lukes Mission Hospital	17	24.5	26.5
St. Michaels Dispensary		22.4	26.4
Stc-Casino	23	24	23.5
Tudor District H	23	25.6	29.3
Utunge Health Centre	22	27.2	27.8
All Facilities	22.3	28.1	27.3

Table 38: Mean scores on quality of maternal health services in Kenya

Name of facility	CBHMIS	CHW refer to ANC	TBA refer to ANC	CHW refer to delivery	TBA refer to delivery	MCH competent to conduct safe deliveries	MCH competent to conduct PAC services	MCH competent to conduct FP services	Mean quality
Bahati Health Centre	3	4	1	4	.	4	4	2	22
Bamburi Health C	3	3	2	1	1	4	4	1	19
Eastliegh	4	4	1	4	1	4	4	4	26
Elwasambi Dispensary	4	3	1	3	1	3	3	2	20
Entarara Dispens	4	4	3	4	3	4	4	4	30
Iltilal Dispensary	1	2	2	2	2	4	4	3	20
Kimana	2	2	2	4	1	3	3	3	20
Loitokitok Distr	.	.	2	4	2	4	4	4	20
Lusheya H.C.	1	4	1	2	1	4	4	1	18
Makunga R.D.H.C.	3	4	3	3	1	4	2	2	22
Malaha H.C.	4	3	2	1	1	4	3	2	20
Mariakani	4	4	1	4	2	4	4	3	26
Mathare North He	3	3	1	3	1	4	4	3	22
SOS	1	2	1	3	1	3	4	3	18
Biafra HC	1	4	2	4	2	3	3	2	21
Kombeni HC	2	4	4	4	3	4	3	3	27
St. Michael	2	4	3	3	3	4	4	4	27
Rabai HC	2	4	1	4	2	4	.	4	21
Miritini Health	4	4	1	.	.	.	4	.	13
Mung'ang'a H.C.	4	3	3	2	2	4	4	3	25
Mwakirunge Health Centre	4	4	1	3	1	4	4	4	25
Nyaporo Dispensary	1	3	2	3	1	4	4	4	22
Ribe Dispensary	2	4	3	4	3	4	4	4	28
Shimo La Tewa Di	3	4	1	4	2	4	4	.	22
Special Treatment Centre	1	1	1	1	1	4	4	4	17
St. Lukes Mission	2	2	2	2	2	3	.	.	13
Tudor District H	4	2	2	2	2	4	4	4	24
Utunge Health Centre	3	3	1	.	.	.	.	.	7
Total	2.7	3.3	1.8	3	1.7	3.8	3.7	3.0	21.3

Table 39 Service records for Kenya, for the January-March 2011 period: number of young people and adults using SRHR services, in numbers, by service

Service	Young people						Total number of young people	Range (lowest visitor number – highest visitor number)	Adults		Total number of adults	Range
	Girls			Boys					Women (24+)	Men (24+)		
	10-14	15-19	20-24	10-14	15-19	20-24						
Condom distribution	0	43	176	0	128	345	692	0 -320	278		278	0-224
Antenatal care	10	2462	2875	n.a.	n.a	n.a.	5347	0 - 2744	1599	n.a.	1599	0-234
Pregnancy test	3	70	89	n.a.	n.a.	n.a.	162	0 - 68	38	n.a.	38	3 - 13
Contraceptives details on the range of method choice												
Pills	0	95	645	n.a.	n.a.	n.a.	740	0 - 210	506	n.a.	506	2 -71
IUCD	0	49	104	n.a.	n.a.	n.a.	153	0 - 48	174	n.a.	174	0 - 71
Injectables	6	288	1986	n.a.	n.a.	n.a.	2280	0 - 779	1765	n.a.	1765	5-476
Implants	0	37	46	n.a.	n.a.	n.a.	83	0 - 18	74	n.a.	74	0 - 27
ECP	0	119	116				235	0 - 125	42	n.a.	42	0 - 9
Births attended by skilled birth attendant	1	223	687	n.a.	n.a.	n.a.	911	0 - 350	551	n.a.	551	0- 50
VCT for HIV	114	345	1162	386	262	800	3069	0 - 452	1071		1071	0-201
STI screening	6	37	118	14	19	46	240	0 - 90	175		175	0-76
Counselling on safe sex, sexuality and life skills	72	245	380	49	277	431	1454	0 - 543	571		571	33-200
Referrals for all services not provided (*with follow-up mechanisms in place)*	0	15	31	1	7	30	84	0 - 44	24		24	4 - 15
Psycho-social support for young people living with HIV/Aids	0	15	23	0	14	107	159	0 - 60	246		246	2-140
Support for victims of sexual violence	2	4	3	0	9	10	28	0 - 20	9		9	0-9
Emergency contraception	0	119	116	n.a.	n.a.	n.a.	235	0 - 125	42	n.a	42	0 - 9
Post-abortion care*	0	18	17	n.a.	n.a.	n.a.	35	0 - 12	15	n.a.	15	0-10
Other services:	0	27	83	0	11	16	137	0 - 50	299		299	0-222

* Including incomplete abortion care, counselling and post-abortion contraception

N= [number of clinics]

Number of respondents in the sample in Kenya per tool used

a. Nairobi – Kamukunji

Young people KAP

Age	10-14				15-19				20-24				TOTAL
Gender	Boys		Girls		Boys		Girls		Boys		Girls		
In/ out of school	School	Not in school	School	Not in school	School	Not in school	School	Not in schools	School	Not in school	School	Not in schools	114
Number of respondents	*0*	*0*	*0*	*0*	*54*	*9*	*49*	*10*	*7*	*36*	*0*	*39*	

a. Magadi – Loitokitok

a. Young people KAP

Age	10-14				15-19				20-24				TOTAL
Gender	Boys		Girls		Boys		Girls		Boys		Girls		
In/ out of school	School	Not in school	School	Not in school	School	Not in school	School	Not in schools	School	Not in school	School	Not in schools	297
Number of respondents	*40*	*25*	*46*	*32*	*20*	*27*	*60*	*2*	*14*	*31*	*0*	*0*	

Women KAP

Age	15-19				20-24				25-49				TOTAL
Marital status	Married		Not married		Married		Not married		Married		Not married		
Motherhood	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	347
Number of respondents	*31*	*20*	*28*	*28*	*32*	*28*	*32*	*28*	*32*	*30*	*31*	*27*	

a. Western – Mumias

Young people KAP

Age	10-14				15-19				20-24				TOTAL
Gender	Boys		Girls		Boys		Girls		Boys		Girls		
In/ out of school	School	Not in school	School	Not in school	School	Not in school	School	Not in schools	School	Not in school	School	Not in schools	255
Number of respondents	*47*	*30*	*41*	*31*	*49*	*25*	*26*	*5*	*11*	*30*	*0*	*0*	

Women KAP

Age	15-19				20-24				25-49				TOTAL
Marital status	Married		Not married		Married		Not married		Married		Not married		
Motherhood	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	With child(ren)	No child(ren)	342
Number of respondents	*26*	*25*	*30*	*33*	*30*	*27*	*29*	*27*	*32*	*30*	*26*	*27*	

a. Coast – Kilifi (Kaloleni) and Mombasa

Age	10-14				15-19				20-24				TOTAL
Gender	Boys		Girls		Boys		Girls		Boys		Girls		
In/ out of school	School	Not in school	School	Not in school	School	Not in school	School	Not in schools	School	Not in school	School	Not in schools	237
Number of respondents	*0*	*0*	*0*	*0*	*100*	*0*	*114*	*0*	*22*	*0*	*1*	*0*	

INFORMED CONSENT STATEMENT FOR PARENTS/TEACHERS OF UNMARRIED ADOLESCENTS SURVEY RESPONDENTS AGED 10-17 YEARS

Hello. My name is _____. I work with …….. on a project on adolescent reproductive health in Kenya. We have been seeking to initiate a project on increasing access to information and services on contraception for sexually active young people aged 15-24 years in this districts. I am seeking your permission to ask your daughter/son some questions to learn more about the health situation, sources of health information and services in this area. The young people we interview will be asked questions about their reproductive health knowledge and experience with existing health services, their health and sexual behavior, and sources of health information.

The information you/son/daughter/student will provide shall be strictly confidential and will be used only for the purposes of this study. Your/son/daughter's name or any other information that may identify you/your son/daughter will not appear in any report from this study.

The interview will take about forty five minutes. Your son's/daughter's/students participation in the study is voluntary. They will also not receive any money for participating in the study.

If any problem arises, or if you have any questions, contact **Martin Omondi** at the Centre for study of adolescents' office in Nairobi on Tel. No. (020) 2398724

You now have an opportunity to ask me questions concerning the study and your consent to participate. Do you have any questions?
1. YES
2. NO

Do you agree your child participates in this study?
1. YES
2. NO

I certify that I read this statement to the respondent, that s/he fully understood its meaning, and that s/he verbally agreed his/her child/student participate in the study

---------- **Interviewer's Signature**

QUESTIONNAIRE
FOMU

INSTRUCTIONS for respondents
Maagizo kwa wahojiwa

Please help us by filling in this questionnaire. Your responses are very important to us and will help us to make good programmes for young people.
Tafadhali tusaidie kujaza fomu hii. Maoni yako ni muhimu sana kwetu na yatatusaidia kutengeneza programu nzuri kwa vijana

- Do not write your name on this questionnaire. **All the information you give us will be kept private.** Nobody will know who filled in this questionnaire. Your teachers, neighbours, family and schoolmates will not see your answers.
- *Usiandike jina lako kwenye hii fomu.Habari/maelezo yote utakayotupa yatakuwa ni siri.Hakuna mtu ye yote atakaejua nani amejaza hii fomu..Waalimu wako,majirani,familia na wanafunzi wenzako hawatayaona majibu yako.*

- This is not a test and there are no right or wrong answers. **PLEASE BE HONEST IN YOUR ANSWERS**. Do NOT give us answers that you think we want from you. We need to know what you and other young people **really** think, so that we can give young people in country/county/district] the information they need.
- *Huu sio mtihani na wala hakuna majibu yalio sawa au mabaya/maovu.Tunahitaji kufahamu mawazo yako na ya vijana wenzako ili tuwape vijana [wa nchi hii/kaunti/tarafa] habari/taarifa wanazohitaji*

- This questionnaire asks questions about your personal life. Filling in this questionnaire is completely **voluntary**. If it makes you feel uncomfortable, you can stop at any time.
- *Hii fomu inauliza maswali juu ya maisha yako binafsi.Kujaza hii fomu ni kwa hiari yako/kujitolea kabisa.Ukijisikia/ukijihisi huna furaha/uhuru unaweza kusitisha/kuacha kuendelea wakati wo wote*

- If you have any questions or do not understand the question, please raise your hand and ask the project staff who are present.
- *Ukiwa una maswali au hujaelewa swali,tafadhili nyanyua/inua mkono wako na uliza wa hudumu wa mradi waliopo(needs to be revised for self-administered or administered)*

- Take your time and answer carefully. There is enough time to complete the questionnaire.
- *Tumia wakati wako kwa kujibu kwa makini.Kuna muda wa kutosha wa kukamilisha kujaza fomu hii*

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1. Do you agree to participate in the interview?
Unakubali [kukamilisha fomu hii/kushiriki kwenye mahojiano]?
Yes (*Ndio*) ❒1
No (*La)* ❒2