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**EXAMINATION OF THE EXTENT TO WHICH ADOLESCENT
REPRODUCTIVE HEALTH SERVICES ARE APPROPRIATE,
ACCESSIBLE AND USER FRIENDLY**

MERCY WAHOME AND Prof. PAUL MBATIA

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REPRODUCTIVE HEALTH SERVICES ARE APPROPRIATE,
ACCESSIBLE AND USER FRIENDLY**

¹* Mercy Wahome, ² Prof. Paul Mbatia

***Post graduate student; Jomo Kenyatta University of Agriculture and Technology**

***Corresponding Author's Email: mercywahome6@gmail.com**

²Lecturer, Multimedia University, Kenya

Abstract

Purpose: The objective of the study was to examine the extent to which adolescent reproductive health services are appropriate, accessible and user friendly.

Methodology: A cross-sectional survey research design was adopted for this study to to examine the extent to which adolescent reproductive health services are appropriate, accessible and user friendly. The survey targeted youth aged between 10 – 25 years and was used to capture their perceptions on the youth-friendliness of the facilities they attended. Through the survey the researcher generated quantitative data. In addition, field research was used to supplement the survey and generate qualitative data. The selected UNFPA trained clinics for the research included: Casino, Woodley, Langata, Kangemi and Dandora Health Clinics. The clinics with untrained health providers for the research included: Ngaira, Makadara, Riruta, Umoja and Westlands Health Clinics. Qualitative data generated from the key informants, was analysed by noting themes that emerged from their opinions.

Results: The youth consider provision of recreational facilities as an important component in the constitution of a youth friendly service. These facilities attract the youth to a health facility thus creating an opportunity to educate them on reproductive health among other prevention services. Thus, the need invest in recreational facilities.

Unique contribution to theory, practice and policy: Health facilities under NCC need to examine their health provision system to ensure that the facilities attract both male and female youth, and that young men can access RH services without feeling out of place. This would require separating formal reproductive health services from MCH/FP services.

Keywords: *adolescent reproductive, health services, appropriate, accessible and user friendly*

1.0 INTRODUCTION

The World Health Organization (WHO) defines an adolescent as a person between the ages of 10 to 19 years (McIntyre, 2002). From a global perspective, it is estimated that adolescents constitute 20% of the total population, (Dehne, 2001). In Kenya however, approximately 26% of the population are adolescents (KDHS, 2003 and Nzioka, 2001).

The International Planned Parenthood Federation (IPPF) defines adolescence as the period of transition from childhood to adulthood, describing both the development to sexual maturity and to psychological and relative economic independence (IPPF, 2004). According to McIntyre, (2002), this period transforms children into mature adults physically, mentally and even more importantly to sexual and reproductive maturity. It is a period of profound change that is mostly physical and

emotional. This period is commonly associated with physiological changes occurring with the progression from appearance of secondary sexual characteristics (puberty) to sexual and reproductive maturity (WHO, 1995).

There are a number of obstacles that make it difficult for young people to protect their sexual and reproductive, health than other age groups. They often have less access to information, services and resources than the older people (Aggleton and Rivers, 1999 and Friedman, 1993). In addition, health services are rarely designed to meet their needs. Young people in a variety of contexts have reported that access to contraception including condoms is usually difficult. The health providers argue that they are meant for the married people. Most religions advocate for abstinence before marriage and ban the use of contraceptives all together for the young people. However, the reality is that young people are sexually active and need these services. According to UNAIDS, (2001) legislation and policies that prevent sex education from taking place shut out young people from maximizing their sexual and reproductive health potential.

At the International Conference on Population and Development in Cairo (ICPD 1994), governments were urged to focus more on the specific reproductive health needs of adolescents by making the services available, accessible, acceptable and affordable to young people. In line with the ICPD1994 Plan of Action, Kenya developed the Adolescent Reproductive Health and Development Policy (ARH&D 2003) and the National Guidelines for Provision of Youth-Friendly Services in July 2005 to harmonize services offered to the young people, which have been fragmented and varied from one institution to another. It is therefore apparent that not much study has been done to investigate the youth friendliness of services being offered and the factors influencing adolescent access and utilization of reproductive health services in Nairobi.

In places where an attempt has been made to incorporate youth services the question on how user friendly these facilities to the youth still remains. Reproductive health services are friendly if they have policies and programs that attract youth to the facility, provide a comfortable and appropriate setting for the youth, meet the needs of young people and are able to maintain the youth clientele for follow-ups and repeat visits (Senderowitz 1999). The aim of this study is to establish the extent to which the available adolescent health services are accessible, appropriate and user friendly. It is based on the assumption that adolescents are less likely to maximize their utilization of the available health services if they are not uniquely designed for them.

1.1 Problem Statement

Adolescent sexual and reproductive health problems cut across both developed and developing countries. A cross national examination of adolescent behavior shows that adolescent pregnancy, abortions and birth rates rank very high in the United States than other developing countries (Darroch *et al.*, 2001). According to the study, young people between the ages of 15-24 account for a high proportion of all cases of gonorrhoea and Chlamydia up to 2/3 in some countries. The same problems are also experienced in developing countries, Kenya being no exception.

Adolescents have in many surveys expressed their views about the type of health services that they want (McIntyre, 2002). They insist on privacy and confidentiality and do not want to seek permission to attend. They want a service in a convenient place and time, which is free or at least affordable. In all, the health services offered for the youth need to be friendly. They must be accessible, acceptable and appropriate for the adolescents. They must be equitable and inclusive

of all the young clientele in terms of gender, ethnicity, religion, disability, or social status. Above all, adolescent friendly services must reach to the vulnerable. The principal purpose of this study is to examine the extent to which adolescent reproductive health services are appropriate, accessible and user friendly.

1.2 Research Objective

The objective of the study was to examine the extent to which adolescent reproductive health services are appropriate, accessible and user friendly.

2.0 LITERATURE REVIEW

According to the WHO Global Consultation Report, Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient (WHO, 2002). First, Adolescent friendly policies must fulfil the rights of adolescents as outlined in the UN convention on the Rights of the Child and other instruments and declarations. They must also take into account the special needs of different sectors of the population, including the vulnerable and under-served groups. They must not restrict the provision of health services on the ground of gender, disability, and ethnic origin, religion or age. In addition, adolescent friendly policies must pay attention to gender factors, guarantee privacy and confidentiality, promote autonomy so that adolescents can consent to their own treatment and must also ensure adolescent services are either free or affordable.

Secondly, adolescent friendly procedures should facilitate easy and confidential registration of patients, retrieval and storage of records, short waiting time and swift referral as well as consultation with or without appointment. Thirdly, adolescent health care providers must be technically competent in adolescent specific areas and offer promotion, prevention, and treatment and care relevant to each client's maturation and social circumstances. Adolescent health workers must have interpersonal and communication skills must be well motivated and supported by health care delivery systems have a non-judgmental attitude and act always on the best interest of their clients.

Fourthly, adolescent friendly health facilities need to provide a safe environment at a convenient location with an appealing ambience. They should have convenient working hours, offer privacy and avoid stigma. They must also be in a position to provide their clients with information and education material in order for them to make informed choices. At the same time they must involve adolescents and the community at large. Adolescents must be informed about services and their rights. They must be encouraged to respect the rights of others and be involved in assessment and provision of their own services. The community must be involved to promote the value of health services, and encourage parental and community support. Community based outreach and peer-to-peer services must increase in coverage and accessibility.

3.0 RESEARCH METHODOLOGY

A cross-sectional survey research design was adopted for this study to to examine the extent to which adolescent reproductive health services are appropriate, accessible and user friendly. The survey targeted youth aged between 10 – 25 years and was used to capture their perceptions on the youth-friendliness of the facilities they attended. Through the survey the researcher generated quantitative data. In addition, field research was used to supplement the survey and generate qualitative data. The selected UNFPA trained clinics for the research included: Casino, Woodley,

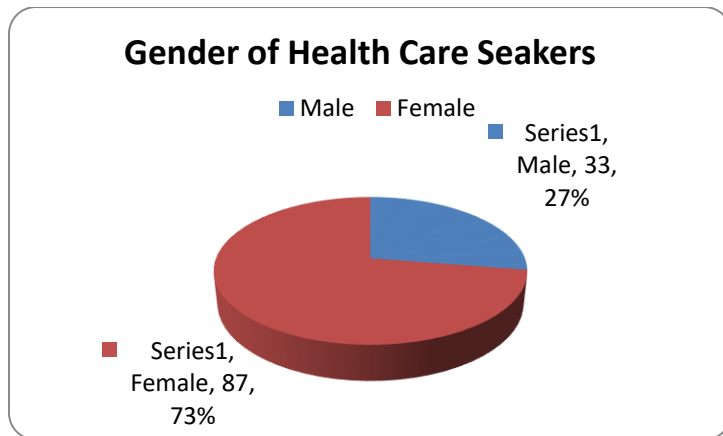
Langata, Kangemi and Dandora Health Clinics. The clinics with untrained health providers for the research included: Ngaira, Makadara, Riruta, Umoja and Westlands Health Clinics. Qualitative data generated from the key informants, was analysed by noting themes that emerged from their opinions

4.0 RESULTS AND DISCUSSIONS

4.1 Demographic Attributes

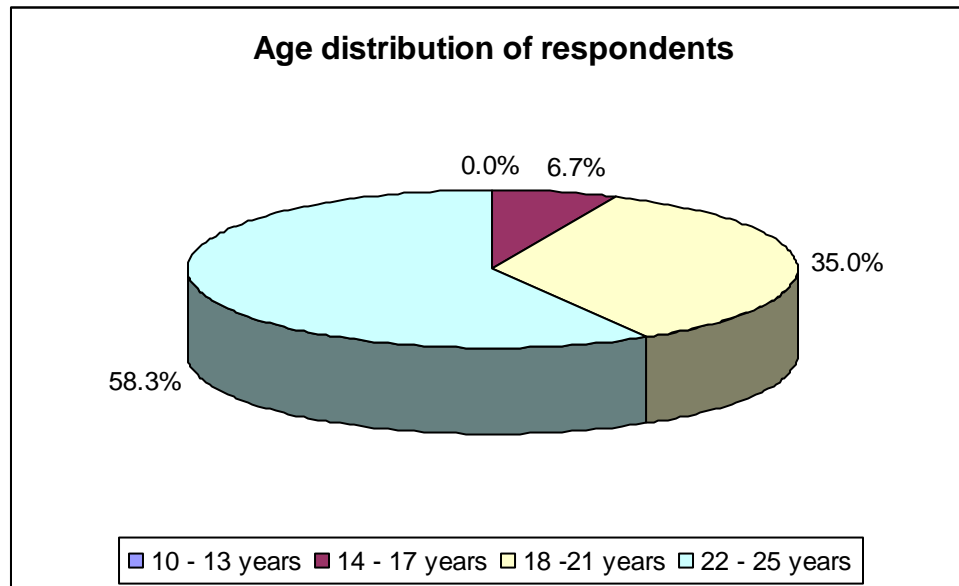
This study attempted to measure the demographic attributes of the respondents, including sex, age, level of education, religious affiliation, and marital status, place of origin and employment status. In this section, the research presents descriptive data on these attributes/variables. Overall, this study covered a total of 120 youth out of whom 33 were male (27%) and 87 were female (73%). The variation in the number of male and female was not achieved by design but an outcome of random sampling through “catch as catch can.”

Figure 1: Distribution of respondents by sex



The study also attempted to capture the ages of the respondents attending the health facilities for reproductive health services. The study defined the age range as 10 -25 years. However, the age range of the 120 respondents was 15 and 25 years, with a mean of 21.92 years, a mode of 25 years and a median of 22 years. The age distribution of the sample was grouped into three, namely, between, 14–17 years, 18–21 years and 22–25 years as shown in Figure 2.

Figure 2: Age distribution of respondents



Drawing from Figure 2, it is evident that majority of the respondents 58.3% were in the ages 22 – 25 year followed by those in the ages 18 - 21 years who comprised of 35% of the respondents. In general, most of the respondents were aged between 18 years and 25 years, accounting for 93.3% of the respondents. Unfortunately, youth in this group are most vulnerable with half of all new HIV infections occurring among young people aged 15-24 years, with the girls being twice as likely to be infected as the boys of the same age (KDHS, 2003).

The study also attempted to capture the level of education of the respondents. Generally education plays an important role in empowering individuals to make informed decisions about themselves and the world around them. In order to capture the level of education the respondents were required to give their highest level of education. The data on this variable are shown in Table 1.

Table 1: Level of Education of Respondents

Highest level of education	Frequency	Percentage	Cumulative percentage
Primary	38	31.7	31.7
Tertiary (vocational training)	8	6.7	38.3
Secondary	52	43.3	81.7
College	22	18.3	100
TOTAL	120	100	

The study also attempted to capture the marital status of the respondents. The findings of the survey revealed that 51.7% of the respondents were married, 44.2% were unmarried, 2.3% were separated and only 1.7% were widowed. The findings depict the typical Kenyan scenario where the mean age at first marriage is 22 years for women and 26 years for men and that 45% of the youth are married by the age of 20 (KDHS 2003) Early marriage is a consequence of many factors, including early pregnant, lack of alternative opportunities for girls and parents' desire for bride wealth (FPAK2003). According to KDHS (2003), variables such as level of education influence the age at which one marries and that women with higher levels of education tend to marry later and have fewer children. Using bivariate analysis, the study went ahead to investigate whether the level of education influenced the marital status of the respondents. The key indicators of the two variables were cross tabulated and the Pearson' Chi square test used to determine whether the relationship existed. The data was tested at 95% (0.05) confidence level.

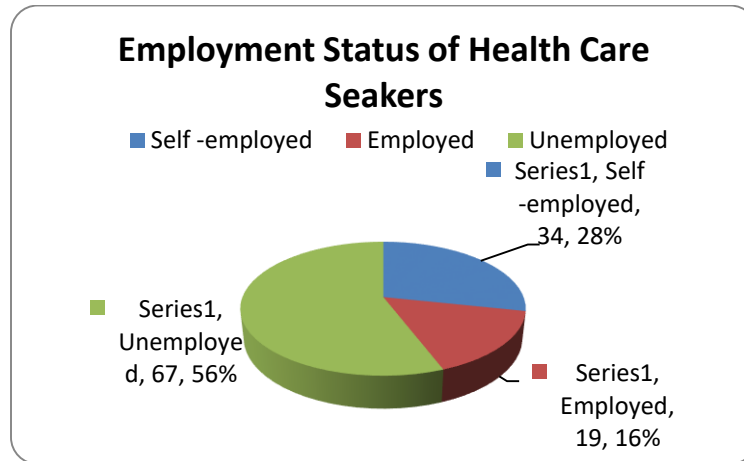
Table 2: Marital status and level of education of respondents

Level of Education		Marital status			chi- square Computation
		Married	Unmarried	Total	
Primary	Count	27	11	38	X2 Value =4.592 Significance level= 0.035
	% of Total	22.5%	9.2%	31.7%	
Tertiary	Count	6	2	8	
	% of Total	5%	1.7%	6.7%	
Secondary	Count	27	25	52	
	% of Total	22.5%	20.8%	43.3%	
College	Count	7	15	22	
	% of Total	5.8%	12.5%	18.3%	
Total	Count	67	53	120	
	% of Total	55.8%	44.2%	100.0%	

Table 2 shows that slightly more than half (55.8%) of the total sample interviewed had been married at one time, with 49.2% of those married not having attained secondary education. Of the 38 respondents who had primary education as their highest level of education, 27 (71%) were married despite their low level of education. The findings also show that only 5.8% of the married respondents had college education. There is some relationship (Pearson's chi- square = 0.035) between education one has attained and marital status. The relationship is however very weak. The study therefore confirms that the level of one's education determines marital status of the youth. Those with higher level of education tend to delay marriage as they probably pursue higher education.

The employment status of respondents was considered in this study. Figure 3 shows that more than half of the respondents (56%) were unemployed with the employed and self-employed accounting for 16% and 28% respectively.

Figure 3: Employment status of the respondents



The findings in the study concur with those established by Kenya Integrated Household Budget Survey (KIHBS 2005-2006) which revealed that the youth form two-thirds of the total labor force in Kenya but the majority (61%) are unemployed. Of these, the majority have formal education but no training. Primary and Secondary school graduates account for 82% of the unemployed and university graduates account for 1.4%. A significant majority (92%) of the unemployed youth have no job training other than formal schooling, showing that youth unemployment in Kenya is caused by lack of skills.

4.2 Adolescent Friendly Health Services

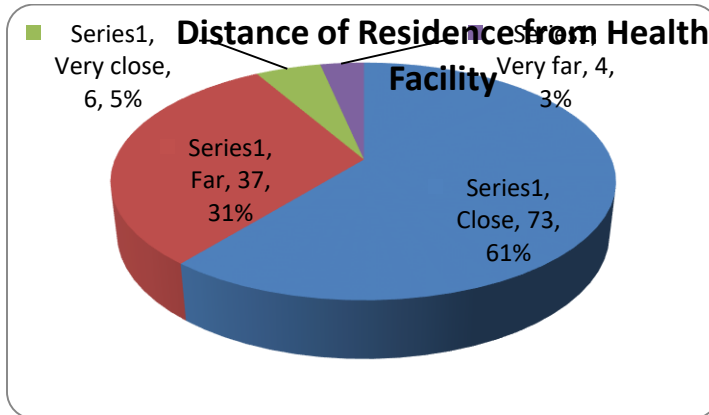
There is no standard definition for youth friendly health services. The services can be variably defined (Guidelines for the Provision of Youth Friendly Services in Kenya MoH, 2005). According to the WHO Global Consultation Report, Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient (WHO, 2002). Adopting from this, the National Guidelines for the Provision of Youth Friendly Services in Kenya (MoH, 2005) describes youth friendly services as, “Services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.” This study sought to investigate the extent to which the Nairobi City Council reproductive health services are youth friendly. The study also critically assessed the patterns of utilization of reproductive health services. In this study the variables that define user friendliness have been operationalized to facilitate measurement

4.2.1 Accessibility of adolescent reproductive health services

In this study, accessibility is operationalized to mean the ability of the youth to arrive at the health facility within the shortest time possible from their residence and at no cost or very minimal if any, and to receive reproductive health services at any time of the day as per their convenience. To establish accessibility, the respondents described the distance between the facility and their

residence as either very close, close, far or very far. The respondents also estimated how much time it took them to get to the facility and how much they paid for transport.

Figure 4: Distance of residence from the health facility



As illustrated in Figure 4, only 3% the respondents reported to live “very close” to the facility attended. 61% lived “close”, 31% lived “far” while 5% said they lived “very far”. Asked how long it took to reach the facility 67.5 % said “less than 30 minutes” with 28.3% reporting times of between “30 minutes and one hour”.

In an attempt to establish whether the respondents had any challenges getting to the facility due to transport expenses, the respondents were asked to state how much they spent as fare to get to the facility.

Table 3: Transport costs incurred by respondents to reach the health facility

Kshs.	Frequency	Percent	Cumulative Percent
0	67	55.8	55.8
5	1	0.8	56.7
10	8	6.7	63.3
20	20	16.7	80
30	10	8.3	88.3
40	6	5	93.3
50	6	5	98.3
60	1	0.8	99.2
100	1	0.8	100
Total	120	100	

As shown in Table 3, 55.8% of the respondents said it cost them no money to reach the facility, with those citing a cost of between 5 and 30 Shillings accounting for 24.2%. 10.8% cited a cost of between 40 and 60 Shillings with only one respondent saying he spent 100 shillings (0.8%)

Based on the finding, the study revealed that the health facilities are within reach for majority of the youth in Nairobi, and where they have to travel to a facility, the cost of transport is minimal and therefore not a barrier to access of reproductive health services.

The study also sought to establish the hours of operation from the key informants and through direct observation. The key informants reported working hours as from 7.30 am to 5.00pm during week days (Monday to Friday) However, this was not the case as observed as facilities were packed in the morning with hardly any business going on in the late afternoons. Only one facility (Woodley) had assigned health providers to work on Saturdays to be able to offer the necessary services for school going youth.

The study also established that the health providers, who formed the key informants, do not understand the convenient time for the youth to seek health services. They argued that youths do not like visiting the facilities during the normal working hours (8 am to 5 pm). They instead prefer to visit during late evenings when not so many people are in the health facility. The key informants observed a difference in time preference in male and female health seekers. Females preferred morning hours, while the males preferred the afternoon often looking for condoms. Drawing from the survey, it is evident that though accessibility of healthcare services terms of, cost and distance does not present a major hurdle for adolescents in Nairobi, the operating hours are not convenient for the youth.

According to the National guidelines for provision of youth friendly services in Kenya, it is important to have health facilities open when youth can attend in order to motivate them to seek services. Many youth are either in school or engaged in other things most of the day. They may find it difficult to miss school sessions or opportunities for employment to attend clinics unless it is an absolute emergency. It is therefore recommended that facilities should fix sessions during late afternoon, after school/work weekends or holydays to make it possible for the youth to attend.

4.2.2 Affordability of reproductive health services by the youth

The study acknowledged the importance of establishing the cost incurred by the youth in order to receive reproductive health services at the Nairobi City Council clinics as major determinant of the level of affordability. Drawing from the survey, it is evident that the services offered were affordable. This is because 100% of all the respondents said they were required to pay 20 shillings as a registration and consultation fee. However services were not denied to those who could not afford the 20 shillings. A total of 62.5% of the respondents said they had paid the registration fee with 36.7 % reporting no charge at all This minimal fee is a cost sharing measure according to the key informants. All prescribed drugs were dispensed free of charge. Other services like laboratory investigations attracted a fee with only 0.8% of the respondents reported having incurred a cost of 350 Shillings for laboratory tests.

The cost of health care services in Kenya can hinders a significant number of young people from seeking health care. The majority of the youth are in school, unemployed and poor. Young people are usually dependent on adults in finances and will not afford expensive services (McIntyre, 2002). As already stated in the demographic attributes of the respondents, more than half (56%) are unemployed. The results of survey indicate that cost is not a hindrance to receiving reproductive health care by the youth in Nairobi.

4.2.3 Appropriateness of adolescent reproductive health services

In this study, appropriateness is operationalised to mean *provision of reproductive health services that are age and gender specific. The availability of youth specific information, education and*

communication (IEC) materials, availability of recreational facilities and involvement of youth in service provision was also considered to determine appropriateness.

From the key informants, the survey established that all the facilities (10) provided a wide range of services although these services were not geared specifically to youth. Respondents were served with the general population on a first-come-first-served basis and had to wait at the common reception before getting the services. A majority 60% of the respondents said they had to wait for more than 30 minutes to be attended by the health provider. Those who waited for less than 30 minutes accounted 22.5% with those waiting for less than 20 minutes accounting for only 17.5%. The respondents reported discomfort in having to wait for long and in a common reception.

“Hatupendi kulampiwa na wasee ju maneibour wakituona wanaenda kutel masa” (We do not like being served with the general public because when the neighbours find us here they report to our mothers)

This confirms findings from previous studies that describe young people as generally nervous and fearful of being seen by family, friends, adults or neighbours seeking health services. Mulindi (1998) observes that, health structures that are specifically designed for adolescents seem not to exist in most of our health facilities, with many hospitals and health centres having departments dealing with specific groups for example, women and children, and many hospitals having children’s wards, male and female wards but not separately for the youth who in reality have special problems. (Mulindi et al 1998)

The results from the survey bring out the social exclusion of adolescents from sexual and reproductive health services manifested in gender differences and restrictions on age. Social Exclusion as a relative concept in the sense that an individual can be socially excluded only in comparison with other members of society: there is no ‘absolute’ social exclusion, and an individual can be declared as socially excluded only with respect to the society it is considered to be a member of.’(Bossert, D’ Ambrosio and Peragine, 2005).

Availability of Information, Communication and Education (IEC) materials on sexual and reproductive health targeting the youth determine the appropriateness of a facility in addressing their reproductive health needs. In this study, respondents were asked whether they found the available IEC materials attractive. Majority of the respondents (76.6%) found the materials attractive with 71% saying that they were satisfied while the remaining 23.3% felt otherwise and therefore were not satisfied. Despite the majority of the respondents finding the materials attractive, only 10.8% carried any reading material with them when leaving the facility. Direct observation by the researcher revealed that most facilities did not have any “take home” materials and that available material was skewed towards HIV/Aids and therefore did not meet all the reproductive health needs. Given that Youth in the urban areas preferred education from peers, while those in the rural areas preferred to get information from people older than themselves (FPAK 1995); provision of IEC materials for the youth to take home would ensure that information shared by peers is correct and authentic.

4.2.4 User-friendliness of adolescent reproductive health services

According to studies by McIntyre (2002), adolescents have expressed about what they consider youth friendly. They want a welcoming facility where they can walk in and be treated quickly, they value privacy and confidentiality and they want staff that will treat them with respect. User-friendliness in the study was operationalised to *mean reception by health providers and other staff,*

confidentiality and privacy, attention and time given to the respondent while receiving treatment from the provider, and the availability of recreational facilities. In determining user friendliness, the study also established the availability of recreational facilities and the perception of the respondents and health providers towards these facilities.

The manner in which one is received at a facility right from the gate to the point at which they get to see the provider can determine how friendly a facility is towards the youth. In this survey, respondents were asked how they considered the reception by the staff at the waiting area. 37.5% of the respondents described the reception as very friendly, 59.2% said reception staff were fairly friendly and only 3.3% reported a negative perception of the reception staff as being unfriendly.

However, of immediate observation by the researcher was that the adolescents were grouped together with the general population, who might have included neighbours the adolescents may have preferred to avoid, thus denying them privacy at the reception. This study attempted to measure the level of privacy by asking the respondents whether they had adequate privacy when explaining their problems to the provider. Only 25.8% of the respondents strongly agreed that they had privacy with a majority 59.2% ticking “agree.” Respondents who felt that there was no privacy at the facility when being treated accounted for 15%. In cases where young people feel a facility lacks privacy, they tend to avoid the facility and seek assistance elsewhere. The study established that not all respondents sought services at the nearest facility to their area of residence given that 41% of the respondents reported that they did not seek for reproductive health services at facilities closest to their residence but preferred to go to other facilities that offered exactly the same services. This underscores the importance of privacy and confidentiality in making a facility youth friendly.

From direct observation, the survey took note of the condom dispensers that were placed in the open waiting area and therefore not according privacy to any person who would have needed them. In some facilities the condoms were given by the provider on request. In Kangemi the nurse explained as follows:

“We encourage the youth to come to us for condoms but only a few of them come, majority are still very shy”

It is noteworthy that only one respondent reported being at the facility for condoms.

In regard to confidentiality, the respondents generally agreed that reproductive health providers at the Nairobi City Council health facilities observed confidentiality. Majority (81.7%) agreed to the statement that “there is confidentiality with information shared with the provider at the facilities” However, 10.8% of the respondents reported not being sure while 7.5% disagreed with the statement. On the same issue, key informants were confident that they provided adequate privacy and confidentiality and blamed the youth for being shy in opening up to discuss their reproductive health problems. The study brings out the contradictions on the understanding of privacy and confidentiality between the youth and the providers. To the youth, there is privacy if they can access services without being seen by the neighbours. Having recreational facilities makes this possible since the neighbours would assume the youth use the facilities for leisure. To the providers, privacy and confidentiality is accorded when a young person is given an opportunity to explain themselves in absence of other people at the facility.

Providers who are trained to work competently and sensitively with young people are often considered the single most important condition for establishing youth-friendly services. The

survey acknowledged that some facilities had been part of a UNFPA program in the year 2000 that aimed at making Nairobi city council health facilities more youth friendly by training staff. For general comparison purposes, an equal number of respondents were drawn from facilities that had been part of the UNFPA program and those that had not taken part. However, apart from staff at the Woodley health facility, staff from the other four facilities that had been part of the project reported that they has not been trained on youth friendly service provision and that those who underwent the training were no longer working with them.

The respondents gauged the level of providers' knowledge in dealing with the youth. Only 35% thought the providers were not knowledgeable on issues of the youth. On the other hand, the nurses and clinical officers expressed a great desire to be trained. A clinical Officer from Kangemi said:

“We really want to be trained so that we know how to handle the youth. It bothers me when I am so willing to help but I am unable to get them to say their problem. I even speak to them in sheng but they are still shy”

Findings in the study concur with other studies which note that where health services exist, providers lack the capacity to deal effectively with adolescent reproductive health issues (Muganda et al, 2003). The desire to be trained was strongly expressed by the key informants, thus affirming Ahlberg's findings that health providers in the public sector want to be a resource to the young people but they do not know how (Ahlberg et al.2001).

Drawing from the findings, it is apparent that the youth in Nairobi have confidence in the quality of reproductive health services provided at the Nairobi City Council health facilities. However, as discussed in the literature, it is important for health providers to receive formal training so that they may apply the Transtheoretical Model in the assessment of which stage the adolescent client is in, their perceptions of risk, previous experience with contraceptive use if appropriate, and barriers to implementing new behaviours. Health service providers recognize that normally they have only brief contact with adolescents at the facilities with little if any opportunity to assess long-term change. However, a basic tenet of this model is that interventions should be “stage matched”. The adolescent's stage of readiness for change must be determined, since targeting the wrong stage would have little or no impact.

Availability of recreational facilities plays an important role in attracting young people to a health facility. However, Nairobi city council facilities have not taken this into consideration. On the 10 facilities sampled in the study, only one was found to have functional recreational services despite all facilities having adequate room. In facilities where attempts had been made, the researcher observed pool tables but there were no balls, rendering the facility unusable.

Drawing from the findings of the survey, Woodley health facility was found to be the most user-friendly based on the following characteristics.

Adolescent reproductive health provision at Woodley Health Centre

The youth are allocated Saturday as their day at the facility and are provided with sports and audio visual equipments. The youth interacted with peer counsellors without the intrusion of health care providers, enabling them to talk freely about their health problems.

Though most health seekers at the facility are female, the males do not have a problem seeking help from them.

To protect privacy of the client, the examination rooms at the facility are labelled with numbers on the door for example 1 for VCT room, so that once a client says what her need is, she is given a number that corresponded with that on the door where the service is provided. This ensured privacy since clients at the reception do not get to know others' needs. All the staff at the facility, including the watchman at the gate, have gone through training on how to deal with adolescents.

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

1. There is a significant difference between the health seeking behaviour of male and female. More female youth tend to visit the health facilities than their male counterparts. Formal reproductive health services are not accessible to the males as they are provided through Maternal Child Health/Family Planning (MCH/FP) clinics. Thus, the need to be gender sensitive when planning for provision of reproductive health services.
2. Mixing of youth with the general population in provision of reproductive health deters the youth from seeking the services. There is need for health facilities to develop structures that are specifically designed for adolescents and youth. It is also critical to integrate the services into other programs to reach out to those in school.
3. Privacy and confidentiality is a critical factor in determining the utilization of reproductive health services by the youth. The seeking of services at other neighbourhood facilities rather than those closest to the youth's area of residence is a clear indication that there is inadequate privacy and confidentiality.
4. The youth consider provision of recreational facilities as an important component in the constitution of a youth friendly service. These facilities attract the youth to a health facility thus creating an opportunity to educate them on reproductive health among other prevention services. Thus, the need invest in recreational facilities.

5.3 Recommendations

1. Health facilities under NCC need to examine their health provision system to ensure that the facilities attract both male and female youth, and that young men can access RH services without feeling out of place. This would require separating formal reproductive health services from MCH/FP services.
2. It is important that reproductive health services are decentralized from health centres to focus not only on curative aspects but also preventive services and reinforcement of positive sexual

behaviour. Designing of outreach programs will help target healthy youth for prevention purposes. This can be achieved through integration of RH services with other ongoing community programs.

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