CONTRIBUTION OF YOUTH FRIENDLY REPRODUCTIVE HEALTH INFORMATION AND COUNSELLING SERVICES ON THEIR SEXUAL BEHAVIOUR CHANGE IN THE RIFT VALLEY PROVINCIAL GENERAL HOSPITAL YOUTH CENTRE, KENYA

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A Research Project Report Submitted to the Graduate School in Partial Fulfilment of the Requirements for the Award of Master of Arts Degree in Guidance and Counselling of Egerton University.

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DECLARATION AND RECOMMENDATION

Declaration

I declare that this research project is my original work and has not been previously presented for the award of a degree in this or any other university.

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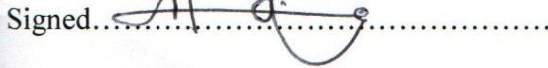
Recommendation

This research project report has been submitted for examination with my approval as a University Supervisor.



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DEDICATION

I dedicate this work to my family; my beloved husband Sammy Kuria Gitome and our children: Branson, Hortensiah, Mary and Sheerah. Who gave me love, encouragement and overwhelming support in my endeavour to understand youth-friendly reproductive health services.

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ABSTRACT

The reproductive health challenges Kenyan youth face are high rates of teenage pregnancy, high and rising rates of HIV infection, early marriage for young girls, malnutrition and harmful traditional practices such as female genital cutting. Policy makers are acknowledging the link between better reproductive health and other aspects of healthy youth development that include livelihoods, mental health and road safety. In recent times, the government has established youth friendly information and counselling centres in hospitals to offer reproductive health services to the youth in a manner that they perceive as more welcoming, comfortable and responsive. However, there is need to assess the contribution of these services on youth sexual behaviour change. The purpose of this study was to investigate the contribution of youth friendly reproductive health information and counselling services on youth's sexual behaviour change. The study was carried out in the Rift Valley Provincial General Hospital Youth Centre. Descriptive survey design was used. A population of 600 youths was involved, drawn from the youths who visited the centre for reproductive health services. A sample of 234 youths was selected through stratified and convenience sampling methods. Purposive sampling was used to select three service providers and a youth group of 6 members. Data was collected by use of questionnaires and focus group discussions, and then analyzed using descriptive statistics. The Statistical Package for Social Sciences (SPSS) version 17.0 was used to aid in data analysis. An analysis of the results indicated that Rift Valley General Hospital youth centre has the recommended essential service package to provide youth friendly information and counselling services to the youth. The study found out that 83% of the youth who had accessed and utilised the youth friendly services reported positive sexual behaviour change. The researcher recommended that quality and sustainable youth friendly reproductive health information and counselling services be provided to empower the youth to develop, adopt, and sustain healthy attitudes and reduce risky sexual behaviour.

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LIST OF ABBREVIATION AND ACRONYMS

AIDS	Acquired Immune deficiency Syndrome
ARH	Adolescent Reproductive Health
ARH&D	Adolescent Reproductive Health and Development
ASRH	Adolescent Sexual and Reproductive Health
CBS	Central Bureau of Statistics
CSA	Centre for the Study of Adolescence
HIV	Human Immuno Deficiency Virus
ICPD	International Conference in Population and Development
KAACR	Kenya Alliance for Advancement of children
KSPA	Kenya Service Provision Assessment
MOH	Ministry of Health
MOE	Ministry of Education.
NASCOP	National AIDS/STDs Control Programme
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Young people in the world face greater reproductive health risks than adults (Senderowitz, Hainsworth & Solter, 2003). Today's young people have diverse experiences given different economic, social and cultural realities they face in their communities. They face many reproductive health challenges, which include HIV/AIDS, teenage pregnancy, unsafe abortion, school dropout and other significant problems which include: physical and psychological trauma resulting from sexual abuse, gender based violence and other forms of physical violence and accidents.

These problems gain urgency when actual numbers are considered. Indeed, the world is experiencing an unprecedented increase in the number of young people (MOH, 2005). Estimates indicate that more than half world's population is below the age of 25. The largest youth generation in history and nearly one – third is between the ages of 10 and 24 (UNFPA, 2003). Their numbers are still growing particularly in sub- Saharan Africa. About 83% of all adolescents currently live in developing countries with Africa holding the largest population. O'Sullivan *et al*., (2007), postulates that in sub-Saharan Africa, youth experience some of the highest rates of HIV infection, early pregnancy in the world and many mature in contexts where poverty, school dropout and multi-partnering are common.

Kenya as it is elsewhere has a very young population between 10 -24 years which is estimated to constitute 36% of the total population (MOH, 2005). In other words, one out of every four Kenyans is a youth, according to the world Health Organization (WHO) definition. Those between 10 and 14, the period during which young people become aware of their sexuality are the largest single segment of the population (NCPD, 2003). This implies that the sexual and reproductive health needs of the youth cannot be ignored given their numerical strength and recognizing that they are the future of the nation.

Youth is thought to be a transition stage between childhood and adulthood, but is a very challenging period of time when many significant life events occur and decisions are made

(Senderowitz *et al.,* 2003). The transition is a time of intense physical and psychological changes. During this time, a person matures sexually and becomes capable of reproduction. The adolescent also experiences psychological and sociological changes related to development in his or her body .Most young people get very confused about their new feeling and also start searching for identity, love, reality and independence (MOE, 2009). The adolescents' response to these changes determines their sexual and reproductive health not only during adolescents but for the rest of their lives. It also affects the way they help or fail to help their own children deal with sexual issues.

Although practices differ by region and culture, young people throughout the world are changing their attitudes and behaviours regarding sexual activity. Typically, there are more premarital sexual behaviours and delay in the age of marriage, creating a longer period of likely unsanctioned sexual activity and pregnancy (Gakahu, 2005). These trends are bound to continue as the influences fostering such behaviours are also growing that include access to sexual images and messages everywhere in the media, they also hear all kind stories and rumours from other peers, most of them inaccurate, new ideas and urbanization. They experience social pressures that tempt them to experiment with casual sex, alcohol and above all the breakdown of traditional communication channels through which adults passed on information and guidance to young people, increased education for women and opportunities for young men and women to interact socially and vocationally.

The teenage years have always been a time of changes and challenges, but two things are different for the youths today. Firstly, they have less access to accurate information than previous generations. Traditionally, young people learned about sex and acceptable sexual behaviours within the extended family and the community (Wanyoike, 2003). Today, they get most of their information about sex and sexuality from magazines, videos, films, television, from advertising images, internet and their peers. These sources of information are not likely to help young people know; how to safeguard their sexual reproductive health and how to make decisions that promote their health and prosperity in adulthood.

Secondly, the emergence of HIV/AIDS means that making the wrong decisions can kill. According to Gakahu (2010) HIV/AIDS pandemic has become the greatest challenge in the 21st century. Statistics show that most of the sexually active adolescents rarely use protection against HIV/AIDS. One in twenty adolescents worldwide contracts an STI each year. Five young people under the age of 24 years are infected with HIV every minute and 7000 everyday (YFS, 2006). It takes between three and ten years to develop AIDS after being infected with HIV/AIDS. This is why the incidence of AIDS rises so dramatically as Kenyans enter their 20s. Most of the people living with AIDS were infected in their teen's years by having unprotected sex.

The key to finding solutions to the reproductive health problems facing young people in Kenya is to recognize that healthy sexuality is a young person's right (MOH,2005). This is true whether a young person chooses to delay sex until marriage or becomes sexually active. In pursuance of this goal of giving priority to the health and development of the youth, so that they achieve and maintain total health and well being. The government of Kenya has developed Adolescent Reproductive Health and Development Policy (MOH, 2003).The policy was guided by the 1994 International Conference on Population and Development (ICPD) which endorsed the right of adolescent and young adults to obtain the highest levels of health care. Broadly, the policy addresses the following adolescent reproductive health issues and challenges; adolescent reproductive sexual health and reproductive right, harmful practices, drug and substance abuse, social – economic factors, and the special needs of adolescents and young people with disabilities. (MOH, 2005 - 2015).

One of the key objectives of the policy is to create an enabling legal and social – cultural environment that promotes provision of information, counselling and service for adolescents and youth (MOH, 2006), through access to and utilization of sustainable youth friendly services. This is to improve the utilization of health services by adolescents. Youth friendly services are services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) to young people who return when they need to and recommend these services to friends, according to WHO definition (MOH, 2005). This is done through establishment of youth friendly centres in hospitals, including the Rift valley provincial general hospital. Yet, despite all these efforts little has been done to assess the contribution of

these youth friendly reproductive health information and counselling services on their sexual behaviour change.

1.2 Statement of the Problem

Young people face a number of Sexual and reproductive health problems, including early sexual debut, unplanned teenage pregnancy, STIs and HIV/AIDS, unsafe abortion, female genital cutting and sexual abuse/violence (UNAIDS, 2006; MOH, 2003). The need for sexual and reproductive health services for the youth has over the years become critical for a number of reasons. Societal change, caused by modernization and urbanization has led to loosening of family ties, leaving many young people unable to rely on intergenerational relationships for information and counselling about responsible sexual behaviour. As the gap between the generations is reinforced by cultural globalization, youth are increasingly left to learn about sexual issues from their peers or from the mass media. Considering that young people are still less willing and able to seek and have been largely ignored by the existing reproductive health services, the government has initiated a strategy to make reproductive health care services more accessible and acceptable. This implies making the services youth friendly. However, No study has been carried out to investigate how these services have contributed to youth's sexual behaviour change in Rift Valley General Hospital Youth Centre.

1.3 Purpose of the study

The purpose of this study was to investigate the contribution of youth friendly reproductive health information and counselling services on sexual behaviour change among the youth in the Rift Valley General Hospital Youth Centre.

1.4 Objectives of the Study

The following objectives guided this study.

i. To identify the youth friendly information and counselling services offered in the Rift Valley General Hospital Youth centre.
ii. To establish whether the service providers have adequate counselling skills to offer youth friendly reproductive health information and counselling services in the Rift Valley General Hospital Youth Centre.

iii. To find out how the youth were informed about the youth friendly information and counselling services in the Rift Valley General Hospital Youth Centre.
iv. To determine the contribution of youth friendly reproductive health information to youth's sexual behaviour change in Rift Valley General Hospital Youth Centre.
v. To investigate the contribution of youth friendly reproductive health counselling services on youth's sexual behaviour change in Rift Valley General Hospital Youth Centre.

1.5 Research questions

What are the youth friendly reproductive health information and counselling services offered at Rift Valley General Hospital Youth Centre?

i. What are the youth friendly productive health information and counselling services offered in the rift valley general hospital youth centers.
ii. Do the service providers have adequate counselling skills to offer youth friendly reproductive health information and counselling services in Rift Valley General Hospital Youth Centre?
iii. How are the youth informed about the youth friendly reproductive health information and counselling services in the Rift Valley general hospital youth centre?
iv. Does youth friendly reproductive health information have any contribution on the sexual behaviour change among the youths who visit the Rift Valley General Hospital Youth Centre?
v. What is the contribution of youth friendly reproductive health counselling services on the sexual behaviour change among the youth who visit Rift Valley General Hospital Youth Centre?

1.6 Significance of the Study

The study might hopefully provide useful information and data to the Ministry of youth affairs and the Ministry of health to facilitate the assessment of youth friendly reproductive health information and counselling services. The findings could also benefit the youths and parents on increased knowledge and awareness of risky sexual behaviour, and to develop and support mechanisms for sustained change, increased availability, accessibility and utilization of integrated quality ARH services.

1.7 The scope of the study

The study targeted the youth who visited the Rift Valley General Hospital youth friendly centre, who are 10 - 24 years age bracket and the providers of the services. The study confined itself to the contribution of youth friendly reproductive health information and counselling services on youth sexual behaviour change.

1.8 Limitation of the study

The study was confined to Rift Valley General Hospital; this could limit generalization to other hospitals.

Difficulties would be encountered in sourcing information from the service providers who may not have been keen to expose the short comings of the youth centre.

1.9. Assumptions of the study

The study was based on the following assumptions:

i. That the hospital has implemented the recommended package of youth friendly reproductive health information and counselling services.

ii. That all the target respondents co-operated and provided true views on youth friendly reproductive health information and counselling services and how they influence their sexual behaviour change.

1.10 Definitions of Terms

The following operational definitions were adapted in the study.

Access: The extent to which services are available at a cost and effort that is acceptable for the youth who need them.

Assessment: Determining, evaluating or estimating to what extent are the youth aware of the youth friendly reproductive Health Services

Awareness: Knowledge that youths have regarding the youth friendly reproductive health services.

Clients: Youths who are in need of Reproductive Health Services.

Counselling: This is the process where professional services are provided to youth by a trained professional counsellor as service providers in order that the client may solve his or her own problems.

Promiscuity: The behaviour where a person has many sexual partners.

Reproductive Health: The state of complete physical, mental, emotional and social well being and not merely absence of disease or infirmity in all matters in relation to the reproductive health system and its functions and processes.

Sexual Behaviour: Any conduct where a youth engages in an intimate relationship with another person with an aim of getting sexual satisfaction.

Sexual Permissiveness: Allowing sexual conduct or freedom that many cultures disapprove.

Safer Sex: Where those involved in sexual intercourse use their male or female condoms.

Sexuality: This includes thinking of oneself as a sexual being, feeling attractive and behaving, dressing or communicating in a sexy way. It includes feeling, thinking or behaving as a male or female. Being attractive, being in love and being in relationship with sexual intimacy and sexual activities.

Youth Friendly Services (YFS): Services are youth friendly if they have policies and Attributes that attract youth to the centre or clinic, provide a comfortable and Appropriate setting for serving youth, meet the sexual and reproductive health needs comfortably and responsively and succeed in retaining young clients for continuing care.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The study drew relevant, valuable and useful information from both local and foreign studies. Issues concerning YFS concept, youth friendly reproductive health products and services, characteristics and barriers to provision of youth friendly reproductive health are addressed. Also addressed is the topic of sexual behaviour and youth needs in reproductive health.

2.2 The concept of youth friendly reproductive health services

Reproductive health programmes targeted at youth are a relatively new phenomenon in sub-Saharan Africa. In response to the understanding that many young people are ill-informed on matters concerning sexuality and reproductive health, most of the early programmes focused on giving RH information to young people or on increasing parents and teachers capacities to convey such information (Erulkar, 2005).Programmes focused on improving adolescents' access to reproductive health services, however, are comparatively less developed on the continent. This is possibly because of the political sensitivity and social-cultural biases surrounding provision of family planning methods to unmarried young people.

The period of Adolescence is increasingly recognized as a universal life phase in which young people are especially vulnerable to health risks, particularly related to sex and reproduction (Nelson, McLaren, & Magnani, 2000). In many places, young people are becoming sexually active at younger ages or are more likely to experience sexual activity outside of marriage. This sexual activity is increasingly occurring in the midst of an HIV/AIDS pandemic that disproportionately affects young people under the age of 24 years. From a public health pespective, young people's sexual activity may have negative consequences including increased total fertility, maternal and infant health risks, dropping out of school and risk for sexually transmitted infections (MOH, 2006). Therefore, the need for young people – male and female, married and unmarried – to receive reproductive health care is becoming widely recognized (Senderowitz, 1999).

Many would agree that to make healthy decisions about illness, it is important to see a trained reproductive health provider. Yet, attending health clinic is often a young person's last resort when seeking health care services. (Nelson *et al.,* 2000). According to Family planning guidelines for service providers (2005), Reproductive health programmes have largely addressed older, married thus, the youth perceive often correctly that family planning and sexually infection (STI) clinics would not welcome them. Many youth therefore rely on resources outside of the formal health service provision system, such as home remedies, traditional methods of contraception, provision of contraceptives through friends or relatives, clandestine abortion and contraception and medication purchased without a doctor's prescription from pharmacies or traditional health practitioners (Kombo, 2004).

Young people tend not to use the reproductive health services developed by the formal health sector (MOH, 2005); therefore, programmes have identified the need to develop specialized approaches that provide youth with services that are of high quality and medically sound and safe (MOH, 2003). The need to provide services that are specific and youth-focused has been recognised by a number of agencies. The Programme of Action adopted by International Conference on Population and development (ICPD) in Cairo in 1994 highlights and endorses the right of young people to information and services to meet their sexual and reproductive health care needs. Chapter 17 of the programme of Action calls for the protection and promotion of the rights of young people to RH information and care, and urges countries to remove all legal and societal barriers to such services. Thus, health care providers, programme managers and researchers are realizing that to increase young people's utilization of reproductive health services, these services need to be "Youth Friendly".

Youth friendly reproductive health services (YFS) effectively attract young people and provide quality services in an environment that is comfortable and responsive. Youth can be provided with quality services in a health facility such as a clinic, health post or hospital, by trained personnel who provide services in a workplace or school setting through community outreach workers or peer educators or through the private sector, including private health care providers and pharmacy (Nelson et al., 2000). It is further noted that regardless of the venue services must have special characteristics that attract serve and retain young people to be effective.

Senderowitz (1999) postulates that services are understood to be youth friendly if they have policies and attributes that attract the youth to the facility or programme, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clientele for follow-up and repeat visits. Some of the adaptations needed to make services youth friendly have been identified by young people themselves and others by service providers, including some that have been evaluated as part of an overall effort to provide effective reproductive health services for youth (Nelson *et al.,* 2000).

From a young person's perspective, there are a number of barriers- broadly understood in terms of access and quality to seeking reproductive health services (Nelson *et al.*, 2000). Issues of access and service quality often determine whether or not young people are willing or able to effectively utilize reproductive health services.

2.3 Barriers to provision of youth friendly services

Young people avoid using existing RH services for a variety of reasons; including policy constraints, operational barriers, lack of information and feelings of discomfort (MOH, 2005). Major impediments to adolescent access and use, include the following as outlined by Senderowitz (1999).

2.3.1 Policy constraints

Providing RH services to young people is a sensitive public issue (MOH, 2006). Laws in many countries restrict access to certain kinds of health services (Including access to specific commodities) according to age, marital status or both. RH services often discriminate against young people, sometimes by requiring a minimum age or parental consent even where the law does not specify restrictions (Pathfinder, 2003). Staff members and providers are negative or ambivalent about providing RH services to young people and sometimes establish their own policies that prevent or diminish adolescent access. Making RH service youth friendly requires additional staff, training.

2.3.2 Operational barriers.

Even when clinics and other service programmes do not intend to bar adolescent clients from their services, operational policies and clinics characteristics can inadvertently serve to reduce access. For instance, timing of services not convenient for the youths; such as, inappropriate opening hours, long waiting time (Brindis & Davis, 1998). Lack of privacy is another concern of the youth because the facilities are not designed to cater for youth and also high cost of services.

2.3.3 Lack of information.

In the Kenyan education system, young people are not taught how to safeguard their sexual and reproductive health. In fact, a programme of family life education in schools was sidelined for political and religious reasons (Wanyoike, 2003). Young people are being denied their right to know about issues of grave concern to them. Those opposed to family life education in schools usually say that the proper place for 'sex education' is the home and that the only people who should talk to children and youth about sexuality are their parents. Yet many parents are uncomfortable talking to their children about sexual matters (UNFPA, 2008). Young people are learning new information and their emerging sexuality and development; often their friends are the source of information. Thus, young people tend to remain poorly informed or even misinformed – about such matters (USAIDS, 2006). MOH, (2006) outlines situations that reflect this condition and comprise additional barriers to services provision. These include:

Poor understanding of their changing bodies and needs.

i. Insufficient awareness of risks associated with early pregnancy and STIs/HIV
ii. Little knowledge of what services are available.
iii. Lack of awareness regarding the location of RH services.
iv. Stigma associated with sexual activity and sexual health problems.
v. Fear of medical procedures and contraceptive methods, including side effects (blood test, Pelvic examination)

2.3.4 Feeling of discomfort

Perhaps the most widespread explanation for young people's avoidance of clinics and service providers is their discomfort with real or perceived clinic conditions and attitudes of providers (MOH, 2006). Such perceptions could result from their own experiences, second hand

information from peers or a general reputation about the services. The following are specific Concerns that young people have suggested as reasons for not seeking or using RH services.

Belief that the services are not intended for them.

i. Fear of medical procedures and contraceptive methods, including side effects.
ii. Concern that the staff will be hostile or judgmental
iii. Fear that their parents might learn of their visit.
iv. Notions that RH services are culturally withheld from unmarried youth.
v. Shame, especially if the visit follows cohesion or abuse.
vi. Service providers are normally stone faced and hostile to young people.
vii. Format used to ask questions are interrogative and unfriendly.

2.4 Youth friendly RH information and counselling services

While emphasizing access to reproductive health information and counselling services, it is important to note not all young people have the same environment or life experiences, for instance not all are sexually active. The content of information and services provided must therefore cater for the diverse needs of young people (MOH, 2003). Senderowitz (1999) postulates that given the rapid changes that adolescents experience, a need exists for information and counselling services, especially related to development and maturation, boy-girl relationships, decision making about sex, gender issues, sexual abuse and contraceptive negotiation, adoption of contraceptive methods and pregnancy options should pregnancy occur. Needed health services include prevention, treatment and follow-up care? The minimum package of youth friendly services as recommended by MOH (2005) include: information and counselling on sexuality, sex and reproductive health; contraception and protective method provision (with an emphasis on dual protection); STI diagnosis and management; HIV/AIDS counselling and testing; Pregnancy testing and antenatal and postnatal care; Counselling on sexual violence and abuse (and referral for needed services); Post-abortion care counselling and contraception (with referral when necessary).

A youth friendly site offers services and skill building opportunities in an entertaining and educational setting. Modelling and social skills training are core activities; seeing is believing, it is said, and behavioural psychologists have found that watching films or videotapes of people

engaging in successful behaviour is sufficient for clients to learn new ways of coping with difficulties (Ivey *et al.,* 2007). Also in order to attract more youth recreation activities are a key aspect (in and out door games). In Nairobi, Kenya slum the Mathare Youth Sports Association was begun as an effort to promote sports and clean-up activities among boys in the neighbourhood, it has expanded to include girls' sports and reproductive health education, especially AIDS awareness. It has provided awareness and information about RH issues, as well as promoting greater skills for young people to manage their lives (Trangsrud, 1998)

2.5 Characteristics of youth friendly services

For the services to be truly youth friendly certain basic factors should be considered and put in place. According to MOH (2006) YF clinics should have for example, some form entertainment as youth wait for services. Service provider characteristics also strongly influence health-seeking behaviour .Facilities should also be designed to cater for the youth clients. Referral system for services not available should be put in place.

2.5.1 Health facility characteristics

Having clinics open at times when young people can conveniently attend is fundamental to effective recruitment, (Senderowitz, 1999). Facilities should be open when youth can attend. For example, weekends and late evenings; while young people who need urgent care may be willing to leave school or work for such services, those who need prevention services but may be unaware of how important they are, may be reluctant or give excuses for not taking the time off (Senderowitz, 1999).

Facilities should be easy to access because youth are generally nervous in seeking services (MOH, 2006). According to national guidelines for provision of Youth Friendly services in Kenya a youth friendly site should provide for ample space for provision of information, education and communication on health, counselling and examination. Rooms where counselling and examination are conducted should ensure there is audio and visual privacy. Young people are overly sensitive and suspicious of others finding out their health concerns. In a situation where there is no special place for young people in a health facility, special arrangements can be made to establish youth friendly corners, where they can be attended to in privacy.

Facilities should offer comfortable and secure surroundings because the youth are attracted to comfortable environment. Young people prefer a setting that is comfortable, has posters or décor that relate to their taste and interests and does not present on overly sanitized environment (Senderowitz *et al.,* 2002). In Chile programme planners converted a Cluster of homes into a clinic. To maintain "demedicalized" ambiance at the clinic, the health care providers wore street clothes instead of medical white (Senderowitz, 1999). Informality and youthful surroundings encourage youth to open up.

2.5.2 Provider and staff characteristics

Having a specially trained staff that is trained to work competently and sensitively with young people is often considered the single most important condition for establishing youth-friendly services (Senderowitz *et al.*, 2002). Staff selected to work with the youth must be compassionate and sensitive to the health concerns of youths. Those expected to counsel or examine the youth must have appropriate skills. Acquired skills must include familiarity with adolescent physiology and development as well as appropriate medical options according to age and maturity. Listening, interpersonal skills and ability to interact with youth are critical requirements so that young people can be at case to comfortably communicate their needs and concerns. This objective is sometimes accomplished when providers are closer in age and /or of the same sex as, the client. The ability to communicate fluently in languages that young people speak who attend a given clinic is also important.

One of the impediments to the provision of youth friendly health services has been the attitude of service providers. Some service providers have pre-judged the youth seeking sexual and reproductive health services (MOH, 2005). Negative providers' attitudes have made young people reluctant to seek for those services. Given this reality clinic managers should carefully consider such attitude as they select trainees or those who will work with young people. Young people are greatly disturbed and affected by a feeling of suspicion that their sensitive and intimate health concerns are being shared with other persons (MOH, 2005). Youth friendly health facilities must assure young people that their right to privacy and confidentiality will be respected at all costs. According to Senderowitz (1999) privacy must be arranged for counselling sessions and examinations; young people must feel confident that their important and

sensitive concerns are not retold to other person. A common fear expressed by young people is that the nurse will tell their mothers they came to the clinic for RH care (Marie stopes international, 1995)

According to Senderowitz *et al.,* (2002) young people tend to need more time than adults to open up and reveal very personal concerns. They come to the clinic with considerable fear, often with a worry about being pregnant and require strong reassurance and active encouragement to speak. Time is needed to bring myths (such as girls cannot get pregnant at first intercourse) to the surface, to discuss them and to dispel them. When young people come to seek advice on various health concerns, counsellors and those conducting examinations should allocate adequate time to them. In addition, to responding to clients' concerns, providers should be able to cover questions about body image and development, sex, relationship, sex and condom negotiation, as well as to clearly explain contraceptive method options and their possible side effects and management, this discussion is crucial to the compliance and retention of the adolescent client (Senderowitz *et al.*, 2002).

According to MOH (2005) evidence shows that many young people prefer talking with their peers about certain sensitive issues. Youth friendly clinics need to incorporate trained peer youth counsellors to deal with the aspects of youth concerns that do not require technical skills. One U.S. study showed that trained peer counsellors (ages 17-18) in a clinical setting more positively fostered contraceptive compliance among sexually experienced young people than counselling efforts by young nurses (ages 26 – 29) to get medicines. It is necessary to recruit true peers; in order to be credible youth peer educators must be true peers that are similar in age, range, sex marital status and sexual experience to the programme's audience. Recruitment and training should emphasize the ability to listen, guide discussions, and talk about sensitive issues. A good peer counsellor does not preach, but instead listens and responds to the audience. They must be perceived as empathetic and genuine, but not perfect and comfortably referring to experts when appropriate (Wilson, 2002).

2.5.3 Supportive elements of youth friendly service characteristics.

Youth involvement in design and continuing feedback is a fundamental principle in designing of youth friendly services so as to ensure participation of young people in identifying their needs and preferences for meeting those needs according to Senderowitz *et al.,* (2002). Young people know better how to identify their health and related needs. They are in a better position to prescribe solutions in meeting those needs. Their involvement in designing, planning and running the services can greatly assist in mobilizing support and sustaining motivation to utilize the services by their peers.

Not only must adolescents know that clinics and other service programmes exist and where they are located, but they must also know what services are provided (Senderowitz, 1999). Importantly, they must be reassured that they are welcome and will be served respectfully and confidently. Communicating this information can often be done as part of a community relations or mobilization effort. In these efforts, programmes explain their service to local youth and other groups who can then provide support and referrals, outreach in the community is particularly important in reaching out of school youth (MOH, 2005).

Senderowitz, (1999) postulates that the more health needs of young people that can be met within the facility or programme the greater assurance that they will receive the care they need. Wide range of services should be available in one location; this is because whenever it is necessary to send young people to another service, there is an increased risk that they will not actually show up. These services should include sexual and RH counselling, contraceptive counselling and provision (including emergency contraception) STI and HIV prevention, STI diagnosis and treatment, nutritional services, sexual abuse counselling, prenatal and post partum care (MOH, 2005)

Necessary referrals should also be available Senderowitz *et al*., (2002) affirms. It is desirable but almost never possible to provide services that meet all the needs of adolescents, including some type of specialized health care and related social services. Thus effective working arrangements should be established to ensure youth receive the services they are referred to and assure that referral sites provide appropriate youth – friendly treatment.

Information, education and communication (IEC) materials particularly those on critical issues in sexual and reproductive health should be available at a youth –friendly clinic (MOH, 2006). The materials should be available to read and to take away for youth who would like to read more on their own to be able to comprehend and clarify issues, especially those which may be complicated.

Given the diverse nature of youth friendly reproductive health services it may not be possible for institution or health facilities to meet basic demand for such services notes MOH (2006). In order to complement each other for effective service delivery, institutions and agencies need to build strong networks at all levels to mobilize support or youth groups to provide outreach IEC support services, and mobilize youth and the public to support youth friendly services. Organizations should collaborate in sharing best practices and building effective referral systems for YFS.

2.6 Sexual behaviour among the youths

Research has shown that in Kenya adolescents are sexually active by age 13 – 19 years, (MOH, 2006). Among adolescent girls 15 – 19 years 44% have had sex, while among young women 20 – 24 years 60% have had sex by age of 20 years (USAID, 2006).Studies have also indicated that, young men of age 15 – 24 have more sexual partners than young women, 16 % of men aged 20 – 24 years have had more than one sexual partner (MOH, 2006) with the newly acquired sexual maturity, adolescents face the challenge of learning the acceptable ways of dealing with matters of sex. The messages they get from the society may be conflicting, in the past, there were clear cut traditional ways of providing relevant sex education to the youth to an extent that young people knew how they were expected to behave (Ingule, Rono & Ndambuki, 1996). For instance, the Agikuyu community treated one as an outcast if she was found not to be a virgin at the time of marriage and the Maragoli community also had the same cultural system. Due to modernization, today it is different, many of these cultural practices as no longer adhered to. The school, on the other hand, may not address the issue adequately (Wanyoike, 2003). This leaves the young person in a position where he has to get information from friends and/or the media, whose information may not be accurate or complete. Today's youngsters encounter sexual images and messages everywhere in the media; they also hear all kinds of stories and

myths from their peers, most of them inaccurate. They experience social pressures that tempt them to experiment with casual sex, alcohol and drug abuse and other high risk behaviour. In Kenya, HIV/AIDS among the adolescents is almost an entirely sexually transmitted infection and the Kenya survey data show that 98% have been infected by sexual contact (Johnstone, 2000) this underscores the need for greater access to youth friendly reproductive and sexual health services.

2.7 Youth awareness of youth friendly reproductive services on their sexual behaviour.

Many people believe that education on sexual reproduction, HIV/AIDS and safe sex will encourage adolescents to engage in sexual activities (MOH, 2006). In fact providing information and services to youth is about helping then to stay safe, not about encouraging them to have sex. (USAID, 2006) studies have shown no evidence that sex education leads to an increase in sexual activities, rather in many cases; it leads to delay in sexual initiation. Johnstone (2001) writes that 28% of adolescent boys aged 15-19 years know more than two safer sex practices. This implies that they know that risky sex could lead to contracting of HIV/AIDS. Further survey by CBS, MOH, ORC, (2003) reflects that young women were better informed about condoms in 2003 that they were in 1998 when 23% of women knew that using condoms can prevent HIV transmission in 2005, 145, 202 clients aged 15-24 accessed VCT services of these, 52% were women (USAID, 2006)

In 2003, the government of Kenya developed a national adolescent's reproductive health and development policy. The purpose of this policy is to provide a framework to respond to the health and related concerns of young people in the country. It elaborates the government's commitment to improve the well being and quality of the life of Kenyan young people through provision of health information and services which is available, accessible and acceptable (MOH, 2005).

Senderowitz (2001) asserts that young people are known to be poor seekers of reproductive health. When taken along with this fact that can easily be used as an excuse not to establish youth friendly services. Coupled with the fact that in Kenya, discussions on providing reproductive health services to young people has always been sensitive, borne out of cultural and

traditional orientation on matters related to sexuality. Scheniker and Nyirenda (2002) argue that effective awareness will be made if we have professionally trained and actively involved service providers. They further tip that we could establish partnerships with schools and community and utilize current non-conventional methods. This is because any youth friendly services established without the support of the community is likely to fail. The community which includes parents, teachers, local opinion leaders and religious leaders are key gatekeepers. They are all interested in knowing what services are being provided to their young people (MOH, 2005). Senderowitz (1999) postulates that their involvement of the community in planning and establishing youth friendly services will help in mobilizing support and ensuring the long term sustainability of such services.

Making the youth friendly reproductive health services known to youth is crucial in effective utilization (MOH, 2005). Nelson *et al.* (2000) asserts that providers should publicize the location of services, the times they are available and assure that privacy and confidentiality are maintained. In addition, young people need to know that the services they need are available and that they can afford them. Physical features of a youth friendly site are important Labelling doors, walls or entrances to the facility should avoid using names which can stigmatize the place (MOH, 2005). This is because Johnstone (2003) reports 50% of Kenyan parents had made no attempts to sexually educate their youths on sexuality and admitted that they had no intention of ever doing so. Kenyan parents believe that threatening, warning and preaching are effective means of communication. They report further asserts that the church (religious groups) have claimed that the introduction of family life, sex education in schools would lead to increased pregnancy rates, adolescents promiscuity, increased school dropout and dramatic increase of STI's.

Aggleton and Show (2002) say that many young people in adolescence do not know how to respond to their physiological changes. In an online study of adolescent, students in Nairobi, 96% of girls believed that schools should teach family life education classes with content on reproduction contraception, and prevention of STIs. However, only 77% of girls reported having had a class that included any of those topics (Mitchell *et al.*, 2004). In this case many engage in

risky sexual behaviours oblivious of the consequences. Young people value hedonism, and thrill seeking without assessing long-term effects or consequences of their action.

In summary, given that among facilities assessed by Kenya service provision Assessment survey (2004) that only 12% percent were able to provide YFS coupled with the limited knowledge and use of modern contraception, limited condom use, and the lack of parental and school sex education, the lives of young people in Kenya must be considered with great sensitivity and awareness campaigns intensified.

The youth need both to acquire knowledge and to develop attitudes and skills for:

i. Participating as members of the household/family and the community.
ii. Making rational decisions and assessing risks and consequences of decisions.
iii. Interacting and communicating effectively and appropriately with peers, sexual partners and adults.

2.8 Theoretical framework.

Albert Bandura's Social Learning Theory (1962) was used to inform this study. Bandura's social learning theory explains human behaviour in terms of dynamic interaction between personal factors (knowledge, expectations and attitudes), behavioural factors (skills and self efficacy) and environmental factors (social norms, access to information, products, counselling services and ability to influence others). He asserts that individuals learn not only through their own experiences but also by observing the actions of others and consequences of those actions. The theory argues that in order to motivate young people to change behaviour, youth programmes must provide opportunities for young people to observe and imitate their peers practising safe behaviour like negotiation skills to delay sexual debut, abstaining from sex; Practice new behaviours in order to increase skills and confidence required to maintain the behaviour for instance putting condoms on a wooden model and receive positive reinforcement and encouragement to maintain

This study was also guided by the communications model. According to Brown and Falb (1981), the communication model is a process that has the following components. Sourceof information, packaged message content, channel receiver of information and feedback. In this study, the

services providers and counsellors are the source of YFS whereas the posters, literature touching in youth concerns, IEC audio visual material and training/counselling sessions are the channels used to pass the message to the receiver. The receiver is the youth in or out of school. The feedback is the sexual behaviour change expected which will help the sources of information to review the approaches or better still innovate effective ways of communication.

2.9 The conceptual framework

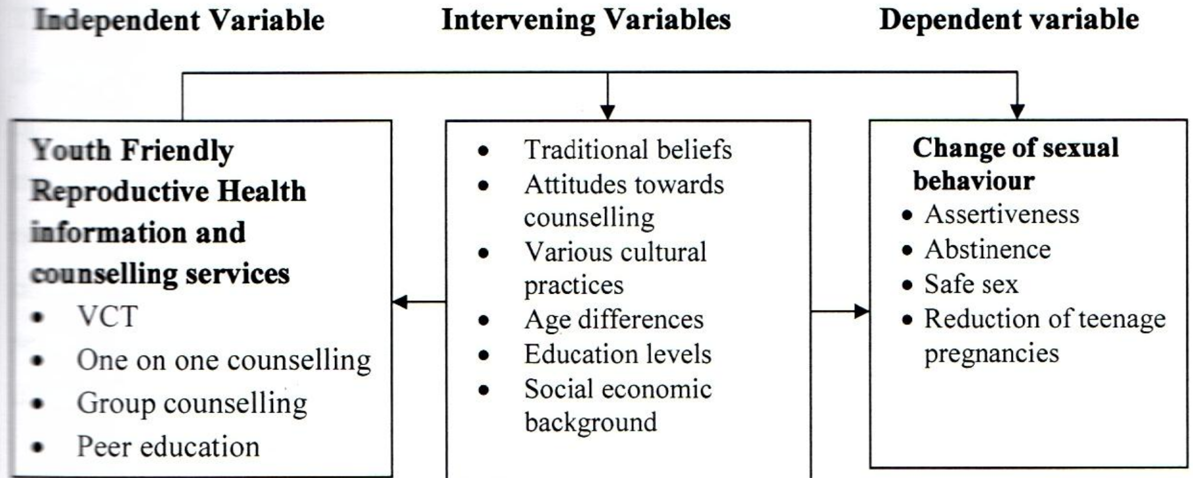

Figure 1: A model showing the contribution of Youth Friendly Reproductive Health Information and Counselling services on sexual behaviour change.

Figure 2 shows providing youth friendly reproductive health information and counselling services and creating awareness of the availability of the services are the main tasks. If the youths get this information, behaviour change is expected. Yet factors like attitude, values, beliefs customs and social economic background need to be addressed if youth friendly reproductive health information and counselling services are to have any effect on the youth sexual behaviour change.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the study's research design, population, sample and sampling procedures, instrumentation, data collection and data analysis procedures.

3.2 Research design

This study utilized descriptive survey design. Mugenda and Mugenda (1999) describes descriptive survey as a method of collecting information by interviewing or administering questionnaires to a sample of individuals to gather information about attitudes, beliefs, experiences, or behaviours of a group of people. The researcher used descriptive survey because no manipulation of subjects was done and the events had already taken place. In this study, the contribution of youth friendly reproductive health information and counselling Services on sexual behaviour change among the youth had already taken place thus; the researcher only described what was already in existence.

3.3 Location of the study

The study was carried out at the Rift Valley General Hospital youth centre. The fact that the youth centre has the recommended essential service package for clinic based model prompted the selection of this location. The programme has been in existence at the Rift Valley General hospital but no systematic study had been carried out to assess its contribution to youth's sexual behaviour change.

3.4 Population of the study

The population from which the study was drawn comprised all the youths between 10 – 24 years who visit the youth centre, 6 members of a youth group attached to the youth centre and 3 full-time medical professionals who provide information and counselling services. On average the youth centre serves 600 youths per month. Records in the youth centre revealed that in the months of June, July and August 2009, it served 1836 youth out of these, 835 were females and 1001 were males.

Table 1:

Population of the youths who visited the centre from June to August 2009

Month	Male	Female-	Totals
June	326	295	621
July	321	243	564
August	354	297	651
TOTALS	**1001**	**835**	**1836**

Source: Records in the Youth Centre (2009)

3.5 Sampling procedure and sample size

A sample is a subset of the population to which the researcher intends to generalize the results (Wiersma, 1986). The study adopted stratified and convenience sampling procedures. The stratified sampling was used to take care of both genders (females and males). Convenience sampling was used to get specific respondents from the centre. The researcher obtained a sample of 234 youths from the target population of 601 as recommended by Kathuri and Pals (1993) in the table for determining sample size (appendix D), which is the average attendance of the youths in the months June-August. It was necessary to get the average attendance to reduce incidences of repeat visit Proportional sampling was used to arrive at the exact number of youths per gender using the formula:

$$\frac{X}{N} * S$$

where (N) The population which is 601

(S) Sample size is 234

(X) Gender target population

The sample size is as illustrated in Table 2.

Table 2:

Proportional distribution of youth

Status	Gender population	Target sample size
Males	1001	128
Females	835	106
Target population/Sample	**606**	**234**

Source: Records in the Youth Centre (2009)

3.6 Instrumentation

The researcher used both questionnaires and focus group discussion to collect data. There were two sets of questionnaires: one for the service providers, which was used to capture their counselling skills on provision of YFS and their views on the contribution of youth friendly reproductive health information and counselling services and the second one for the youths which captured the services offered and the promotion of awareness. The focus Group Discussion was used to evaluate the contribution of youth friendly reproductive health information and counselling services on sexual behaviour change among the youth.

3.6.1 Validity of instruments.

Research instruments should measure precisely what they are meant to measure, (Kathuri & Pals, 1993). Validity refers to the extent to which differences found with a measuring instrument reflects a true difference among those being tested (Kothari, 2005).To ensure the validity of the questionnaire the researcher developed the instruments based on the objectives of the study. This was to ensure content validity of the items. By reading widely, consulting other experts and seeking help from the supervisor the researcher checked the validity of instruments.

3.6.2 Reliability

Reliability is the ability of the instruments to return the same responses after repeated trials (Orodho, 2005). Reliability of a study will give the information on the degree to which a measure will yield similar results for the same subjects under different circumstances. In order to establish the reliability of the study instruments; a pilot study was conducted using a sample of ten youth. The internal consistency of data was determined using the Cronbach's co-efficient alpha.

Cronbach's alpha is a measure of internal consistency, measuring how closely related a set of items are. The Cronbach's co-efficient alpha was used to calculate the reliability co-efficient and it yielded 0.832. This was considered an acceptable threshold (Mugenda & Mugenda, 1999).

3.7 Data collection procedures

The researcher obtained an introductory letter from the university. Further permission was sought from the Medical superintendent who is in charge of the Rift Valley Provincial General Hospital. The researcher then presented the letters to the programme officer in charge of the youth centre to be allowed to collect data .The researcher administered the questionnaire to the respondents with the help of the service providers. Few youth who sought clarification were assisted accordingly.

3.8 Data analysis procedures

Descriptive statistics were used to give descriptions and summarise data .All the objectives of the study were analysed using descriptive statistics. In each objective, the data was analysed and presented using frequencies and percentages because the data was mostly qualitative. The frequency tables were used to simplify the presentation of findings. The statistical Package for Social Sciences (SPSS) version 17 for windows was used to aid in the analysis.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The chapter presents the results and discussion of the findings. The data collected from respondents was analysed using SPSS version12.5 for windows. The analysis was guided by the following objectives:

i. To identify the youth friendly information and counselling services offered in the Rift Valley General Hospital Youth Centre.
ii. To establish whether the service providers have adequate counselling skills to offer youth friendly reproductive health information and counselling services in the Rift Valley General Hospital Youth Centre.
iii. To find out how the youth were informed about the youth friendly information and counselling services in the Rift Valley General Hospital Youth Centre.
iv. To determine the contribution of youth friendly reproductive health information to youth's sexual behaviour change in Rift Valley General Hospital Youth Centre.
v. To investigate the contribution of youth friendly reproductive health counselling services on youth's sexual behaviour change in Rift Valley General Hospital Youth Centre.

To investigate the contribution of youth friendly reproductive health counselling services on youth's sexual behaviour change in Rift

4.2 General information of the youth respondents

The first part of the research instruments aimed at finding out the general information of the youth. This was deemed important because it enabled the researcher to know the composition of the respondents.

Table 3 captured the various characteristics of the youth in terms of age, gender, sexuality

Table 3:

Demographic Characteristics of the youth

Characteristics	Frequency (f)	Percentages (%)
Gender		
Male	128	58.2
Female	106	41.8
TOTAL	**234**	**100.0**
Age		
10-14yrs	3	1.3
15-19yrs	27	11.5
20-24yrs	180	76.9
Other age groups	23	9.8
No response	1	0.4
TOTAL	234	100.0

A total of 234 youths responded to the questionnaire out of this 106 or (41.8%) were female and 128 that (58.2%) were male. This is presented in table 3. It was also necessary to find out from the youth the number of times they had visited the youth centre. Those who reported that it was their first time these were discarded because they could not possibly be able to evaluate the contribution of youth friendly reproductive health services on sexual behaviour change. Further the sampled youths were distributed according to their ages, this was deemed necessary because youth friendly services are primarily targeted at youths between ages 10-24 according to MOH (2005).From table 3, 90.1% of the respondents are between ages 10-24years.These are important target groups for youth friendly services as these groups often lack access to reproductive health services in many settings (MOH, 2006).

Table 4:

Age at first sexual intercourse

Age	Frequency (f)	Percentage%
Below 12 yrs	5	2.1
12-15yrs	27	11.5
16-20yrs	114	48.7
21-24yrs	49	20.9
Not had sex	27	11.5

Information about early sexual activity is of obvious value in defining the onset of potential exposure of various types of risks; such as STIs, HIV/AIDS, unwanted pregnancy and higher reproductive risks. Table 4 shows that 2.1% of the youth below 12 years are sexually active. 48.7% were sexually active among the 16-20 years olds only 11.5% of youths aged 10-24 years are not sexually active. This confirms the earlier findings by IPS (2009) that, there is a high level of sexual activity among the youth in the Kenyan society.

4.3 The youth friendly information and counselling services offered at the youth Centre

The first objective of this study was to identify the youth friendly information and counselling services offered at the youth Centre. Identifying and meeting the needs and expectations of the youth and the communities in which they live is an important feature of any successful youth friendly initiative (Pathfinder, 2003). Services must be designed and implemented to meet the needs and aspiration of the intended youth clients as the beneficiaries, therefore, it was important to find out from the youth their reproductive health needs. Their responses to this item are summarized in table 5.

Table 5:

Youth's reproductive health needs

Youth Reproductive Health Needs	Frequency (f)	percentage %
Lack of access to youth-friendly services	75	32.1
Lack of information on availability of services	91	38.9
Lack of reproductive health knowledge and information	140	59.8
Abortions	75	32.1
Infections of S.T.Is and H.I.V./AIDS	124	53.0
Stigma associated with seeking sexual and Reproductive health services by the youth	217	92.7
Limited understanding on the need for youth friendly Sexual; and reproductive health services by parents, Teachers, policy makers and faith leaders	119	50.9
Poor skills among service providers on how to deal With the youth	118	50.4

According to the adolescent Reproductive Health and development Policy; Plan of Action 2005-2015, it identifies youth as a cohort with special needs. Table 5 shows that 92.7% of the youth cited with stigma associated with seeking sexual and reproductive health services by the youth as one of their greatest sexual and reproductive health needs 59.8% indicated that the youths lacked reproductive health knowledge and information. From the youths' responses it is evident that the youths require sexual and reproductive health information/guidance and counselling; that is they need information on growth, sexual development and provision of sexual and reproductive health services for those who are sexually active. They also need to be handled with care (need sensitive and friendly sexual and reproductive information and services) because most are afraid to walk into a hospital and seek assistance. The researcher also sought to know from the youth, the services offered. Their responses were summarised in Table 6.

Table 6:

Youth friendly information and counselling services

Services offered at the centre	Frequency (f)	percentage
Information and counselling on sexuality, safe sex and Reproductive health	167	71.4
Contraceptive with an emphasising dual protection	141	60.3
STI diagnosis and management	174	74.4
Voluntary counselling & Testing (VCT)	202	86.3
Pregnancy testing and antenatal and post natal care	114	48.7
Post abortion counselling with referral for management	119	50.9
Recreation facilities in and outdoor activities	164	70.1
Counselling on sexual violence and abuse	137	58.5
Comprehensive post rape care	157	67.1
Availability of reading, materials.	184	78.6

An examination of the needs of the youth reveal that the management of youth sexual and reproductive health needs includes, promotion of healthy development, the prevention of SRH problems as well as the response to specific sexual and reproductive health needs. The findings show that VCT is the most popular with the youth with 83.3%. One possible reason, as one service provider revealed is that every time a youth enters a new relationship they get tested. According to UNAIDS (2006) the campaign for testing has been aimed at young people for a long time and this has contributed significantly to the increased demand for VCT. Pregnancy testing, antenatal and post natal care is the least with 48.7%. Lack of knowledge about these services remains one of the major barriers to access for the young women. Lack of knowledge is sometimes related to low or non-utilization of services (UNAIDS, 2006). From the youth questionnaire it is evident that the basic reproductive health services are available in the youth centre. However, the centre does not provide a comprehensive set of SRH services as stated in the minimum package (MOH, 2005).Curative services for minor illnesses including ante and postnatal care are lacking. Also very important condom promotion and distribution is very low

and only within the framework of family planning services. If the youth require these services they are referred to in the main hospital for specialised care.

4.4 Providers counselling skills to give youth friendly reproductive health services

The second objective in this study was to establish the providers' counselling skills in provision of youth friendly reproductive health information and counselling services. Staff selected to work in a youth friendly centre must be understanding and sensitive to the health concerns of the youth. Those expected to counsel or examine youth must have appropriate skills (MOH, 2005). Training service providers in youth friendly service provision assists in addressing the barriers that hinder adolescents from accessing reproductive health information and counselling services. An item was constructed to find out whether service providers have the necessary skills. The service providers admitted having been trained on some counselling skills, these included:

i. Active listening that is; maintaining eye contact, demonstrating interest, being attentive to the young person ,asking questions, showing empathy, clarifying paraphrasing and reflecting.
ii. Effective questioning skills.
iii. Attending skills : SOLER is an acronym used to describe attending skills for the service providers. This communicates to the clients that you are there for them. S-sit squarely, O-open posture, L-lean forward. E-maintain eye contact and R-relax.
iv. Rapport building
v. Exploration
vi. Decision making and Implementing the decision

The researcher also found it necessary to find out from the youth how the service providers treated them when they went to seek for services.

Table 7:

Providers' counselling skills

Counselling skills	Yes	%	No	%
Greeted and made to feel comfortable	215	91.9	19	8.1
Introduced himself or herself	214	91.5	20	8.5
Assured of privacy and confidentiality	224	95.7	10	4.3
Asked about the reasons of my visit	227	97.0	7	3
Asked open-ended and simple questions	209	89.3	25	10.7
Listened actively and showed interest	211	90.2	23	9.8
Expressed empathy	144	61.5	71	30.3
Is non judgemental	215	91.9	19	8.1
Told me about the services available	224	95.7	10	4.3
Helped me make informed choices	155	66.2	79	33.8
Explained how I could do what I have decided	163	69.6	71	30.3
Scheduled a return date	215	91.9	19	8.1

Service providers who counsel young people must possess certain personal qualities, attitudes, knowledge and skills (MOH, 2006). Table 7 gives the perception of respondents on the attending skills of the service providers. About 92 percent said that they were greeted and felt welcomed this was very important for the youth because it makes them feel free to express their feelings, needs, wants, doubts, concerns or questions. 95 percent reported having been informed about the services available hence able to make informed choices as 66 percent indicated. Although being non-judgemental is high; about 92 percent, expressing empathy is not that high; 61 percent this may be because discussions on providing reproductive health services to young people has always been sensitive (MOH,2005). This is borne out of cultural and traditional orientation on matters related to sexuality. Further, none of the service providers had their own personal bias against providing the youth with contraceptives or felt that young people should not be sexually active, thus hindering services to the youth.

Table 8:

Training needs of the service providers

Training Needs	Frequency (f)	Percentage (%)
Special needs of the youth	3	100
Psychological trauma counselling	2	66.7
Communicating with a youth client	2	66.7
Training in life skills	3	100

As Table 8 shows, majority of the service providers felt that they needed more training on adolescent issues to be able to provide effective youth friendly information and counselling services. This is because young people need specialized reproductive health services due to their biological and psychological needs.

4.5 Ways of promoting awareness of youth friendly information and counselling services

The third objective of the study was find out ways of promoting awareness of youth friendly information and counselling services among the youth who visit the Rift Valley General Hospital Youth Centre. Youth clients must know that youth friendly information and counselling services exist, the facility location and its hours. It is important that any publicity on services stress that young people are welcome and that they will be served respectfully and confidently (MOH, 2005). The researcher sought to establish how the youth learnt about the youth centre. Table 9 gives the youth responses.

Table 9:

Publicity of services

Source	frequency	percentage%
A friend	118	50.4
Peer Educator	55	23.5
Poster	30	12.8
Radio	22	9.4
Newspaper	2	0.9
No response	7	3.0
TOTAL	**234**	**100.0**

These findings show that friends 50.4 percent and peer educators 23.5 have a major role in informing other youths about the services offered at the centre. Newspaper and radio were the lest mode of disemitation of reproductive health information 0.9% and 9.4% respectively. This may be because it is expensive to advertise in these types of media. Making the youth-friendly services known to youth is crucial for effective utilization (MOH, 2005). According to Senderowitz *et al.,* (2003) it is important that any publicity on services also stress that young people are welcome and that they will be severed respectfully and confidentially.

On whether they felt welcomed and encouraged to visit the youth centre, 217 (92.7%) of the youth 92.7% answered YES and 7 answered NO. 10 did not respond. Table 10 Summarised the youth responses on how the service providers encourage the youth to visit the centre.

Table 10:

Promotion of youth friendly information and counselling services

Promotion of YFS	Frequency	Percentage (%)
Reaching youths through variety of channels Such as outreach including peer education	116	49.6
Availability of wide range of services and contraceptive methods	132	56.4
Availability of behaviour communication materials on adolescent sexual and reproductive health issues	120	51.3
Privacy and confidentiality honoured	215	91.9
Staff trained in youth friendly sexual RH	144	61.5
Adequate time allocated for client and provider Interaction	209	89.3
Have signs directing youths or indicating the type of available services	211	90.2
Have relevant information, Education and Communication materials	194	82.9

From the study it was evident that majority of the youths who visit the centre felt welcomed. The findings showed that 91 percent of the youth value privacy and confidentiality this confirms an earlier report by Senderowitz *et al.,* (2003) that young people are greatly disturbed and affected by a feeling or suspicion that their sensitive and intimate health concerns are being shared with other persons. 89.3 percent think that adequate time for client and provider interaction is important to them. These findings also suggest that a wide range of services need to be availed to meet the widest possible range of individual youth health needs. Whenever it is necessary to send young people to another location for other services, there is an increased risk that they will not actually show up (Pathfinder, 2008). The service providers also have a role to play in publicizing the services that they offer. An item was constructed to get their views on how they do it. The findings showed that the youth centre recruits and trains the local youth groups to provide outreach IEC support services and mobilize youth and the public in support of

youth friendly services; they also publicize the location of services using posters, have a signboard listing all the services offered. In addition, they have trained peer youth educators who help in running and planning the services offered and assist in mobilizing support and motivating the youth to utilise the services. Group discussions and talks on various aspects related to sexual and reproductive health are held routinely.

However, the youth centre had no arrangement for allocating specific times to provide services to young people the sexual and reproductive health services were invariably only offered between 8:00-4:30 pm indeed this was seen as a barrier to accessing services for most youth, given that it coincided with school hours and work hours.

4.6 Contribution of youth friendly reproductive health information on their sexual behaviour change

The fourth objective of this study was to investigate the impact of youth friendly reproductive health information and counselling services on youth sexual behaviour. Sexual behaviour has been one issue often avoided during discussions among the youth. In Kenyan education system, young people are not taught how to safeguard their sexual and reproductive health. Many parents mistakenly believe they are (IPS, 2009), However, it is clear that majority youth face many sexual and reproductive health problems including unwanted pregnancies, abortions, premature parenthood, early marriages, STIs and HIV/AIDS. The researcher wanted to establish whether the youth discussed sex issues with their parents, Among all the sampled youth 206 (88%) said that their parents did not allow them or encourage them to ask questions about sexuality.10.7% said that their parents and not peers were their first and primary source of sex information. This implies that a good number of youth do not discuss sex issues with their parents. This explains why 88.3% of the youth said that they did not feel that they grew up with healthy comfortable attitude towards sex and reproduction. Table 11 reflects these findings

Table 11: Proportion of responses of behaviour change of the respondents

Behaviour change	Youth response			
	Yes	%	No	%
Know ways to avoid getting STIs & HIV	209	89.3	25	10.7
Abstain from sex	120	51.3	95	40.6
Use condom during sex	79	33.8	10	4.3
Avoid multiple partners	86	36.8	5	2.1
Be faithful to partner	227	97	5	2.1
Know how to avoid unwanted pregnancy	224	95.7	10	4.3
Know how to say no to unwanted intimacy	203	86.3	31	13.2
Seek proper Rh services early	224	95.7	10	4.3
Avoid high-risk behaviours; drug abuse	215	91.9	19	8.1

About 90 percent of the youths feel that after receiving youth friendly reproductive health information and counselling services they have increased knowledge and awareness of risky sexual behaviour. They also know how to protect themselves from STIs, HIV and unwanted pregnancies. Only 4.3 percent of the respondents said they don't use condom during sex. Empowered young people are able to develop , adopt and sustain health attitudes and behaviours towards reproductive health and development this reflected in the table above. The researcher sought to know from the service providers who work at the youth centre their opinion, on whether the youth friendly reproductive health information and counselling services led to an increase or decrease or no change in the youths' sexual of behaviour. Their response are summarised in the table 12.

Table 12:

Responses on whether youth discuss sex issues with parents

Sex issues	Not true		True	
	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
Allowed and encouraged questions on sex	206	88	28	12
My parents not peers were my primary source of sex information	198	84.6	36	15.4
I feel grew up with healthy comfortable attitude towards sex	208	88.9	26	11.1

The impression created here is that the youth grow up with a lot of mysteries surrounding sexuality. Knowing the truth is less disturbing than not knowing the facts and wondering what they are. Indeed sex experimentation comes mostly frequently from the youth person who is uniformed, for experimentation is one way of getting information. The family seems to have neglected the responsibility of educating their youth on the dangers of casual sex in the light of HIV/AIDS scourge. To fill the gap, the youth friendly centres were established where young people can access reproductive health information. During the research, items were constructed to assess the contribution of youth friendly reproductive health information and counselling services. The response of the youths on behaviour change after accessing youth friendly reproductive health information in the youth centre are shown in Table 12.

Table 13:

Responses of behaviour change of the respondents

	Youth response			
Behaviour change	YES	%	NO	%
Know ways to avoid getting STIs and HIV	209	89.3	25	10.7
Abstain from sex	120	51.3	95	40.6
Use condom during sex	79	33.8	10	4.3
Avoid multiple partners	86	36.8	5	2.1
Are faithful to partner	227	97	5	2.1
Know how to avoid unwanted pregnancy	224	95.7	10	4.3
Know how to say no to unwanted intimacy	203	86.3	31	13.2
Seek proper Rh services early	224	95.7	10	4.3
Avoid high – risk behaviours like drug abuse	215	91.9	19	8.1
Greater awareness of youth programmes	209	89.3	25	10.7

About 89.3% of the youth felt that after receiving youth friendly health information, they have increased knowledge and awareness of risky sexual behaviour. They also know how to protect themselves from STIs, HIV and unwanted pregnancies. Only 4.3 percent of the respondents said do not condom during sex. Empowered young people are able to develop, adopt and sustain health attitudes and behaviours towards reproductive health and development.

The researcher sought to know from the services providers who work at the youth centre their opinion, on whether the youth friendly reproductive health information led to an increase or decrease or no change in the youth's sexual behaviour. Their response are summarized on Table 13

Table 14:

Providers' views on youths' sexual behaviour

Aspect of behaviour	%increase	% decrease	No change
Teenage pregnancy incidences	-	66.7	33.3
Youth self-assertive	66.7	-	33.3
Ability to adopt safer sexual behaviour	-	100	-
HIV/AIDS and STIs injection rate among the youth	-	100	-
Incidences of unsafe clandestine abortions	-	66.7	33.3
Refuse unwanted sex		33.3	66.7
Seek proper reproductive health care	100	-	-
Positive prevention of HIV/AIDs and STIs	66.7	-	33.3
Delay of sexual debut	33.3	33.3	33.3
Early diagnosis and effective treatment of STIs	66.7	-	33.3
Voluntary counselling & Testing	66.7	-	33.3
Desire to postpone child birth by two or more years for females	100	-	-

From the providers' response, 66.7% said that incidences decreased while 100% indicated that the youth adopted safer sexual behaviour after receiving youth friendly information. However, only 33.3% indicated it led to delay of sexual debut. It is evident that provision of youth friendly information empowers the youth make healthy decisions including protecting themselves from unwanted pregnancy and HIV/AIDS

4.7 Contribution of youth friendly reproductive health counselling on youth sexual behaviour

The fifth objective of this study was to investigate the contribution of youth friendly reproductive health counselling services on youth sexual behaviour change. Counselling is a vital part of reproductive health care (MOH, 2005). It is a person to person interaction in which the service provider provides adequate information to enable the youth client arrives at an informed choice of reproductive options. From the Focus Group Discussion the researcher sought to find out whether the youth friendly reproductive health counselling services offered at the centre help: meet youth reproductive health needs. Out of the 6 youth who had met for the discussion, 5 said -Yes. Those who said yes gave the following reason, 83.3% said that there is provision of reproductive health information and counselling services which is accessible, affordable, and acceptable. This confirms an earlier report by MOH (2005) 'information and counselling services should be made available to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility'.

On whether the youth friendly reproductive health counselling services have had any impact on your sexual behaviour? After a lengthy Discussion, the youth agreed that the reproductive health counselling services provided at the centre: have had a positive contribution on their sexual behaviour. The youth gave the following responses on how counselling have contributed to their sexual behaviour change: One gains information about oneself that enables one make informed voluntary decisions on sexuality, prevention of pregnancy and STIs, these findings confirm what the providers had said earlier that incidences of teenage pregnancies had reduced. The Focus Group Discussion responses are summarised in Table 14.

Table 15:

Contribution of youth friendly reproductive health counselling on sexual behaviour

Responses	Frequency (f)	Percentage (%)
Setting personal goals and working towards them	5	83.3
Focusing on building strong friendship	4	66.7
Avoiding negative media influences	4	66.7
Setting boundaries in relationships	5	83.5
Overcoming peer pressure	3	50
Searching for answers to fears and concerns	4	66.7
Practicing negotiation skills	5	83.3
Seeking for help	4	66.7
Being able to express oneself clearly on sexual desires	5	66.7

83.3 % of the youth feel that getting youth friendly reproductive health counselling services Have helped them practice the skill of decision making and goal setting. Only 50% said they are able to overcome peer pressure, this could be because most youth are sensitive about their peers' opinion on matters to do with sexuality, Wilson (2002) asserts that since adolescents seek approval for their behaviour by those opinions they regard most highly, 'It is the peer group which creates a specific micro world guiding male and female roles, sexual ideologies and patterns of intimate relations[5]. This implies that peer counselling is an important tool in modifying behaviour. If peer counsellors are carefully selected and trained in the counselling skills they can go a long way in communicating moral and ethical values. 66.7% of the youth also asserted that they arc able to avoid negative media influences. Statistics show that media in general, television movies, magazine, and music videos are some of the ways today's young people are influenced. Music videos and lyrics encourage sexual promiscuity and consequently

resulting in sex becoming the 'in tiling' at a young age. They therefore follow a long such trends in their quest of self-affirmation and discovery leading to risky sexual behaviour (Kiuna, 2008). Youth friendly reproductive health counselling helps the youth explore attitudes and values about growing up, gender roles, risk taking, sexual expression, negotiation skills and friendship formation (MOH, 2006).

In conclusion most of the youth who have been to the youth centre more than once reported having acquired skills to adopt safer sexual behaviour and feel that any time they have any sexual and reproductive health related problem that the service providers will be able to help them. Moreover they also feel comfortable asking the providers questions about sexuality and reproductive health.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMEDATIONS

5.1 Introduction

The present study was designed to evaluate the impact of youth friendly reproductive health information and counselling services on youth sexual behaviour. The conclusions arrived at are stated and recommendations made with an overall goal of enabling youth to make healthy decisions; including protecting themselves from unwanted pregnancy and HIV/AIDS.

5.2 Summary of the findings

The purpose of the study was to investigate whether youth friendly information and counselling services have any impact on youth sexual behaviour.

i. Results from the findings indicate that Nakuru youth friendly centre has the recommended essential reproductive information and counselling service package to provide services to the youth.
ii. The study revealed that service providers have the appropriate counselling skills to give youth friendly reproductive information and counselling services to the youth, however, more training on adolescent issues is required.
iii. It was also discovered that the youths were informed about the services offered at the centre mostly through friends and peer educators. Providers also publicized the services available and assured privacy and confidentiality to the youth.
iv. From the study majority of the youth felt that youth friendly reproductive information and counselling services had made a positive contribution on their sexual behaviour change.

5.3 Conclusion

The findings of the study form the basis upon which the conclusions and recommendations of the study were made. This study came up with the following conclusion-:

i. The Rift Valley General Hospital is meeting its goal of providing reproductive health information and counselling services for the youth.
ii. The youth friendly information and counselling services are effective in improving key youth reproductive health behaviours. Such as delaying sexual initiation, reducing the

number of sexual partners and increasing use of condom among the youth who are sexually active.

iii. Trained providers in youth friendly services assure youth utilization of the services.

iv. Youth friendly information and counselling services are on appealing strategy for improving youth service use because they tend to provide supportive, non-threatening environment where the youth have access to information, counselling, contraceptive, preventive services and referral. These services are derived alongside recreational activities that draw the youth to the centre at a regular basis.

v. Trained peer educators are an added advantage in offering youth friendly information and counselling services.

5.4 Recommendations

i. The MOH to provide quality and sustainable youth friendly information and counselling to empower the youth develop, adopt and sustain healthy attitude reduce risky sexual behaviour.

ii. The MOH and Ministry of Youth Affairs to document and disseminate information on programmes that have already been effective in reaching young people with accurate information on sexual related information and counselling services

iii. Parents must ensure that they talk to their children about the right attitude to sex because the role of parents cannot be substituted by outside interventions.

5.5 Suggestions for further research

This study suggests that:

i. Studies of similar nature be carried out in other parts of the country, where there are other youth friendly centres.

ii. A study could be carried out to establish the effect of sex education on youth's sexual behaviour.

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APPENDIX A

THE YOUTH'S QUESTIONNAIRE

My name is Beatrice Kuria a student at Egerton University, currently doing a masters degree in Guidance and Counselling. Am carrying out a research on "Impact of Youth Friendly Reproductive Health Information and Counselling on youth sexual behaviour". I am interested in what you think about the reproductive health services provided at this facility and would like to know your feelings about the service that you just received.

I would like you to answer a few questions about the meeting you have just had with the centre staff and would be grateful if you could spend a little time talking with me. I will not write down your name, and everything you tell me will be kept strictly Confidential. Your participation is voluntary and you are not obliged to answer any questions you do not want to .Do I have your permission to continue?

Please answer the questions given as honestly as possible. The information you give will be treated in confidence. Do not write your name anywhere in this questionnaire.

SECTION A

(Please tick the correct choice)

1. How old are you? 10 – 14 yrs ☐ 15-19 years ☐
   20 – 24 years ☐ other age group ☐

2. Gender: Male ☐ Female ☐

3. Sexually active: Currently sexually active
   Have been sexually active but not currently active
   Have never been sexually active

4. State the age at which you experienced the pleasure of the first sexual intercourse

Below 12 years ☐ 16 – 20 years ☐
12 – 15 years ☐ 21 – 24 years ☐
Not applicable ☐

5. i) Is this your first time in this youth centre?

☐ Yes ☐ No

ii) If no how many times?

☐ 2 ☐ more than 2

SECTION B.

6. What are the reproductive health needs that people of your age may have?

i. Lack of access to youth-friendly services ☐

ii. Lack of information on availability of services. ☐

iii. Poor skills among service providers on how to deal with youth ☐

iv. Stigma associated with seeking sexual and reproductive health services by youth ☐

v. Limited understanding on the need for youth-friendly sexual and Reproductive Health services by parents, teachers, policy makers and faith leaders. ☐

7. Of the needs that you mentioned, which one do you think is the biggest problem?

....

8. How did you learn about this youth centre?

A poster ☐ a radio advert ☐ a peer educator ☐

a newspaper ☐ a friend ☐

9. Do you think that this centre encourages youth to visit and use its service?

Yes ☐ No ☐

If yes how?

i. By reaching young people through a variety of channels such as outreach (including peer education) and the private and commercial sectors. ☐

ii. Availability of wide range of services and contraceptive methods ☐

iii. Availability of Behaviour Change Communication materials on adolescent Sexual and Reproductive Health issues ☐

iv. Privacy and confidentiality honoured. ☐

v. Staff trained in youth-friendly sexual reproductive health ☐

vi. All staff demonstrates respect and concern for young people ☐

vii. Adequate time is allocated for client and provider interaction ☐

If not, what need to be done?

i. Have signs directing youths or indicating the type of available services. ☐

ii. Have separate rooms for the youth and relevant information, ☐

Education and communication materials. ☐

iii. Improve confidentiality and privacy. ☐

iv. Training service providers in provision of effective youth-friendly sexual reproductive health services ☐

v. Offer convenient hours and affordable fees. ☐

10. During your visit to this centre, how were you treated by the service provider?

	Yes	No
Greeted and made to feel comfortable		
Introduced himself or herself		
Assured of privacy and confidentiality		
Asked about the reasons of my visit		
Asked open-ended and simple questions		
Listened actively and showed interest		
Expressed empathy		
Is non judgemental		
Told me about the services available		
Helped me make informed choices		
Explained how I could do what I have decided		
Scheduled a return date		

11. Do you believe condoms are effective for preventing HIV/AIDS, STIs and pregnancy?

Strongly agree ☐ Agree ☐

Strongly disagree ☐ Disagree ☐

12. Overall, would you say you were satisfied with your visit to this youth centre.

Strongly agree ☐ Agree ☐

Strongly disagree ☐ Disagree ☐

13. Do you feel that you received the information and counselling services that you needed ?

Yes ☐ No ☐

14. Any time I have sex, from the time I visited this youth centre I must use a condom for protection from HIV/AIDS/STIS

Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐

15. Since I came to know of HIV/AIDS from Peer educators in this centre I decided to retain only one sexual partner.

Yes ☐ No ☐

16. I have stopped sexual intercourse since I started visiting this youth centre.

True ☐ False ☐

17. Since I started visiting this centre I have developed good health habits and seek regular care at an early stage.

True ☐ False ☐

18. Do you know the Reproductive health information and counselling services that are provided at this centre?

Yes ☐ No ☐

If yes tick in the appropriate column the services provided.

Reproductive health services provided	Provided	Not provided	Referred
a) Information and counselling on sexual and safer sex.			
b). Counselling services on: • STI & HIV (testing and care) • Contraception with emphasis on dual protection. • Post- abortion (with referral for management of emergency complications when necessary). • Sexual violence and abuse • Prevention of pregnancy • Abstinence, consequences of unsafe abortion.			
c. Provision of contraceptives			
d. Recreation facilities in and outdoor activities			
f. Voluntary counselling and Testing (VCT)			
g. Comprehensive post rape care.			
h. Availability of reading materials.			

APPENDIX B

SERVICE PROVIDER'S QUESTIONNAIRE

The following items are to capture your evaluation on the impact of youth friendly reproductive health on youth sexual behaviour. As well as you a training to work with youth issues.

Kindly respond to all the items as honestly as possible. The information will be treated in confidence.

Thank you.

SECTION A

1. I am comfortable discussing sexual behaviour and reproductive health issues with the youth.

   True ☐ False ☐

2. What kind of training have you received to provide youth-friendly reproductive health information and counselling services?

   ____

   ____

3. Have you had a refresher training class recently?

   Yes ☐ No ☐

   If yes, what did it cover?

4. Have you had any special training on youth reproductive health issues?

   Yes ☐ No ☐

   If so, what did it cover?

5. Are there any services that this facility provides to the youth that you think are not appropriate?

   Yes ☐ No ☐

   If yes, what are they?

6. In order to adequately serve the youth; do you think you have enough training?

   Yes ☐ No ☐

7. What would you like to have more training on?
   i. Special needs of youths. ☐
   ii. Providing youth-friendly services ☐
   iii. Basic reproductive health. ☐

8. In your position at this youth centre, what kind of services do you offer?
   i. Information and counselling on sexuality, safer sex, and reproductive health ☐
   ii. Contraception with an emphasis on dual protection ☐
   iii. STI diagnosis and management ☐
   iv. HIV counselling (and referral for testing and care) ☐
   v. Pregnancy testing and antenatal and postnatal care ☐
   vi. Post-abortion counselling and contraception (with referral for management of emergency complications when necessary) ☐
   vii. Counselling on sexual violence and abuse (and referral for needed services)

9. Do you have peer counsellors in this centre?

Yes ☐ No ☐

If yes what is their role________________________________

10. How do you motivate the youth to seek out and use the services provided in this centre?

____

SECTION B

In your opinion has the youth friendly reproductive health programme led to an increase or decrease or no change in the following aspects of behaviour among the youths.

Aspect of behaviour	Increase	Decrease	No change
1. Teenage pregnancy incidences	☐	☐	☐
2. Youth self-assertiveness	☐	☐	☐
3. Ability to adopt safer sexual behaviours	☐	☐	☐
4. HIV and STIs infections rate among the youth	☐	☐	☐
5. Incidences of unsafe clandestine abortions	☐	☐	☐
6. Refuse unwanted sex	☐	☐	☐
7. Seek proper reproductive health care	☐	☐	☐
8. Positive prevention of HIV/AIDS and STIS	☐	☐	☐

9. Delay of sexual debut	☐	☐	☐
10. Early diagnosis and effective treatment of STIS	☐	☐	☐
11. Voluntary Counselling & Testing	☐	☐	☐
12. Desire to postpone child birth by two years or more for females	☐	☐	☐

APPENDIX C

FOCUS GROUP DISCUSSION:

1. What are the reproductive health problem / needs do youths have?

2. What services do this youth centre offer?

3. Do the youth friendly reproductive health services offered in this centre help solve your problems/ needs

4. Do you think the youth friendly reproductive health services has had any impact on your sexual behaviour.

5. Suggest ways in which this youth centre can improve in its service delivery.

6. How often do you hold discussion about sexual behaviour.

APPENDIX D

REQUIRED SIZE FOR RANDOMLY CHOSEN SAMPLE

N= Population Size

N	S	N	S	N	S	N	S
10	10	140	103	550	226	4500	354
15	14	150	108	600	234	5000	357
20	19	160	113	650	241	6000	361
25	24	220	140	700	248	7000	364
30	28	230	144	750	254	8000	367
35	32	240	148	800	260	9000	368
40	36	250	152	1200	291	10000	370
45	40	260	155	1300	297	15000	375
50	44	270	159	1400	302	20000	377
55	48	280	162	1500	306	30000	379
60	52	290	165	1600	310	40000	380
65	56	300	169	1700	313	50000	381
70	59	320	175	1800	317	75000	382
75	63	340	181	1900	320	100000	384
80	66	360	186	2000	322		
85	70	380	191	2200	327		
90	73	400	196	2400	331		
95	76	420	201	2600	335		
100	80	440	205	2800	338		
110	86	460	210	3000	341		
120	92	480	214	3500	346		
130	97	500	217	4000	351		

S = Sample size

Source : Kathuri ,J.N. & Pals D.A (1993)

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UNIVERSITY

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DEPARTMENT OF PSYCHOLOGY, COUNSELLING AND EDUCATIONAL FOUNDATIONS

11th August 2009

TO WHOM IT MAY CONCERN

RE: MASTERS' STUDENTS' FIELD RESEARCH

It is a requirement for our Master of Education students to carry out a field research for their project report. The research can be carried out in institutions of learning or other institutions that the student may be interested in.

I therefore wish to introduce to you **Kuria Beatrice Njeri** registration number **EM20/1602/06** for your kind assistance in her study entitled: ***The Impact of Youth Friendly Reproductive Health Services on their Sexual Behaviour: A Case of Rift Valley Provincial General Hospital Youth Centre.***

Please, accord her the help she may need in order to achieve this objective. While she is carrying out the research, she is familiar and bound by the ethical standards of collecting information, safeguard of the same, and using the findings pro-actively.

On behalf of the University, I wish you well and thank you for your partnership in the training of our students.

Sincerely,

Dr. M. Chepchieng
CHAIRMAN, DEPARTMENT OF PSYCHOLOGY, COUNSELLING AND EDUCATIONAL FOUNDATIONS.

For: Vice-Chancellor- Egerton University

MINISTRY OF HEALTH

Telegrams: "PROVMED", Nakuru
Telephone: Nakuru 215580-90
When replying please quote

Ref. No. ....

PROVINCIAL GENERAL HOSPITAL
RIFT VALLEY PROVINCE
P.O. Box 71
NAKURU

RII/VOL.I/08

Date: 26/8/2009

To: Beatrice Kuria
P.O. Box 604
OL Kalou

Dear Beatrice Kuria

RE: APPROVAL TO UNDERTAKE RESEARCH AT THE RIFT VALLEY PROVINCIAL GENERAL HOSPITAL

Reference is made to your letter dated 19/8/2009 seeking permission to do research at Provincial General Hospital, Nakuru on "The impact of Youth Friendly Reproductive Health information and counselling services on Youth Sexual behaviour: A case of Rift Valley Provincial General Hospital Youth Center"

Permission has been granted/Not granted for the research. It is hoped that you will adhere to the ethics and standards that relate to research at our institution.

Thank you.

Yours sincerely

Dr. Gamasi

MEDICAL SUPERINTENDENT

MEDICAL SUPERINTENDENT
PROVINCIAL GENERAL HOSPITAL
P.O. BOX 71 NAKURU

CHAIRPERSON
RESEARCH AND ETHICS COMMITTEE