EVIDENCE TO ACTION

A RAPID ASSESSMENT OF REPRODUCTIVE MATERNAL NEWBORN CHILD AND ADOLECSENTS HEALTH AND NUTRITION (RMNCAH+N) INVESTMENT PROGRESS ON ACCESS TO ADOLESCENTS AND YOUTH SEXUAL REPRODUCTIVE HEALTH SERVICES AND RIGHTS (SRHR) IN NAIROBI AND KISUMU COUNTIES, KENYA

EXECUTIVE OFFICE OF THE PRESIDENT
NAIROBI METROPOLITAN SERVICES
REPUBLIC OF KENYA
nms

COUNTY GOVERNMENT OF KISUMU
HARBOUR OF PROSPERITY

HENNET
Health NGO's Network

"conquer with love"
OAyouth

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About Organization of African Youth Kenya

Organization of African Youth Kenya (OAY) is a continental, member based, non-profit organization registered in 11 countries and operating with 35 chapters in Africa. OAY is an empowerment vehicle and a revolutionary movement for all youth in Africa. It is a regional platform for young people to assert their power. OAY champions Meaningful Adolescents and Youth Engagement (MAYE) through leadership development, social and gender inclusion, and evidence-based policy advocacy. We empower tomorrow's leaders today.

VISION

- Strong representation and participation of youth in championing social, political and economic development in Africa.

MISSION

- To be the continental umbrella organization for all African youth, providing a platform for youth-led programs, a forum for dialogue, and a network of future leaders.

STRATEGIC AREAS

- Health & well-being
- Climate Action
- Economic Empowerment

Cross cutting themes

- Gender and Social Inclusion
- Leadership Development
- Governance and Civics

Acronyms and Abbreviations

APOC	Adolescent Package of Care
AY	Adolescents and Youth
AYWG	Adolescent and Youth Working Group
AYFS	Adolescent Youth Friendly Services
AYSRHS	Adolescent and Youth Sexual and Reproductive Health Services
CHA	Community Health Assistant
CHW/V's	Community Health Workers/volunteer
COVID-19	Corona Virus Disease of 2019
CIDP	County Integrated Development Plan
CSES	Civil Society Engagement Strategy
CSOs	Civil Society Organizations
FGD	Focus Group Discussion
GFF	Global Financing Facility
HCP/HCW	Health care provider/ health care worker
HENNET	Health NGOs' Network
IC/F	Investment Case/Framework
KII	Key Informant Interview
MAYE	Meaningful Adolescent and Youth Engagement
MCP	Multi-stakeholder Country Platforms
MoH	Ministry of Health
NACC	National Aids Control Council
NCPD	National Council for Population and Development
OAY	Organization of African Youth
OECD	Organization for Economic Co-operation and Development
PAD	Project Appraisal Document
PWDs	People with Disabilities
RMNCAH+ N	Reproductive, Maternal, Newborn, Child and Adolescent Health + Nutrition
SDG	Sustainable Development Goal
THS-UHC	Transforming Health Systems for Universal Care Project
VYA	Very Young Adolescents
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
YSOs	Youth Serving Organizations
YPLWD	Young People Living with Disability

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We believe that the findings of this rapid assessment will guide different stakeholders in enhancing AYSRH projects that will improve the status of the health of Adolescents and Youth in Nairobi and Kisumu Counties. OAY recognizes the fact that it may not be able to thank all who participated in the study, but we are grateful for their contribution and support.

Thank You!

GLOSSARY OF TERMS

Adolescents: WHO standard defines adolescents as people between the ages of 10 and 19 years

Youth: WHO standard defines the youth as people between the ages of 15 and 24 years. The African Youth Charter and some governments define youth as people between the ages of 15 and 35 years. In this Assessment, youth is referring to those between the ages of 15-24 years.

Young People: WHO standard defines people between the ages of 10 and 24 years as youth

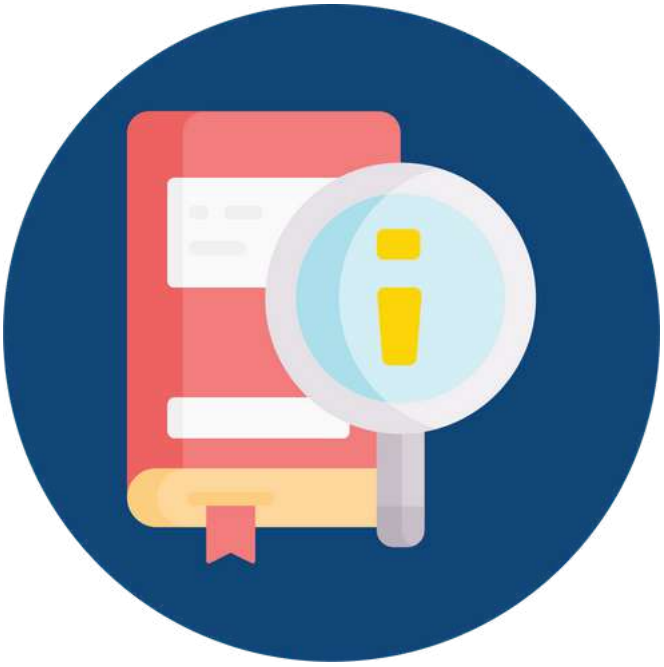
AY-Friendly Health Services: those that are based on a comprehensive understanding of, and respect for, young people's rights and realities of their diverse sexual and reproductive lives. These are services that young people trust and feel are there for them

Community Health Worker: Any health worker who performs functions related to healthcare delivery in the community. Community health workers have received training on the interventions and activities they are involved in, but have not received formal professional, paraprofessional or tertiary education. They are normally members of the communities where they work, selected by the communities, answerable to the communities for their activities and should be supported by the health system

Health Literacy: The cognitive and social skills that determine the motivation and ability of an adolescent or young person to gain access to understand and use information in ways that promote and maintain good health.

Meaningful Adolescent and Youth Engagement: an inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and world

Standard: A statement of a defined level of quality in the delivery of services that is required to meet the needs of intended beneficiaries. A standard defines the performance expectations, structures, or processes needed for an organization to provide safe, equitable, acceptable, accessible, effective, and appropriate services.



EXECUTIVE SUMMARY

In 2021, the Organization of African Youth (OAY) conducted a rapid assessment on the AYSRH policies and strategies in Kenya. This assessment reviewed the implementation of the Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition (RMNCAH+N) investment framework and associated policies, and their effect on delivery of AYSRH services, information and products at the national level as well as in Nairobi and Kisumu counties. The aim was to establish the priority given to Adolescents and Youth (AY) (age 15-24 years) in the national and county governments' policies and strategies

Addressing and engaging adolescents and youth in matters around their Sexual and Reproductive Health (AYSRH) and access to good nutrition is a global concern. The Global Strategy for Women, Children and Adolescent Health 2016-2030[i] highlights the importance of adolescent and youth health and well-being, essential to achieving the Sustainable Development Goals (SDGs) by 2030. It emphasizes that for adolescents and youth to survive, thrive and transform their societies, the global community needs to invest in their health and well-being.

[i] World Health Organization. 2015.The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)

A Focus Group Discussion session with young women held in NAIROBI COUNTY

Targeting adolescents and youth is important if the country is to realize its development goals. National indicators show that women's sex debut is at 18 and men at 17 years, and that they first marry at 20 and 25 years respectively. The 2019 population census report (KNBS, 2019) depicts Kenya as a youthful country with 75% of its population below the age of 35; adolescents aged 10-19 constitute about 11.6 million of the population, accounting for 24.5%[1] of the total population. According to the 2015 National Adolescents and Youth Survey (NCPD, 2015), the major challenges Kenyan youth face that impact on their health and wellbeing include;

- Low quality education,
- Early and risky sexual encounters
- Low contraceptive use and unmet needs despite demand
- HIV/AIDS, and
- Unplanned pregnancy, early marriage, and early childbearing

COVID-19 has further eroded the gains made in RMNCAH+N indicators. The Kenya GFF publication, Preserve Essential Health Services during the COVID-19 Pandemic, estimated that the pandemic has disrupted the provision of essential services due to barriers to the supply and demand for services in Kenya, leaving 230,400 women without access to facility-based deliveries, and 1,698,800 fewer women receiving FP services[2]. Organization of African Youth (OAY) carried out a study in April 2020 which revealed that, for the youth, COVID-19 has affected their income affecting their purchasing power, hence their ability to access healthcare services and health commodities, and peer engagements capabilities that enhance health services demand creation.

[1] 2019 Kenya Population and Housing Census: Volume III
[2] Preserve Essential Health Services During COVID-19 Pandemic: Kenya. GFF Publication 2020

The aim was to generate evidence on how national and county governments' policies are prioritizing Adolescents and Youth (AY), including the effect of COVID-19 pandemic on access to SRH services, among the adolescents and youth.

Methods

A mixed methodology, with both qualitative and quantitative approaches, was applied which included literature review, Key Informant Interviews (KII), facility checklists, client exit interviews at selected health facilities and Focus Group Discussions (FGDs). These ensured that adolescents' voices and concerns were adequately captured within a safe environment. The tools were developed using the Global Standards for Quality Health Care Services for Adolescents framework (WHO, 2015).

Summary of Findings

This rapid assessment reviewed the implementation effect of the Reproductive, Maternal, New-born, Childand Adolescent Health plus Nutrition (RMNCAH+N) investment framework and associated policies on delivery of Adolescents Youth Sexual Reproductive Health (AYSRH) services, information and products at the national level and sub-regional levels, mainly in Nairobi and Kisumu counties.

Service Recipients of AYSRH services and information in a dialogue session

i.Global and National level AYSRH policies prioritization

- Key guiding global and national policy documents have explicitly highlighted adolescent (10-19) health, although there is vague mention of the youth (20-24yrs) in most documents, such as the initial GFF 2015 Business plan (Global Financing Facility, 2015), and Kenya's RMNCAH+N IC(MoH Kenya, 2016-2020). Transforming Health Systems (THS)-Universal Care Project (UCP) and the Project Appraisal Document (PAD) (World Bank Group, 2016) have no AY specific indicators and this compromises targeting and measurement of progress.
- AY Addendum to GFF Civil Society Engagement Strategy (CSES) (GFF, 2016) and the Global Statement on Meaningful AY Engagement (WHO, 2016) have substantially emphasised on inclusive and holistic MAYE, including youth representation on the GFF investors group and in the Multi-stakeholder Country Platforms (MCPS). This has been a huge step towards bringing AY health agenda on the decision-making table.
- At country level, adolescent health is among High Impact Interventions (HII) prioritized in Kenya's RMNCAH+N investment framework. Key components include, scaling up adolescent responsive and friendly health services, providing comprehensive sexual education and innovative interventions to retain girls in school. However, there is limited focus on the youth (20-24 years) in the framework
- In view of the COVID-19 pandemic, the WHO's Maintaining Essential Health Services: Operational Guidance for the COVID-19 (World Health Organization, 2020) has to a large extent prioritized adaptations to AYSRH services including suggestions of innovative ways to reach the adolescents and youth with information, products and services. Kenya's COVID-19 RMNCAH guidelines (MOH, 2020) do not specifically address AY focusing on protocols for safe continuity of RMN and FP services.

ii.Monitoring and accountability for AY issues

- The RMNCAH+N investment framework's results monitoring framework has only two AY indicators i.e., teenage birth-rate and FGM. Other AY indicators are aggregated in maternal health indicators.
- Adolescents and youth are allocated 5% of the project finances, and without targeting specific AY indicators, this may not translate to actual implementation since most of the indicators are aggregated within maternal health indicators.
- Implementation of the RMNCAH+N investment framework is anchored on the THS-UCP project, which uses the results-based framework (RBF) mechanism in its implementation. The RBF approach uses 6 project result indicators to monitor results at the national level. However, none of these indicators mentions the AY and the youth are not mentioned in the Project Appraisal Document (PAD)
- The Kenya ASRH Policy (2015) and the National Guidelines for AYFS 2016 explicitly prioritize adolescents. Unfortunately, key subpopulations such as sexual minorities are not highlighted.
- At the subnational level, the County Development Integrated Plans (CIDP) for Nairobi and Kisumu counties highlight the need to focus on AY in their rationale, especially on reduction of HIV prevalence and incidences, although their implementation matrices do not explicitly outline the AY agenda.

iii.Health Facility and workers perspectives on AYSRH services

- Health workers at the county and national respondents have a good knowledge of the existing guidelines policies and frameworks and support adoption of the RMNCAH+N Investment Framework and the National ASRH policy of 2015, albeit with some scepticism with regards to the adequacy of funding and domesticating of the policies to local settings.
- Health workers have been trained in adolescent health care with an emphasis on confidentiality and non-discrimination. However, concern was raised that newly recruited health workers had not been trained on Adolescent Package of Care (APOC).
- Health facilities had competent health care workers who offered these services. There was clear signage of AYSRH services at the facilities (n=3) that were included in the rapid assessment except for a few at the PHC facilities level. In Kisumu, few health facilities offered AY talks to clients or through community outreaches.
- While appropriate package of AYSRH services are available in health facilities, none of the facilities interviewed had AYFS corner or youth friendly educational activities on site or during outreaches. Most of the facilities that responded operated from 9am to 5pm on weekdays, apart from the referral hospitals that stretched to 11pm.
- The facilities offered a wide range of services to the AY and half of them had a broad-mix of contraceptives.However, mental health, SGBV and drug/substance abuse services were found to be insufficient and the referral systems to support these services were weak.
- A majority of the facilities assessed did not have a dedicated AYFS staff since services were integrated. There was a positive rating of services, with 97% of AYs who responded saying they would recommend services to their peers and 90% said they would return. However, AYs in the FGDs reported discrimination of very young pregnant or teenage mothers and boys, and lack of a feedback mechanism.
- All facilities reported that they uphold equity and non-discrimination, although most facilities in Kisumu did not have written policies and procedures on this. Nairobi County performed better on reaching the vulnerable sub-populations although it lacked facilities for YPLWD, especially those that are physically, visually and hearing challenged. In Kisumu only one of three facilities that responded reached very young adolescents, YPLWD, and those abusing drugs. There were no specific ways of reaching sexual minorities.
- Assessment of utilization data of AYSRH services and information showed an increasing utilization of HIV care services, suggesting possible increase of STIs in both counties. Skilled delivery was the second most popular service followed by modern FP.
- The effect of THS-UCP on the implementation of the RMNCAH+N investment framework and the utilization of AYSRH services, products and information was not very clear among the health care workers. While most national respondents hailed the achievements of GFF mechanism and THS-UCP at county and facility level, respondents at the subnational level expressed insufficient knowledge of the funding stream. Although it was hard to attribute the quality and uptake of AYSRH services, national and some county health management respondents attributed the general improvement in healthcare system strengthening to GFF mechanism, THS-UCP and other partners.

iv.Adolescents, Youth SRH service users and community perspectives

- The adolescents and youth exhibited low knowledge of national and subnational level AYSRH policy documents but demonstrated sufficient knowledge on available range of services at the health facilities.
- There was noted preference for chemists or drug shops by AY. These chemists or drug shops appear to be a more convenient alternative for services and information, despite the financial implication that comes with spending out-of-pocket for health services.
- The users raised issues affecting PHC service delivery include inadequate supplies e.g., diagnostic tests, erratic commodities such as FP and other key essential drugs, frequent strikes and infrastructural issues related to PLWDs. From the facilities that responded in Kisumu, half of them were found lacking functional essential equipment.
- Although 64% of AY clients interviewed found the facilities welcoming and clean, they stated that the waiting time was too long, while some expressed concern with the privacy in the consultation rooms.
- In terms of MAYE, youth cited engagement of a few of them in decision making, health promotion and providing feedback, although only a few facilities involved them in daily activities. In Nairobi County members of Youth Advisory Council (YAC) were involved in youth desk operations, demand creation, mobilization and awareness creation. At national level the youth are represented in the country platform.
- Half of the facilities interviewed had educational materials, although AYs prefer talking with peers or use their phones. Education materials for PWDs or those with challenges in English or Kiswahili were not available in all facilities.
- Within the communities, cultural and religious beliefs continue to shape acceptability of AYSRH services.
- Some vulnerable groups felt left out in service delivery and policy formulation, including young boys, YPLWDs (physically disabled, hearing and speech impaired) and sexual minorities.

v.Covid-19 impact on AYSRHR Services

- All the three facilities in Nairobi and one in Kisumu reported that they inform community of benefits of AYSRH services though community dialogues or collaborative outreaches, although this was uncommon and irregular because of COVID-19 in 2020.
- MOH and county governments made efforts using innovative ways to reach the AY with information especially during COVID-19 on digital and media platforms such as TUJULISHANE toll free number and social media links.
- COVID-19 affected access and utilization of services in both counties, mainly due to reallocation of personnel to manage the emergency, lack of drugs, and closure of some facilities which were set apart for COVID-19 isolation. Other reported causes of the disruption were infections among health workers and insufficient personal protective equipment (PPE's) for the health workers at the onset of the pandemic. There was also noted fear among the clients leading to lack of trust of the quality of services delivered at the PHC facilities and a preference for chemists and private clinics etc.

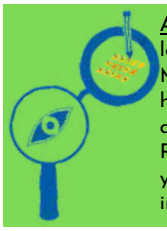
RECOMMENDATIONS

Summary of Recommendations

The assessment identifies the following investment opportunities to address the identified gaps.

Support: Fund and Support CSOs and youth to expand and deepen their participation in country platforms and advocate for holistic approach and ensuring vulnerable and marginalised populations are not left behind, country government needs to support these efforts for mutual accountability.

Monitoring and accountability: Explicit indicators on adolescents and youth age 15-24 should be incorporated in the monitoring and evaluation matrices of the AYSRH frameworks including in national and county RMNCAH policies. A sector based platform with county to national level AY wellbeing issues and data should be established.



AY Responsive UHC Benefits Package: At national level there is a need to engage the youth beyond the MCP as the country transitions to UHC to ensure their health agenda is prioritised and included in all key documents especially in the next phase of RMNCAH+N investment case, key is ensuring that youth specific indicators are incentivised and included in monitoring progress of access to AYSRH services

THS-UC Results Based Financing: Explore opportunities within the results-based financing approach or conditional granting process to incentivize/incorporate AY specific indicators in the RMNCAH+N investment framework

Drugs abuse: Clear policy actions are need to address the emerging problems of drug and substance abuse and mental health among young people and other concerns of adolescents and youth.

Coordination: Strengthen coordination between implementing partners and national team to enable them support the achievement of the medium-term targets and goals

Policy Review: Engage the AY in the review of the next phase of investment framework , ASRH Policy 2015 and UHC to ensure prioritization of AYSRHS.

Referral: Strengthen referral mechanisms for AY services including increasing the scope to include counselling on mental health, drug and alcohol use and sexual gender-based violence and innovations around community health strategy.

Health Promotion: Diverse outreach programs to reach the vulnerable and marginalized adolescents and youth including sexual minorities and YPLWD. Explore untapped opportunities eg schools, tertiary institutions, churches, markets, digital space, and political arena among others.

Innovation: Integrate use of telemedicine, longer (3 months) FP refills for condoms and oral contraceptives, increase of minimum stocks at facilities and use of pharmacies and drug stores to distribute the same.

Incentives: Integrate adolescent health, YFS and value clarification in the healthcare workers training curricula. This will result in creation of an enormous pool of competent and skilled health care workers.

Training: Integrate pharmacists in health provider trainings since they are key partners in care targeting the youth.

Contextualize: The assessment revealed that an "ideal and practical AYFS cannot be one size fits all but should be responsive to all AY within their context"

Diversity: Ensure health system to reach the underserved populations and those that are stigmatized to ensure no one is left behind. These include; young adolescent boys, teenage mothers, visually and hearing impaired and lesbian, gay, bisexual, transgender, intersex, and queer (LQBTQI) community.

Youth Work: Explore innovative ways of linking youth organisations with facility to improve quality and referral systems.

New frontiers: The approach to address and improve SRH services among the youth should be mainstreamed in other global health as well as economic initiatives such as HIV drop-in centers.

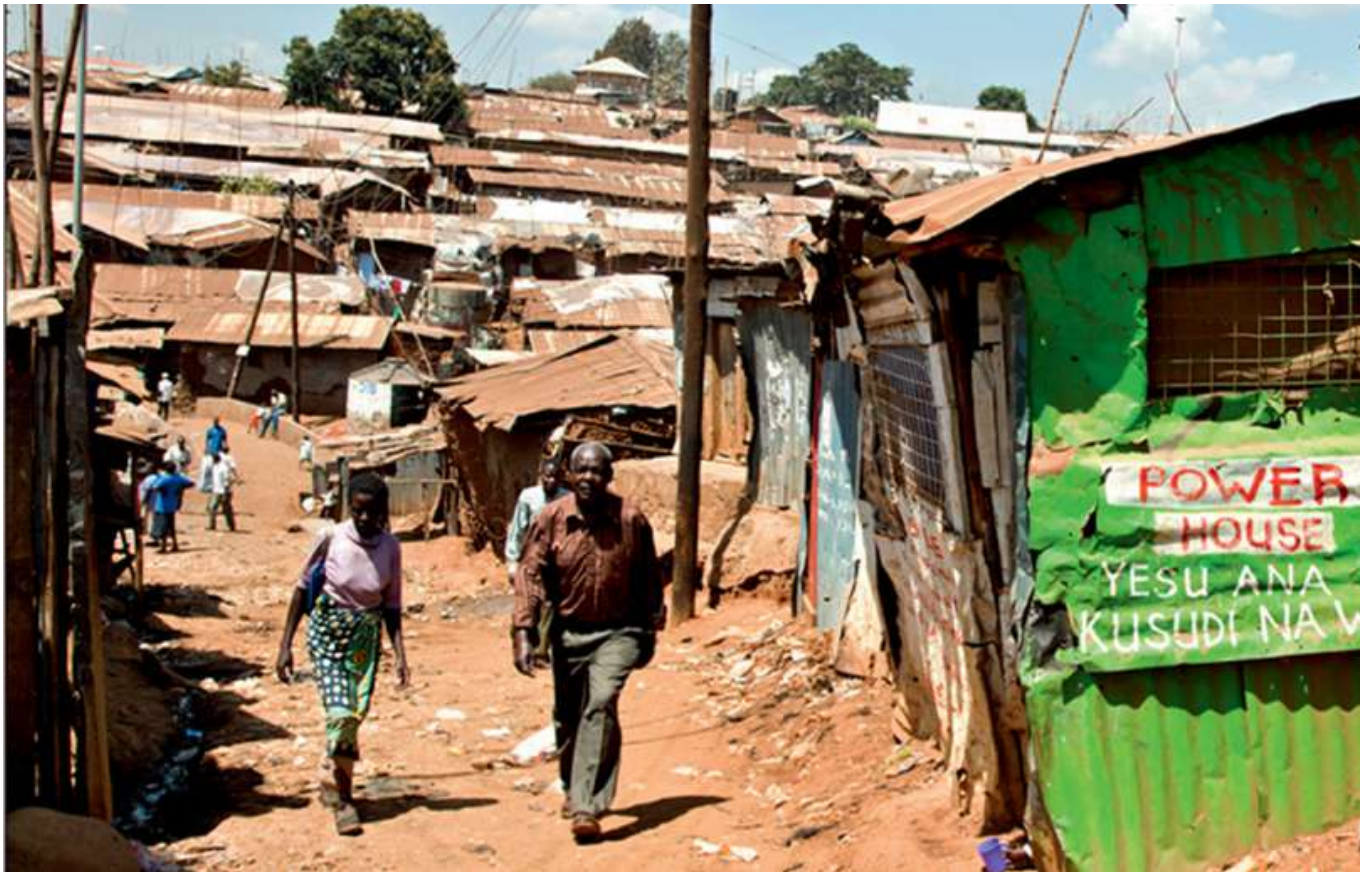
Youth Knowledge and Capacity: Incorporate policy formulation and implementation in youth-related capacity strengthening activities, to increase literacy in adolescent and youth health as well as enhance awareness of SRH rights.

Advocacy: Advocate for increased funding allocations and corresponding disbursement to ensure availability of equipment and commodities for adolescents' package of care (APOC) and competent health care providers (HCP) and support for advocacy

MAYE: Actualize meaningful adolescent and youth engagement so that they can complement the expressed intentions to promote the engagement of young people including engagement at facility and decision-making structures

CONCLUSIONS

Adolescents and Youth are faced with several challenges, which have been worsened by the COVID-19 pandemic, and there is need to prioritize their health and wellbeing. Implementation of the above recommendations will strengthen the environment for the implementation of policies and programmes that seek to enhance AYSRH and also enable track positive change towards AYSRH services.



"Yes we need to incorporate AY indicators in the next phase of the IC and data team should pay specific attention to data disaggregation to reduce duplication, create clarity on AY issues to ensure not falling behind. Further it is important for YSOs to come together and advocate as one."

KII, Dr. Mercy Mwangangi,
Cabinet Administrative Secretary MOH

"The policies should not be a one size fits all. For us in our setting we would rather not have a fancy youth friendly corner but ensure we offer youth responsive services even if integrated with other services as resources don't even allow"

Dr. Carol Ngunu,
ASRH coordinator,
Nairobi Metropolitan Services .

"Wengine walemavu wanaona haya kuenda sipitali" (most disabled may feel awkward to seek AYSRHS in hospital); FGD, Nairobi.

"PWDs are extremely discriminated- providers have an attitude towards them- patients being ignored and lack of translators"
FGD, Nairobi

"When you come to the facility for clinic the staff look at you and treat you funny like to ask why you are pregnant and maybe you are also stressed, so you avoid and go last days"
FGD, Kisumu

"Key populations like the gay and lesbians still get stigmatized and facility staff don't know how to treat them"

FGD, Nairobi

"Boys don't feel the need to seek these services since they're not sensitized"
FGD, Nairobi.

"No, girls are treated better than men in that girls are always given free sanitary towels and boys are not motivated in any way and also girls are always given more opportunities"

FGD, Kisumu

1.0 INTRODUCTION

1.0 INTRODUCTION

1.1 Introduction and background

Adolescent and Youth Sexual and Reproductive Health (AYSRH) is a global issue, especially in developing countries. The Global Strategy for Women, Children and Adolescent Health 2016-2030 highlights the importance of adolescent health and well-being as essential to achieving the Sustainable Development Goals (SDGs) by 2030, as well as states that for adolescents (and youth) to survive, thrive and transform in their societies, the global community needs to invest in their health and well-being (WHO, 2015)

The 2019 population census report (KNBS, 2019) depicts Kenya as a youthful country with 75% of its population below the age of 35; adolescents aged 10-19 constitute about 11.6 million of the population, accounting for 24.5% of the total population. According to the 2015 National Adolescents and Youth Survey (NCPD, 2015), the major challenges Kenyan youth face that impact on their health and wellbeing include;

- Low quality education,
- Early and risky sexual encounters
- Low contraceptive use and unmet needs despite demand
- HIV/AIDS, and
- Unplanned pregnancy, early marriage, and early childbearing

These issues contribute to increased dependency ratio thus slowing economic growth and realization of the demographic dividend, a key agenda for African Union (AU) member (AUECHO, 2017) countries. SRH services that target this group of the population are rarely planned for, resourced and rarely evaluated with RH indicators resulting in the need for improvement.

Targeting adolescents and youth is important if the country is to realize its development goals.National indicators show that women's sex debut is at 18 and men at 17 years, and that they first marry at 20 and 25 years respectively. Childbearing starts at 18 years resulting in a high prevalence of teenage pregnancies. In 2017, teen pregnancy and motherhood rates in Kenya stood at 18%, implying that about 1 in every 5 adolescent girls had either had a live birth, or was pregnant with her first (GoK, 2017). These rates increase rapidly with age: from 3% among girls at 15 years, to 40% among girls at 19 yrs. There is also unmet need for Family Planning (FP). For instance, in 2014, only 37% of married adolescents and 49.3% of sexually active unmarried adolescents were using contraceptives, while 23% would have liked to prevent pregnancies but were not using contraceptives (ASRH fact Sheet; MOH, 2016 & 2017).

National HIV prevalence among males and females aged 15-24 years was estimated at 1.34% and 2.61% in 2017 respectively, with overall prevalence being 1.98%, which means 184,718 young adults were living with HIV in 2017 (NACC, 2018). However, the annual infection rate among the youth (15 -24 Years) as defined by the National Aids Control Council (NACC) in Kenya is highest among the youth at 33%. These infections are concentrated in the eight high prevalence counties with Nairobi leading (2,587) and Kisumu being the fourth county (1,630) in terms of number of new annual infections (MOH, 2018)

In **Kisumu County** 43% of the population is aged below 15 years while 25% are adolescent (10-19 yrs.). Among the women, 50% have sex debut at 16yrs with men at 18 years. Nearly half of all girls (50%) were married at 19 years, while men appear to marry later – 50% were first married at 24 years of age. Fifteen percent of women started to have children by age 15-19 years. Among the married youth aged between 15-19 years, 50% reported using modern contraceptives while 46% wished to prevent pregnancies but were not using any method (KNAYS, 2015 Kisumu County). Kisumu is classified among the nine high HIV incidence counties in the Country.

In **Nairobi County,** majority of the population is aged 20-30 years. Those under 15 years constitute 30% of the population while 16% are adolescents aged 10-19 years. Fifty percent of the women aged 20-49 years first had sex at age 19 years, while fifty per cent of women aged 25-49 years were first married at 22 years of age, while men aged 30-54 years were first married at 26 years. Seventeen percent of girls aged between 15-19 years have started having children, while 78% of married teens (15-19) use modern contraceptives, with 6% not using (2016 Fact Sheet; MOH)

Improving access to quality SRHR services among AYs, especially the marginalized and vulnerable, is among the top health priorities in Kenya. To this end, Kenya's RMNCAH+N investment framework 2016 - 2020, the Kenya Adolescents SRH policy of 2015 and National Guidelines for the provision of Youth Friendly Services (YFS) (2016), provide clear mechanisms for improving access to SRH services.

This is anchored on GOK's Vision 2030, Kenya's Constitution 2010 and the Kenya Health Sector Strategic and Investment Plan 2014-18, as well as the updated health sector strategic and investment plan 2018 - 2023.

However, despite Kenya having a robust RMNCAH+N investment framework, demand and supply side gaps still exist in terms of access and quality, affecting uptake of RH services and information among AY, especially the marginalized and vulnerable populations such as persons with disabilities (PWDs), and those in informal settlements.

While Transforming Health Systems for Universal Care Project (THS-UCP)- an operationalization tool for the Global Financing Facility (GFF) mechanism in Kenya- has led to great results in overall health systems improvement.

There is concern on its low focus on adolescents and youth in general. Probable gaps may include but are not limited to inadequate prioritization of AY in the RMNCAH+N investment framework 2016-2020 and related documents such as The Project Appraisal Document (PAD).

While the youth addendum was developed to guide meaningful engagement of the youth on RMNCAH+N issues including the GFF at the global level, at the national level there is insufficient evidence showing adolescents and youth engagement on AYSRH, including adequacy of access to and provision of quality Adolescent and Youth Friendly Services (AYFS) information and products.

Unfortunately, the onset of COVID-19 has further eroded the gains made in RMNCAH+N indicators. The Kenya GFF publication, Preserve Essential Health Services During the COVID-19 Pandemic, estimated that the pandemic has disrupted the provision of essential services due to barriers to the supply and demand for services in Kenya, leaving 230,400 women without access to facility-based deliveries, and 1,698,800 fewer women receiving FP services.

Organization of African Youth (OAY) carried out a study in April 2020 which revealed that, for the youth, COVID-19 has affected their income affecting their purchasing power, hence their ability to access healthcare services and health commodities, and peer engagements capabilities that enhance health services demand creation.

A report by Plan International and UNESCO warn that globally, COVID-19 related school closures have adversely affected girls, because being out of school increases teenage girls' vulnerabilities to sexual exploitation, leading to early and unplanned pregnancies, early marriages or increased prevalence of Sexually Transmitted Infections (STIs) including HIV/AIDS (UNESCO, 2020). Anecdotal data has revealed that in Kenya, among the 47 counties, Nairobi County had the most (11,795) girls aged between 10-19 years who reported being pregnant between January and May 2020, although the trends are not different in the other counties. It is thus imperative to mainstream AYFS within COVID-19 RMNCAH+N protocol.

OAY is a key advocate for the formalization and full operationalization of the Multi-stakeholder Country Platform (MSCP), with two permanent youth seats. The youth representatives will ensure implementation of policies/laws that support realization of the goals and targets outlined in the RMNCAH+N investment framework and PAD, to achieve Meaningful Adolescent and Youth Engagement (MAYE) - ensuring that young people are meaningfully engaged and participate in the development and implementation of all policies, programs, and processes that affect them.

Although efforts are being made at the national level to engage the adolescents and youth on AYSRH, counties are yet to create spaces for this engagement.

For instance, Nairobi County has an active Youth Advisory Council (YAC) at the directorate of health, which is also recognized as an extension of the County Health Management Team (CHMT).Similar structures with clear roles outlined on AYSRH could be created to foster MAYE across the sub national level (counties).

1.2. Rationale

The World Health Organization (WHO) recommends that, to make progress toward Universal Health Coverage (UHC), the health sector must respond to the health needs of adolescents. One of the key challenges faced by the global health community is how to take proven interventions and implement them in the real world.

Affordable, evidence-based high impact interventions exist in documents but bridging the "know–do gap" is one of the most important challenges in public health. To disentangle the rhetoric and the reality, there is need to establish whether the AYSRH policies are implemented at primary health care (PHC) level and generate evidence of their effectiveness in terms of access to AYSRH services and information among AY.

While Kenya has operationalized the RMNCAH+N investment framework 2016-2020, implemented through THS-UCP project, evidence of AYSRH prioritization in policies has not been generated.

The COVID-19 pandemic brings with it unprecedented massive consequences that need to be identified to enable policy and decision-makers to device ways of mitigating them.

In recognizing AY as equal partners in driving social change and transformation, OAY has been vocal in advocating for MAYE in the implementation of the RMNCAH+N IC, the GFF mechanism and thus there is a need to assess the progress in terms of strategic opportunities and provide platforms for AY engagement aligning health sector goals to the global goals outlined in the GFF Youth addendum and the new GFF strategy as well as the new GFF Civil Society and youth framework.

1.3. Purpose

The purpose of this rapid assessment was to assess AY prioritization in the RMNCAH+N IC 2016-2020, and other global, national and county level policies and strategy policy documents, their implementation and effect on responsiveness of AYSRH services, products and information in Nairobi and Kisumu counties. The aim was to generate evidence, including the effect of COVID-19 on access to SRHR services, products and information for vulnerable AY, to inform the prioritization of AY agenda.

1.3.1 Objectives of the Assessment

- Assess the extent of AYSRH prioritization in RMNCAH+N policies and planning frameworks
- Determine the level of implementation of AYSRH interventions and associated factors including COVID-19 in Nairobi and Kisumu counties
- Assess utilization of AYSRH services and information among the youth
- Establish the effect of THS-UCP (GFF mechanism) and other complementary financing on responsiveness of AYFS
- Identify platforms, opportunities and spaces for MAYE in THS-UCP in line with the GFF Youth addendum

2.0 METHODOLOGY

2.0 METHODOLOGY

Study design

This was a descriptive cross-sectional study, applying both quantitative and qualitative data collection methods.

Study location

Kisumu and Nairobi counties were purposefully selected based on OAY's previous project, "Youth Engage and Take Action on SRH" and its GFF related advocacy.Both counties have high population and a proliferation of informal settlements, with Kisumu having in addition, a remote rural population where marginalized and vulnerable AY are known to experience differential access to health services.

In each county, 3 facilities (2 PHC and 1 referral) were purposefully selected in different sub-counties based on where OAY had previous engagements as follows:

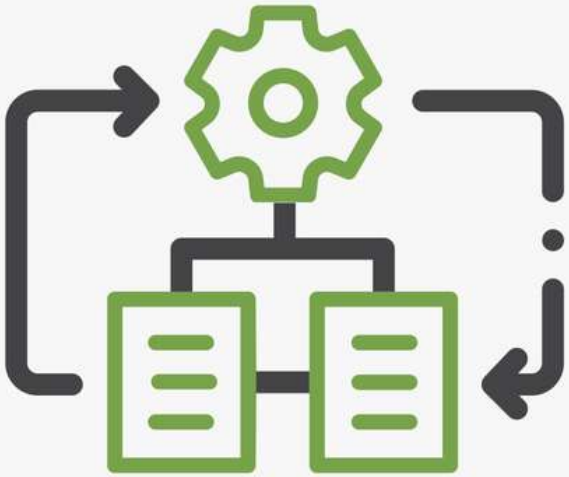
- Nairobi County: 1. Kasarani Sub- County; Kasarani Health Centre; 2. Westlands Sub county- Kangari Health Centre 3. Embakasi West Sub-county - Mama Lucy Referral Hospital
- Kisumu County: 1. Seme Sub- County; Oriang Alwal Dispensary; 2. Kisumu East Sub- County; Nyalunya Dispensary 3. Muhoroni Sub-County- Nyangoma Sub- County referral

Summary of Methods, Tools and Assessment Respondents

Table 1: Methods, tools and respondents

Level	Targets	Tool	No of Respondents
National level	Key informants at Council of Governors (COG), MOH GFF focal person, RH coordinator at the MOH, Member of Parliament Health budget committee – KII National Non-state actors (RMNCAH+N related CSOs) - KII CSOs National	KII guide	1
County level	Members of County Assembly in the budget/health committee – KIIs Nairobi or KIIs Kisumu County Health Director – KIIs Nairobi or KIIs Kisumu The county RH coordinator and the county AYSRH coordinator – KIIs Nairobi or KIIs Kisumu	KII guide	2
Facility level	Facility in charge – KIIs Nairobi or KIIs Kisumu RH in charge – KIIs Nairobi or KIIs Kisumu Users the AY (15-24 years) exiting the facility were targeted – FGDs, Kisumu or FGD Nairobi	Facility checklist Exit interview guide	39
Community level	AY aged (15-24 years) were targeted for FGDs - – FGDs, Kisumu or FGD Nairobi The second FGD targeted the CHV's, opinion leaders and peer educators – FGDs, Kisumu or FGD Nairobi Youth CSOs and youth leaders were also targeted for their perspectives* – FGDs, Kisumu or FGD Nairobi	FGD guides	39

** See Annex 2 and 3*



Sampling techniques

Non-probabilistic sampling method was applied based on the objectives of the assessment; the respondents were purposively and conveniently selected as follows:

1. .AY respondents for exit Interviews: Convenience sampling of 7-10 AY's per facility.
2. Facility in charge, facility RH in charge, County CHMT, stakeholders: - **Purposeful sampling-based areas of operation and expertise.**
3. **AY FGD participants**: purposefully selected from the community as guided by the NMS through Youth Advisory Council (YAC) and Kisumu County [Department of Health] to attain the desired diversity (age, in/out of school, vulnerability e.g., YLWD, teenage mothers etc. and gender balance to acquire sex-disaggregated data).
4. CHVs, opinion leaders, peer educators FGDs: **purposefully selected**

Data collection process and techniques

The study team obtained all the necessary written approvals from the county health departments in Kisumu and Nairobi, and 4individual informed consent from each participant. Both quantitative and qualitative data collection methods were used.

The data collection tools were adapted from the *WHO Global Standards for Quality Health Care Services for Adolescents and The National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya, 2016*. A few more targeted questions, based on the objectives were added.

The quantitative data was collected on digital forms on Open Data Kit (ODK) using enumerators' mobile devices, while qualitative data was collected on written scripts. To ensure youth involvement in the process, some of the youths were trained and participated as research assistants.

The youth volunteers at OAY and members of Youth Advisory Council (YAC) were used in collecting the data. Ethical standards were observed throughout the process. The study was carried out between December 2020-February 2021.

Data collection challenges and limitations

Some of the challenges encountered include health workers strike, which led to the delaying in data collection for over two months.

COVID-19 pandemic restrictions, regulation protocols and demand on the few HCWs on duty also delayed the process. The restrictions also may have affected AY's access and utilization of services.

At the national level, it was difficult securing appointments with key government staff including the Parliamentary and County Assembly respondents.
It was also difficult to access some documents such as the national RMNCAH+N scorecard and annual work plans from the county governments or health facilities.
The sampling approach that was used in this rapid assessment is mainly purposive and focused on three high volume facilities in the two counties. This may not be a true representative of all health facilities in the two counties and so the results cannot be generalized or draw inference but provide useful insights into AY programming to inform policy and decision makers as well as partners working in AYSRH activities.

Data Management and Analysis

The quantitative data were managed using the ODK suite. As data were being collected, they were uploaded automatically to the cloud server (ODK Aggregate) where they were stored awaiting analysis.After all data were collected, they were downloaded and converted to SPSS version for cleaning and analysis. All data cleaning analysis was done using SPSS Version 20.0. The final charts and tables used in the report were generated using Microsoft Excel.

Qualitative data scripts were transcribed, and the scripts preserved by OAY. The data were analysed using content analysis to identify and interpret topics, issues, similarities, and differences revealed through the participants' narratives, which were coded and tabulated along the emerging themes and arranged systematically as per the research objectives. Field notes compiled during FGDs and interviews were analysed for any essential and useful complementary information.

COVID 19 – Adaptations

Given the COVID-19 containment measures and prevention protocols, most activities were conducted virtually including interviews and where physical engagements applied, the health protocols were strictly observed.

3.0 FINDINGS


Organization of African
Organization of African Youth
continental, member-based, no
registered in 11 countries an
chapters in Africa OAYouth is a
and a revolutionary movement
is a regional platform for you
power.
KIIFI

3.0 Findings

This chapter outlines the extent of prioritization of AYSRH in global, national and sub-national level health policies, using the eight WHO global standards to assess the quality in delivery of adolescents and youth SRH services. The section presents the findings across each of the standards and provides user (adolescents and youth) perspectives on various aspects of access to SRH information services and products among the youth in two counties in Kenya and overall policy framework.

3.1 Global and National level AYSRH policies prioritization

An intense desk review was conducted focusing on global documents supporting Every Woman Every Child (EWEC), national and county strategic policy documents relating to RMNCAH+N investment framework, to identify adolescent and youth prioritization, investment, responsivenes of services and demand creation/or generation for AYSRH services.

Five global documents were reviewed to establish AY related gaps, these included:

- Global strategy for Women's Children and Adolescents health (2016 – 2030),
- GFF Business Plan, GFF Strategy 2021 – 2025,
- Civil Society engagement strategy, GFF CSOs New engagement framework,
- addendum to the global financing facility (GFF) Civil Society engagement strategy (CSES),
- Global Consensus statement on Meaningful adolescents and Youth engagement.

The review found that all the documents prioritized adolescents (10-19yrs) in their narrative, but there was minimal mention of the youth aged 20-24 years, in the strategic priorities (see annex 5). Some of the findings are outlined below:

- The previous CSES was found to have gaps in addressing AY challenges and this led to the development of the AY addendum to the GFF.
- The current GFF CSOs strategy explicitly captures CSO and youth engagement.
- There are no adolescent and youth specific indicators included in the monitoring and review frameworks, making it difficult to track progress.

At the National/Country level, seven documents were reviewed:

- RMNCAH+N Investment framework (MoH Kenya, 2016),
- THS-UCP , Project Appraisal Document (PAD),
- National Adolescent Sexual and Reproductive Health Policy, 2015, National Guidelines for Provision of AYFS in Kenya,
- WHO's Maintaining essential health services operational guidance for the COVID-19 context and
- Kenya's COVID-19 RMNH guidelines, 2020.

The following were the findings around the prioritization of the AYSRH activities in national policies and plans.

- Prioritization of youth (20-24 years) is minimal, with only a few mentions in relation to contribution of the youth to new adult HIV infections, raising a concern about meaningful targeting and involvement of youth in ASRH programming.
- RMNCAH+N indicators do not explicitly outline the AYSRH indicators in the performance framework. The only indicators included is teenage birth rates and FGM. There is lack of further disaggregation of the maternal indicators such as ANC, skilled birth attendance, and access to modern contraceptives, into age specific tiers making it difficult to have adolescents and youth specific data.
- There were no specific interventions targeting emerging problems among the youth such as mental health and drugs abuse etc.
- The THS-UCP does not have AY specific indicators as part of the RBF approach being implemented in counties. However, the MCH project indicators on ANC, skilled birth attendance, and use of modern contraceptives are included
- The PAD lacks any adolescents and youth specific indicator, despite ASRH strategies being highlighted in the document.
- Specific vulnerable populations such as SRHR of LGBTQI+ adolescents who face unique challenges are not included in the national policies (Kenya Human Rights Commission, 2020)
- Whereas, some of the national policies such as the ASRH policy of 2015 are currently used to give directions for both adolescents and youth services, they only mention adolescents in their narratives, yet adolescents and youth have different needs therefore require different interventions.

3.2 Health Worker Perspectives on AYSRH services

Most of the health workers at the national and county levels demonstrated good knowledge of the existing guidelines policies and frameworks. They expressed goodwill in adoption of the RMNCAH+N investment framework and the National ASRH policy of 2015, albeit with some scepticism on sufficiency of funding for implementation, calling for more resource allocation to specifically support youth activities.

There was a general consensus to ensure that the national policies related to adolescents and youth need to be contextualised to address emerging needs in the varied regions in remote rural set ups, these needs may include, facility infrastructure, availability of workers etc. For instance, it was noted that although the counties were still working towards having the youth friendly corners as recommended, competing needs led to this commitment not being fulfilled.

"The policies should not be a one size fits all. For us in our setting we would rather not have a fancy youth friendly corner but ensure we offer youth responsive services even if integrated with other services as resources don't even allow" KII, Nairobi.

"Kenya has improved its investment in policy that support sexual health but still insufficient. National government not equipped with enough resources for implementation at the county level" KII, Kisumu.

"As we prioritize, we need to understand what is important for the different age groups. We need to separate the adolescents and the youth. Their needs are different. We have policies but implementation is the issue especially in facilities due to failed dissemination due to reasons such as funding". KII, National

Within the COG, it was noted that counties take policy directions from the national MOH. For the adolescents and youth interventions, the RMNCAH+N investment framework articulates priorities for various population. Implementation of RMNCAH investment framework and associated guidelines is however plagued by challenges such as insufficient funds especially at the county level as highlighted by the county respondents.

"The SRH policy is there and even implementation framework for it but we have challenges implementing it due to lack of capacity and funds. KII, National

"The national policy on SRH touches on issues of financing and ensuring adequate funding, but we need not only to increase domestic funding but also to promote some costing to guide national and county government to earmark specific funds for the AYSRH programs" KII, National

The County Integrated Development Plans, 2018-2022 (CIDPs, 2018-2022), Kisumu County prioritized AY better than Nairobi. Adolescents and Youth SRH friendly services in Kisumu are prioritised, for instance students are targeted for training on age-appropriate sexuality education, and increment of sex debut age. Further, given the high prevalence and incidences of HIV among young people in Kisumu County, efforts are being made to increase the proportion of head teachers sensitized on adolescent HIV treatment, stigma and discrimination and increase the percentage of AY people (in and out of school) reached with targeted HIV & AIDS interventions in an attempt to reduced annual new HIV infection and reduce barriers to access of HIV services (Kisumu County, 2018). Nairobi County included a plan to address the rampant HIV epidemic among AY people, but no AY specific indicator was included in the CIDP, except a plan for school health programmes targeting adolescent health. (Nairobi City County, 2018). A concern was raised by key informants in both counties that the CIDP and the Annual Work Plans (AWPs) implementation was a challenge, whereby although resources were allocated for a few indicators, it is not always availed to the facilities, or ring-fenced for AYSRH.

"CIDP, implementation has always been a challenge, not everything is always featured" KII, Kisumu
"Resources are limited at sub-counties and lack of resources of an ideal youth friendly corner" KII, Kisumu

According to the 2016 national guidelines for the provision of AYFS, there are specific basic characteristics that should be in place to offer quality AYFS namely;

- Equity
- Accessibility
- Acceptability
- Appropriateness and
- Effectiveness.

The study assessed quality by applying a checklist of a set of recommended components for each characteristic and calculated an aggregate percentage score for the 3 facilitates per county. Equity had 3 indicators, Accessibility 13, acceptability 13, Appropriateness 7 and Effectiveness 7.

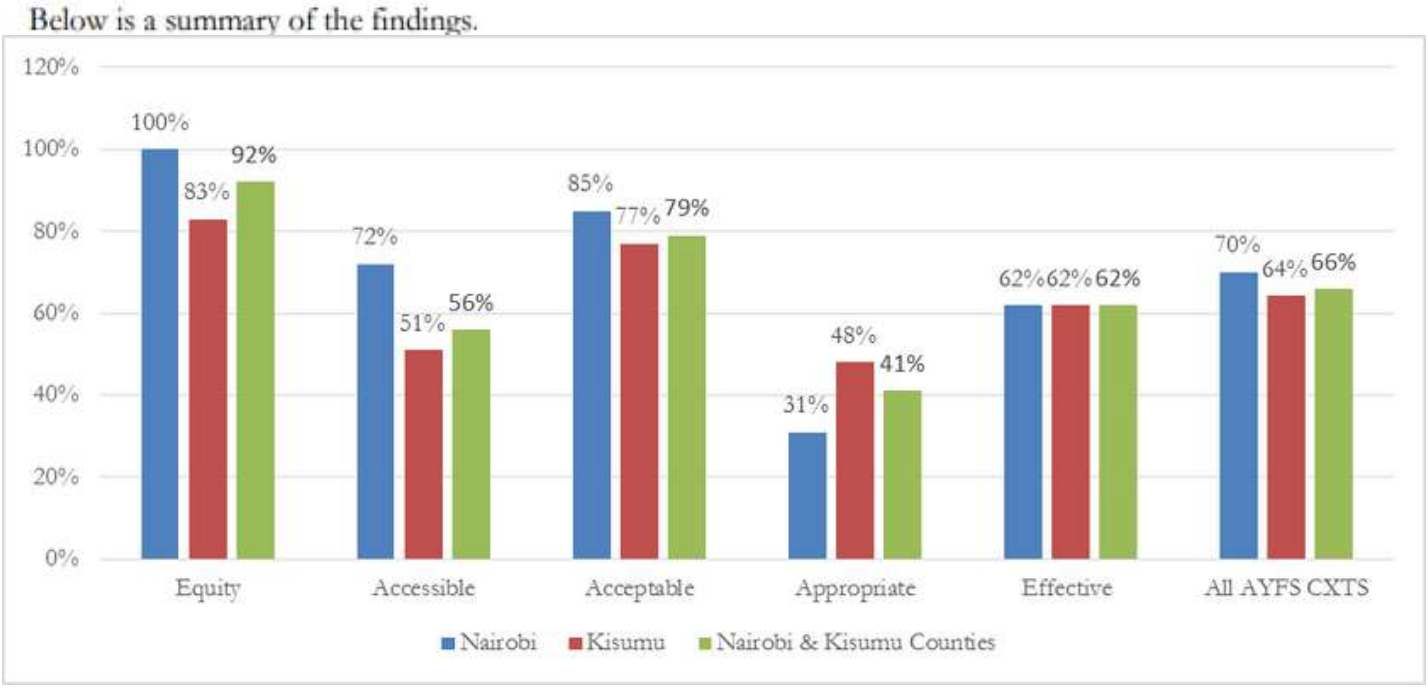


Figure 1: Characteristics of quality adolescents and youth friendly service score

All facilities assessed performed above average in all the characteristics, besides appropriateness of services.

- **Equity:** The three facilities assessed in Nairobi scored 100% while those in Kisumu scored 92% adherence to the components specified for equity such as availability of AY non-discrimination policy and administration of the same level of care for all AY.
- **Accessibility:** The three assessed facilities in Nairobi scored 72% while Kisumu scored 56% among the key components for accessibility. Notably none of the facilities had a youth friendly corner. However, all facilities accept clients without any appointments and offer integrated services to all including the AY. In terms of affordability- a key component of accessibility- 83% of the three facilities assesses in the two counties indicated that all services were free, with one facility levying a charge for some of the "special" services. Two of the three facilities indicated that the AYs are well advised about the range of services available for them, while only one facility indicated that the AY have to wait for unreasonably long time to be seen.
- **Acceptability:** Nairobi County scored 85% while Kisumu scored 77%. Notably data from all facilities in both counties showed that AYs can be seen without spousal or parental consent, that service providers are respectful and non-judgmental, that HCW spend enough time with the AY clients and that there were suggestion boxes for confidential feedback. On whether educational materials are provided in a familiar language, easy to understand, eye-catching and responsive to different disabilities and other needs of AY, this had not been achieved as well as the involvement of AY in decision making on YFS provision which was found to be below average.
- **Appropriateness**: Both counties performed below average on the suitability of key indicators for AYFS. For example, none of the facilities were reported to hold youth friendly educational activities that address topics of interest to youth, and only one facility in charge reported that they advertise services to young people where they congregate. However, half of the facilities were reported to have a package that fulfils the needs of all AY clients, have appropriate referral and linkages, AYSRH IEC, and have peer support services. Two of the three facilities reported to have appropriate infrastructure such as desks, electricity, water, toilets and hand washing area.
- **Effectiveness**: In terms of effectiveness, both counties scored 62%. All the health facilities in both counties were reported to have health care providers who use evidence-based protocols and guidelines to provide services. Eighty-three of the service providers that responded had the required competencies to work with and provide AY with all the services required and address any other concerns and needs. Only one of the three facilities were reported to have been assessed and certified as AYFS facility, but this conflicted with the fact that there was none with an AY friendly corner. Further, only one of the three facilities had a youth-friendly strategy or action plan in place to direct the services.

"We have really worked towards having youth friendly centres, where adolescents and youth can access services in a friendlier manner" KII CSOs, Nairobi

3.2.1 Performance of the health facilities in line with the WHO standards of quality AYFS.

The facilities were assessed for the eight WHO standards for quality AYFS namely;

- Adolescents' health literacy
- Community support
- Appropriate package of services
- Providers' competencies,
- Facility characteristics
- Equity and non-discrimination
- Data and quality improvement and Adolescents' participation

The performance of the 3 facilities assessed per county were analysed and percentages score for each of the indicators for each standard computed. For each county n=3

3.2.1.1 Adolescents' and Youth health literacy

The study assessed whether health facilities implement systems that ensure that AY are knowledgeable about their health, and know where and when to obtain health services. The presence of well displayed signage is also a key indicator of the accessibility characteristic of AYFS. All facilities in the two counties, except for one in Kisumu, had signage available and visible at the point of service delivery, indicating range of services and operating hours. Apart from the two referral hospitals in Nairobi and Kisumu, data from all the other facilities showed that AY are well-informed about the range of available services and how to obtain them.

However, in Kisumu County, only one facility showed availability of items to help youth pass time such as TV, IEC materials, magazines, health education, etc. One facility in Nairobi and two in Kisumu County indicated availability of posters, brochures and other IEC materials targeting young people, including information about their rights. Two thirds of the facilities in both counties had a telephone contact where AYs can reach them. However, it was difficult to establish or share contacts from the youth whether they had accessed these materials.

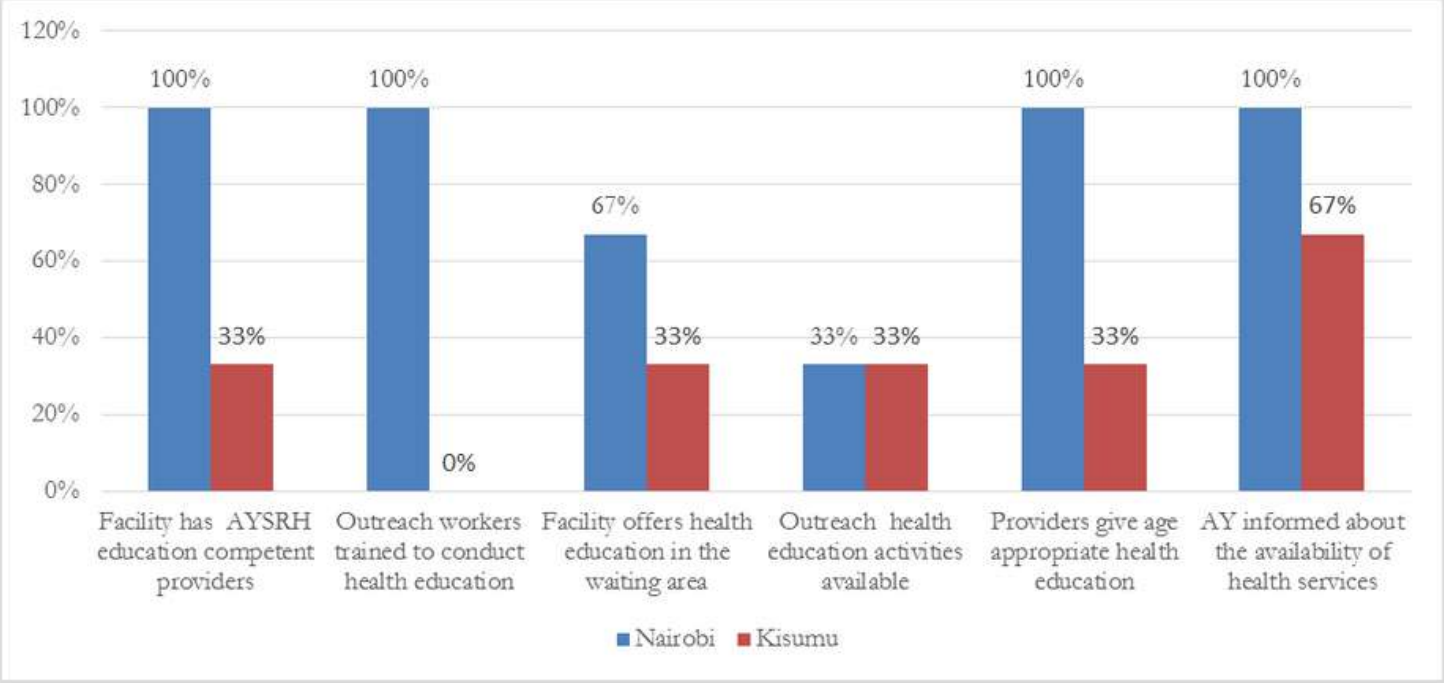


Figure 2: AY Literacy and health education

All the three facilities sampled in Nairobi reported to have AYSRH education competent service providers, and availability of outreach workers trained to conduct health education for AY in the community and other settings. Only one facility in Nairobi did not offer health education in the waiting area.
In **Kisumu**, only the sub-county referral hospital had service providers competent in AYSRH education, while none of the facilities had trained outreach workers for AY in the community and other settings.

Only the sub-county facility offered health education in the waiting area. Only one facility in each county indicated availability of outreach health education activities. Kangemi HC in Nairobi had data indicating that the last outreach was done about a month prior to the data collection, while Nyangoma sub-county hospital in Kisumu County indicated it had been done 12 months prior. All facilities sampled in Nairobi County and Nyangoma sub-county hospital in Kisumu had health service providers who provided age-appropriate health education and counselling to AY clients

3.2.1.2 Availability of appropriate package of services

Availability of appropriate package of services for adolescents and youth was assessed, including information, counselling, diagnostic, treatment and care services that fulfil the SRH needs of all adolescents and Youth.

Table 2: Essential Package for youth friendly service provision

No	Essential Package for youth friendly service Provision	NRB	KSM	Both
1	Broad mix of contraceptives /Family planning services	67%	67%	67%
2	Antenatal and postnatal care	100%	100%	100%
3	Delivery / newborn care services	67%	67%	100%
4	Psychosocial care / mental health support	100%	67%	83%
5	24/7 referral system for obstetric emergencies	67%	33%	50%
6	Prevention of mother-to-child transmission of HIV (PMTCT)	100%	100%	100%
7	Pregnancy testing	100%	67%	83%
8	Post abortion care	67%	67%	67%
9	HIV counselling and testing services	100%	100%	100%
10	HIV & AIDS antiretroviral prescription or antiretroviral treatment follow-up services	100%	100%	100%
11	Diagnosis or treatment of STIs,	100%	100%	100%
12	Awareness creation, prevention and management for survivors of sexual violence, GBV and appropriate referral	100%	100%	100%
13	Engagement of AYRH Promotion and education	100%	100%	100%
14	Linkage with CHV or peer educators on AYSRH services	100%	67%	83%
15	Disability specific AYSRH services	67%	67%	67%
16	Updated system of capturing utilization of AYSRH services data?	67%	33%	67%
17	Drugs and Substance abuse counseling and treatment	33%	67%	50%
18	Laboratory diagnostics, including common rapid diagnostic testing	100%	67%	83%
19	Referral, linkages and follow-up	100%	67%	83%
	Total score	**88%**	**76%**	**83%**

Kisumu: Although in Kisumu County the services are integrated within the mainstream health service delivery system, AYSRH services are available in the assessed health facilities. A significant number of AYs were reported to access the services.

"Curative services are integrated; there is a tool for measuring integration of Youth Friendly Services (YFS), the best practices, what worked well and areas that need interventions" KII, Kisumu

The HCWs are available and there is good collaboration between the Reproductive Health (RH) coordinator and CHVs who refer clients to the facility. There is availability of county ambulance for emergencies and referrals.

"There's availability of a number of ambulances within the sub-county that make it easy to coordinate referral services" KII, Kisumu

PWDs are always treated equally and there is provision of a ramp to accord them easy access to the health facility in the referral facilities, though this was missing in the lower lever primary health care facilities.

Nairobi: Nairobi County, health facilities offer wide range of services, including long-acting contraceptives, diagnostic and rehabilitative services. It was reported that about half of the adolescents and youth visiting the health facilities seek SRH services.

The county and referral hospitals are close and convenient for the AYs. Those seeking PrEP and PEP services are referred to the Comprehensive Care Clinic (CCC).

AY services are integrated in such a way that referral is done within and for those that need to be referred to another high-level facility e.g., for post abortion care services such as manual vacuum aspiration (MVA), SGBV, drug abuse etc. Some facilities that have youth desks receive significantly higher number of adolescents and youth.

There was no congruence in some of the responses where some county respondents highly praised the quality of services even though most respondents raised concerns with aspects such as erratic stock-outs especially for contraceptives and essential drugs.

"Our facilities have skilled workers who give the information; available methods that are often sought by the young people." KII, Nairobi.

Respondents emphasized the need to expand disability friendly services in both counties to accommodate those living with sight, hearing and other physical disabilities. This would include having translators, braille materials, ramps and elevators at health facilities etc.

"We are not able to serve some PLWDs in most facilities due to lack of personnel and infrastructure, and this needs to be addressed" KII, Nairobi

The working hours and health worker to client ratio are not sufficient to provide quality service delivery, given that health providers are few, and this leads to long queues and long waiting times. Respondents also reported challenges on stock-outs and lack of equipment, resulting in young people being sent to private health providers for tests and commodities that they may not afford to pay.

Laboratory services are rarely available. For those PLWD, there is need for translators, specialists and counsellors to serve them and the mentally ill.

3.2.1.3 Health-care providers' availability and technical competence

A key requirement to quality adolescents and youth friendly services (AYFS) is assessing if health workers respect, protect and fulfil adolescents and youth rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect. The three facilities in each county were assessed and a percentage score per county calculated.

Table 3: Provider Characteristics and Availability

Provider characteristics and availability	NRB	KSM
• ASRH staff allocated on a daily basis	67%	33%
• Availability of ASRH staff today	33%	33%
• Health worker have received training on AYSRH	67%	67%
• Do the service providers and support staff follow policies and		
• procedures to protect the privacy and confidentiality of AY	100%	67%
• Do you always utilize guidelines; job aids, counselling job aids		
• for information, counseling and clinical management of AYSRH issues?	100%	100%
• Do you have tools for self-assessment?	67%	0%
• Do you carry out the self-assessment on regular bases as per your policy	33%	0%
• Do you have a working reward system for performance?	33%	0%
Total score	63%	38%

Although the majority of the health facility in charges had indicated having an AYSRH staff on the duty roster on a daily basis, only one of the health facilities had such staff available on the day of data collection in both counties. Respondents from all the health facilities indicated that they utilize guidelines and job aides for counselling and clinical management of AYSRH issues. Respondents suggested that some the issues that affect provision of AYSRH services were that the health care some of the issues that affect provision of AYSRH services were that the health care providers often felt demotivated due to lack of or delayed payments, leading to constant strikes.

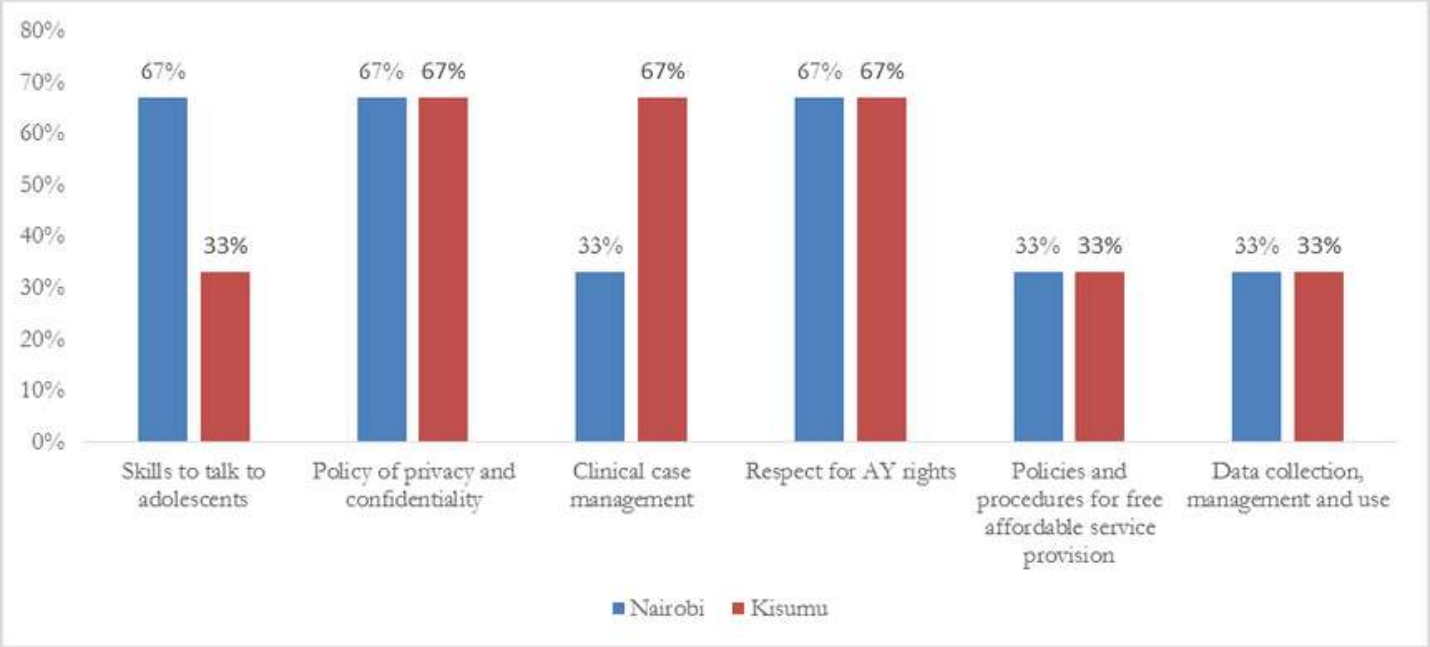


Figure 3: Health care Workers AYSRH Training Areas covered

In terms of training, two out of the three facilities assessed had trained their workers on privacy and confidentiality as well as respect for AY rights. However, training on policies and procedures for free affordable service provision, data collection management and use, lagged behind with only one of the three health facility trained in both counties (Fig. 3).

Nairobi: Qualitative data revealed that most health care workers are trained on provision of AY services including respect for the AY clients.Though integrated, YFS are available, with trained providers who understand the needs of adolescents. A concern was raised in Nairobi that newly recruited health workers during the COVID-19 pandemic were not getting sufficient training on the adolescent package of care (APOC) before being placed in health facilities, which eventually has an effect on quality-of-service delivery.

"We are in the process of recruiting new health workers in Nairobi County due to shortage caused by COVID-19 needs. These workers are not trained on APOC and we might not get time to train. They will just start working" KII, Nairobi.

"There is need for training the health providers on advocacy on SRH, SGBV" KII, Kisumu

In Kisumu the HCWs were reported to be continually trained on clinical case management and AYFS provision.

3.2.1.4 Health Facility characteristics

Key indicators of quality standards in health facilities include; convenient operating hours, a welcoming and clean environment, affordable or free services, maintaining privacy and confidentiality, availability of equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents and youth.

Some of the facilities sampled did not have youth friendly corners although it was reported that Kisumu had 9 while Nairobi had 21 youth friendly services spread across other health facilities. The facilities were also reported to be conveniently located for ease of access to AY clients. All the three health facilities in Nairobi County and two health facilities in Kisumu had free or affordable services.

Those in Nairobi were reported to have convenient operating hours unlike in Kisumu, where it was indicated that health facilities did not have convenient operating hours for the adolescents and youth. The referral health facility in Nairobi and one other health facility in Kisumu were reported to have no TV, IEC materials, or health education to keep the youth productively engaged as they waited for services. A majority of the health facilities sampled, in both counties were found to be welcoming, to all drop-in clients. Most of the health facilities were also reported to provide a clean environment as well as maintain privacy and confidentiality of clients. A few of the characteristics are tabulated in figure 4.

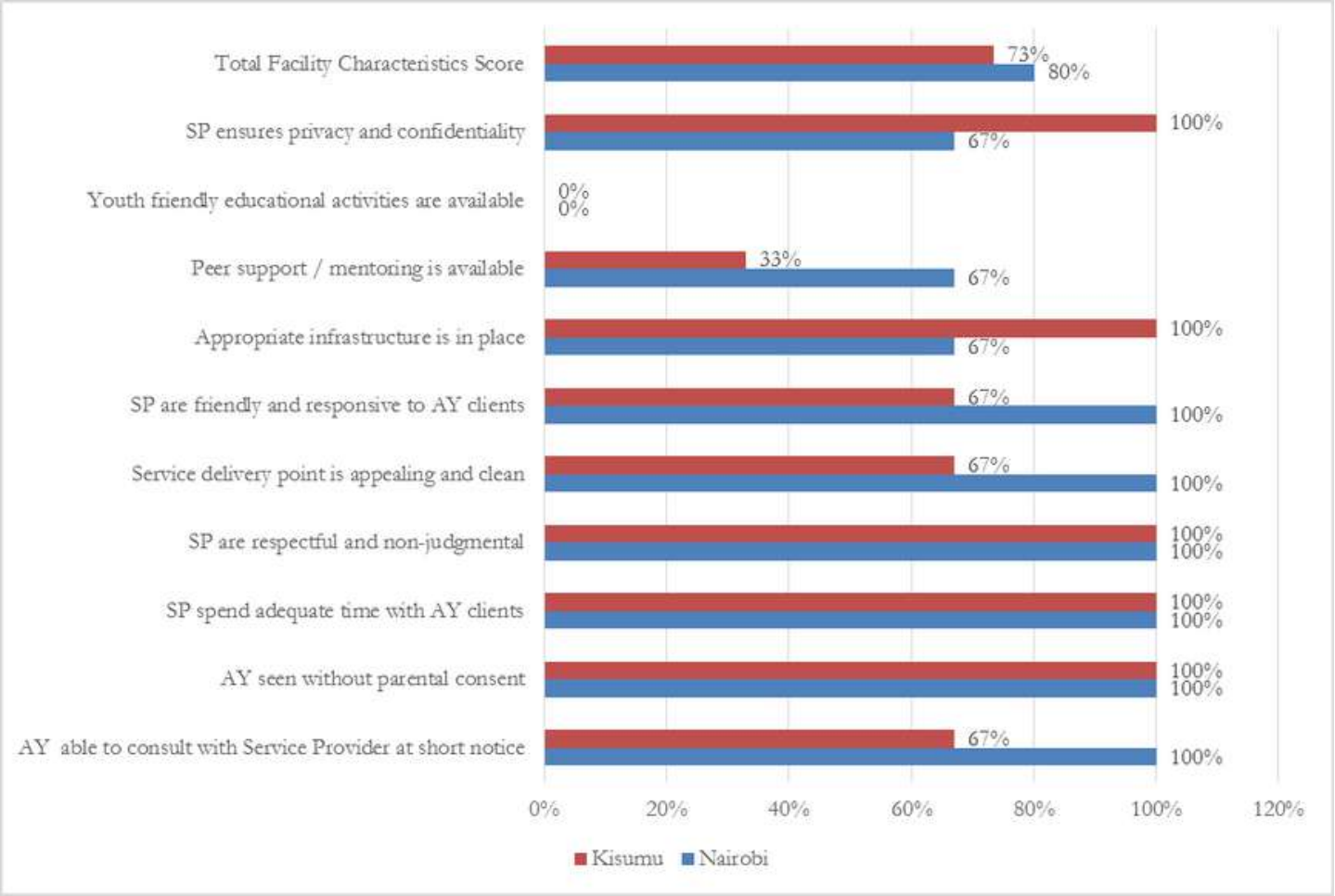


Figure 4: Adolescents and Youth Friendly characteristics

AYFS health facility characteristics in Nairobi and Kisumu were found to be favourable with 80% and 73% scores respectively. Assessed facilities in both counties did not have youth friendly educational activities. However, all health facilities were reported to offer services to the AY without needing parental consent, providers were respectful and non-judgmental, and they also spent sufficient time with the AY clients despite some sharing that they have to wait for long hours.

Kisumu: Majority of the respondents confirmed that facilities had most essential products and services and that the operating hours for the referral hospitals were convenient - 24hrs or 8am-11pm - unlike in the primary health care facilities, where services were closed at certain times.

The health facilities were reported to have a digital system of reporting SGBV and platforms for fighting stigma. Respondents also reported that health facilities did not have adequate staff, leading to clients waiting long hours. In terms of infrastructure, the facilities reported inadequate space for expansion of AYFS.

"We have digitalized SGBV reporting, platform to curb stigma" KII, Kisumu

"Youth especially males access condoms and VCT services during closing hours" KIIs, Kisumu

"We have no YFC due to lack of infrastructure" KII, Kisumu

Nairobi: Similarly, to Kisumu, the qualitative information showed that though the health facility respondents indicated that facility timings were convenient, only the referral facilities operated 24 hours while the primary health care facilities work from 9am to 5pm and are not open on weekends yet the AY preferred weekends and evenings.

"No, because the youths are only free evening and weekends and during this time, the health facilities are always closed. 24hrs would help" FGD, Nairobi.

Though equipment is available, commodities supplies are not consistent. Laboratory and diagnostic services are unavailable and often clients are referred to private health facilities, even though facilities have laboratories. Most facilities also lack some equipment such as diagnostic scans.

The adolescents and youth are able to converse and interact with the CHVs who are younger and friendly. For the needy adolescents and youth, there is a waiver system of user fees in the facilities. There are waiting bays for the adolescents and youth, though congestion affects engagement.

Supply chain management:

A majority of the assessed health facilities in Nairobi (83%) reported insufficient quantities of commodities citing stock-outs due to delays in receiving supply, apart from the referral hospital in Nairobi County. All health facilities in Kisumu County did not have the equipment necessary for AYFS. In terms of availability of essential commodities in health facilities that were assessed, Nairobi scored 71% with Kisumu being way below average at 37%.

Availability of essential commodities on the assessment date is shown in the table 4.

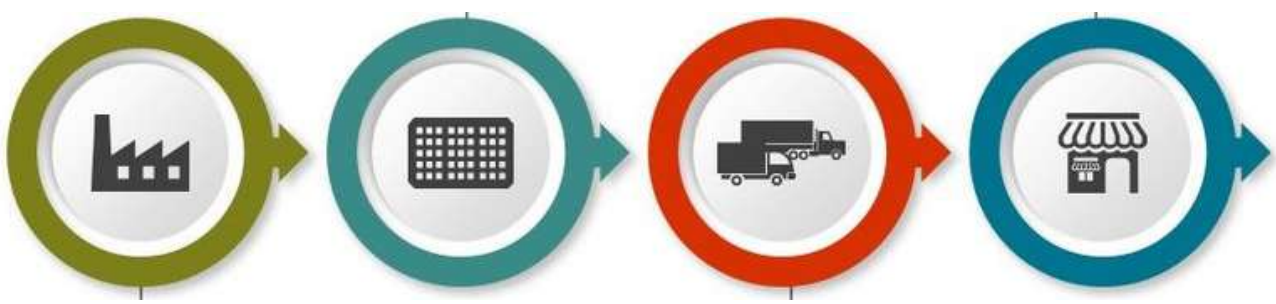
Table 4:Availability of Essential Medicines

Essential commodities	NRB	KSM
1 -Supplies and medicines for STI management	100%	33%
2 -Pregnancy testing kits	67%	33%
3 -Broad mix Contraceptives (Condoms, Oral contraceptives, Emergency contraceptives, Injectables, others)	67%	33%
4 -Post Abortion Care kits	67%	0%
5 -Sanitary pads	67%	33%
6 -Antiretroviral drugs	100%	67%
7 -Post Rape Care kits	33%	33%
8 -Vital maternal drugs (Misoprostol, Oxytocic, magnesium sulfate, gentamycin)	67%	67%
Total	71%	37%

Availability of essential contraceptives is vital in reducing the unmet need for FP among the adolescents and youth. However, stock-outs continue to be a concern for key commodities such as IUCD.
"There is erratic supply of commodities; late delivery of commodities is a problem" KII, *Kisumu*
This has implication on the efficiency of services.

"Often there is stock-out of some of the commodities that the youth will need, for example like family planning, and they will visit the facilities and realize that the commodities are not available affecting their view of services"
KII, Nairobi.

Availability of the contraceptives in health facilities on the date of the rapid assessment (figure 5)



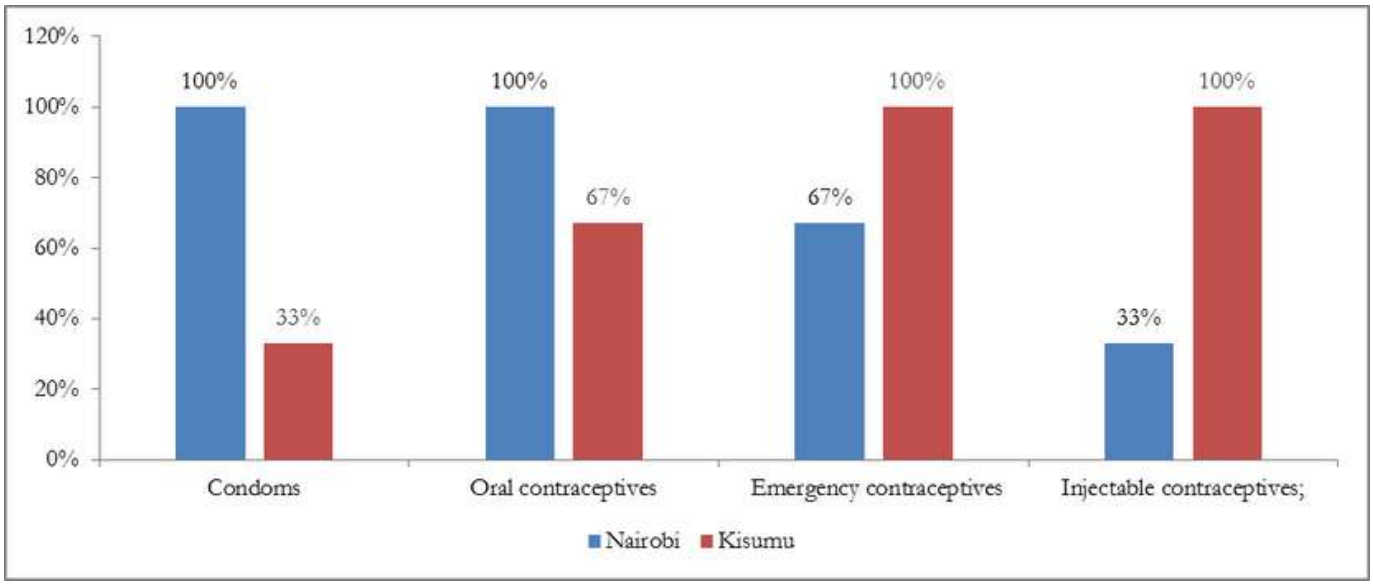


Figure 5: Availability of contraceptives

Assessed facilities in Nairobi had condoms and oral contraceptives while Kisumu had emergency and injectable contraceptives in all health facilities. In terms of equipment Nairobi facilities had all the equipment's checked while only one facility in Kisumu, the referral had all of them (Table 5).

Table 5: Availability of Essential Medicines

Essential equipment's available today	Nairobi	Kisumu
a) BP machine	100%	33%
b) Adult stethoscope	100%	67%
c) Fetal stethoscope	100%	67%
d) Clinical Thermometer	100%	33%
e) Adult weighing scale	100%	67%
f) Light source e.g., torch	100%	33%
g) Hemoglobin meter	100%	33%
h) Computer with email and internet)	100%	67%
Total	**100%**	**50%**

3.2.1.5 Equity and non-discrimination

This a critical standard of quality AYFS as per WHO in safeguarding provision of care to all adolescents and youth, irrespective of their social economic status, age, ethnic origin, sexual orientation etc. One of the measures of this is the availability of policies and procedures in the health facility.

All health facilities in Nairobi and a third of Kisumu health facilities reported to have these. Though all facilities in both counties were reported to provide non-discriminatory services, some are limited by infrastructure, where it was noted that most health facilities lacked disability friendly infrastructure such as ramps and the expertise needed, including braille, and sign language interpreters etc.

Table 6: Availability of Services for Vulnerable adolescents and youth Populations

Special characteristics	NRB	KSM	Both counties
Young first-time parents and young married couples/girls	67%	33%	50%
Young people living with HIV (YPLHIV)	100%	67%	83%
Very young adolescents (VYAs)	100%	33%	67%
Young people living with disability (YPWD)-	67%	33%	50%
Young people in school	100%	67%	83%
Pregnant teenagers	100%	67%	83%
Those who abuse drugs	100%	33%	67%
Total	**91%**	**48%**	**69%**

On availability of services for vulnerable adolescents and youth sub-populations, assessed health facilities in Nairobi County scored 91 % with Kisumu scoring 48%. A gap was noted in the provision of care to YPLWD especially those with hearing and visual impairment. None of the facility had such services.

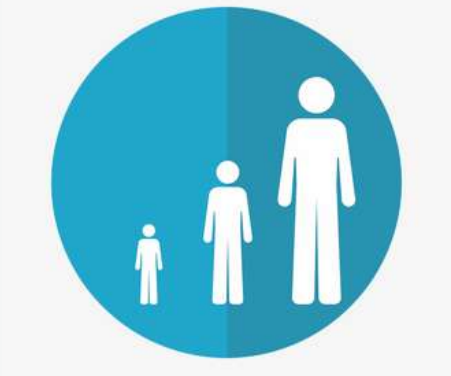
"We have a challenge on infrastructural issues that are not disability friendly for YPLWD, deaf or blind" KII, Kisumu

In Nairobi some facilities were found to give special attention to PWDs. Ongoing sensitization on ensuring no one is left behind, showed that some health facilities reported to have plans to construct restrooms that would accommodate YPLWDs.

In Kisumu there was a shortage of availability of most services, only one of the assessed health facilities provided services to very young adolescents, young people in drug abuse, young married youth and YPLWD. Shortage of trained health workers in special care and lack of requisite infrastructure attributed to the poor access. It was clear from the FGDs that the vulnerable, though they had needs, may not feel welcome to the facilities and fear them.

"Wengine walemavu wanaona haya kuenda sipitali" (most disabled may feel awkward to seek AYSRHS in hospital); FGD, Nairobi.

"PWDs are extremely discriminated- providers have an attitude towards them- patients being ignored and lack of translators" FGD, Nairobi



"Very young adolescent's fear visiting health facility due to the fear of stigma or confidentiality" KII, Kisumu

It was also noted that young men have poor health seeking behaviours in relation to SRH services compared to women. In fact, only one young male was captured in the exit interview in the six facilities that were assessed. Pleasantly though the health care providers asserted that the boys who came for VMMC were able to easily access them though not in all health facilities. However, key populations are still stigmatized especially the LGBTQI+.

Some adolescents and youth respondents felt that teen mothers are sometimes discriminated by health care providers given the societal belief that they are on the wrong.

"When you come to the facility for clinic the staff look at you and treat you funny like to ask why you are pregnant and maybe you are also stressed, so you avoid and go last days" FGD, Kisumu

"Key populations like the gay and lesbians still get stigmatized and facility staff don't know how to treat them" FGD, Nairobi

Some males too feel like they are treated differently from the females when they seek services.

"No, girls are treated better than men in that girls are always given free sanitary towels and boys are not motivated in any way and also girls are always given more opportunities" FGD, Kisumu

"Boys don't feel the need to seek these services since they're not sensitized" FGD, Nairobi.

The need to sensitize the health care providers and the community on forms of gender-based violence was raised with most respondents feeling that males do not get attention for the same. Drug and alcohol users are also underserved in both counties with no active awareness and demand creation activities

3.2.1.6 Data and quality improvement

AYSRH data is essential to support quality improvement. The process includes ensuring facilities collect, analyze and use data on service utilization and quality of care, disaggregated by age and sex and that the staff participate in continuous quality improvement. Quality of care depends much on accuracy of data and information to inform decisions for improvement of care and evidence-based decision-making.
Therefore, data collection, analysis and reporting on AY health are vital in planning for continuous improvement.

In all the assessed health facilities in Nairobi County, there is a system of data collection on service utilization in place, and the service providers are trained to collect and analyze data Figure 6.

The facilities report disaggregated cause-specific data on service utilization by AY in the county (county aggregated data). In Kisumu County, only one of the sampled health facilities have such a system in place.

Some PHC facilities do not capture and report on procurement and stock management of medicine, equipment and supplies specifically for AY. However, some respondents affirmed that the data collected presents opportunities to inform sustainable learning, and research to positively improve AY Health outcomes. It was also confirmed that youths engage in performing research and providing feedback.

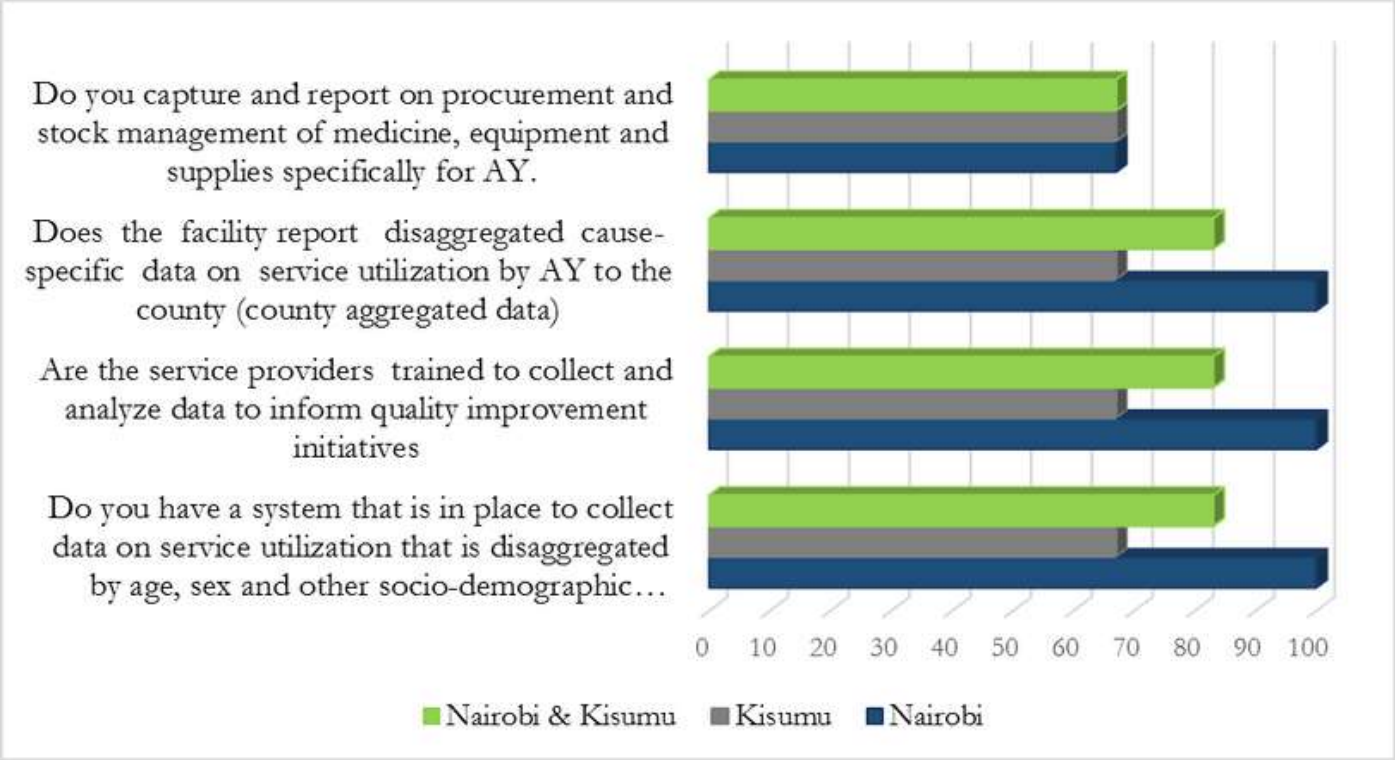


Figure 6: AYSRH Data Management

COG *Health secretariat too noted that there is valuable evidence drawn from the outcomes that are reported annually and during medium-term expenditure reviews. There are routine surveys and the evidence is showing that there are gaps such as prevention of teen pregnancies.*

"There is monitoring and evaluation, which is done on a monthly basis and also involves external partners and it gives us evidence which is a basis for quality improvement" KII, National.

Other respondents too expressed optimism with data management in both counties
"There is proper data management, health records are effectively distributed and trained staff on documentation" KII, Kisumu
"The monitoring and evaluation process is done on a monthly basis and also involves external partners so that we are able capture all gaps; maybe also to include a Monitoring and evaluation professional" KII, Nairobi

Availability of reports/records and tools on AYSRH activities at health facility

A physical check on availability of reports/records and tools on AYSRH activities at the health facilities revealed that some forms, reports/records were not available.

This is as illustrated in Table 7.

Table 7: Availability of Reports and Records

Reports/Records seen	NRB	KSM	Both Counties
1 Stock of medicines and supplies register	100%	67%	83%
2 Referral register	100%	67%	83%
3 Records of AYSRH health outreach activities	67%	67%	67%
4 Records of outreach activities with parents, teachers on AYSRH	33%	67%	50%
5 Record(s) of formal partnerships with community organizations	0%	0%	0%
6 Tools for facility self-assessment of the quality of AYSRH	67%	0%	33%
7 Reports on self-assessments of quality of AYSRH (feedback)	0%	33%	17%
8 Records of supportive supervision visits on AY healthcare by county	33%	33%	33%
9 Reports to the county on cause-specific service utilization by AY	33%	0%	17%

Utilization of AYSRH services and information

Trends of utilization helps us to understand the demand and access to services. However, the trends of uptake of some SRH services e.g., FP, among AYs are challenging to measure given that not all need the services and not all are sexually active as opposed to for instance married women.

"We do not want to look at uptake of services in terms of numbers because sometimes and those young people do not need those services, but if you come to the youth up to 24, if they are sexually active, they can get the services because those are adults. I will be more worried of the % of teenage pregnancies that we have in Kenya, than the uptake of FP services for young people" KII, National.

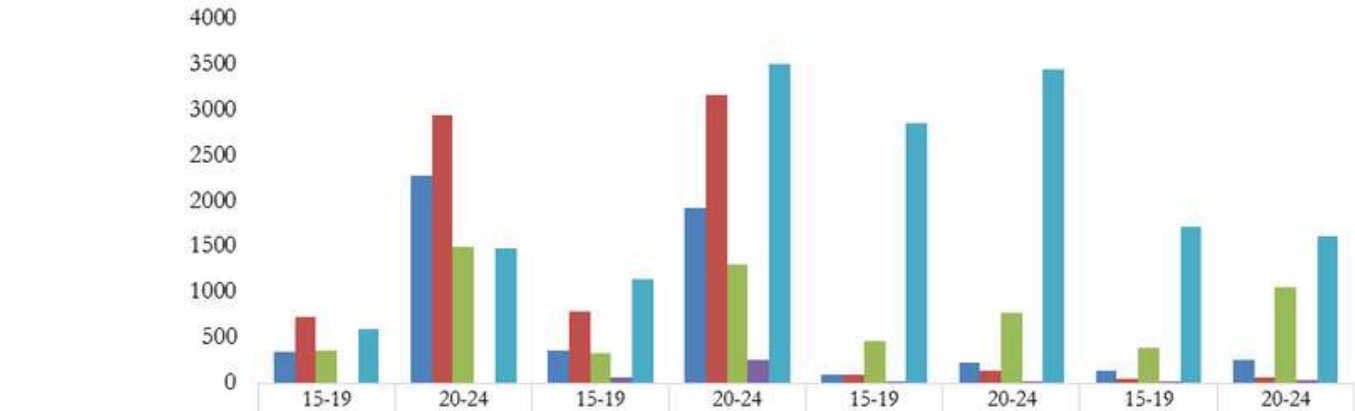
Key service utilization in Nairobi and Kisumu counties

The facility trends for key SRH services are shown on below. Notably trends for post abortion care (PAC) in Nairobi could not be established since records from 2018/19 were unavailable figure 7.

Nationally there has been concern over increase of HIV cases among the young people and the trend of utilization in the two study counties reflects this increase. In both counties, HIV services topped the list of services sought by both the adolescents and the youth though the rates increased in Nairobi between 2018/19 and 2019/20, while they decreased in Kisumu.

"Like the current study shows that HIV is higher in that age group so we should not concentrate on uptake of FP but on behaviour change and condom use" KII National.

Kisumu respondents indicated that STIs have increased among the young people. However, there is stigma, fear of coming to the health facility for testing and treatment and thus the captured data may not represent all cases. Pregnant teens also avoid heath facilities showing up at 2nd or 3rd trimester. A need to increase the service indicators to include rehabilitation for the rising drug and alcohol abuse was expressed. Insufficient knowledge /awareness on SRH in the community, limited operating hours and long queues at the facility were said to affect utilization of services.



	Nairobi				Kisumu			
	2018/19		2019/20		2018/19		2019/20	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
ANC uptake	340	2276	355	1927	99	223	137	256
Skilled births uptake	722	2944	793	3154	99	142	50	71
Modern FP uptake	362	1490	327	1306	468	772	390	1057
Post abortion care uptake	0	0	61	254	23	20	24	30
HIV servicesuptake	601	1485	1135	3494	2853	3438	1713	1612

Figure 7: Service Utilization Trends 2018/2019 - 2019/2020

"The increase in teen pregnancy and STI is partly due to poor uptake of services" FGD, Kisumu

"First time pregnant adolescents do not like going for clinical services but visit traditional birth attendants secretly" KII, Nairobi

Nairobi respondents raised a concern about the media, saying it portrayed public health facilities workers as lazy, rude and prone to strikes, making adolescents and young persons have a bad attitude towards them, therefore affecting their utilization of these services. Long queues, erratic supply of commodities and diagnostic tests at public health facilities, force adolescents and young persons to seek services from the private health facilities even though they can't afford the cost. Religion often interferes with provision of services because some don't approve of SRH.

The health care workers expectations and questions of what adolescent can or cannot do and the reprimand they give to the adolescents was highlighted to have an effect on service utilization. In communities where people know each other the adolescents will find it hard to seek FP services because "ataambia mom nilikuwa hapo nikitafuta FP" (she will tell mum I was there looking for FP services) (FGD, Nairobi)

"In communities, you know, wanajuana, (they know each other) if my neighbour is a nurse at the local health centre and they go to the same place or church or whatever with my mother I can't go to seek services like FP" KII CSOs National

Other barriers to utilization identified in the study include myths, religious and cultural beliefs against SRH services.
"Sometimes we have a lot of myths of traditional perspectives which affect uptake, for instance that you get FP products you are likely not to get children later on" KII, CSOs National

"A lot of maternal deaths are actually youths, including adolescents. One of the key drivers is abortion, but our healthcare system, because of possibly our history as a people, our values, our religious beliefs, the social norms and values that we sort of uphold as a society or seem to uphold don't enable young people to seek such services" KII CSOs National

"The church/religion aspect; some churches are against usage of some contraceptive methods thus limiting service uptake" KII, Nairobi

"Cultural beliefs and age difference make service providers judge especially teen mothers" FGD, Nairobi

"The barriers to utilization include language barrier, stigma and discrimination, negative perception from the peers, lack of privacy and religious differences and beliefs" FGD, Kisumu

In addition to the secondary data for service utilization, the assessment sought to find out the services the adolescents and youth respondents were seeking from the respective health facilities during the exit interview day Figure 8.

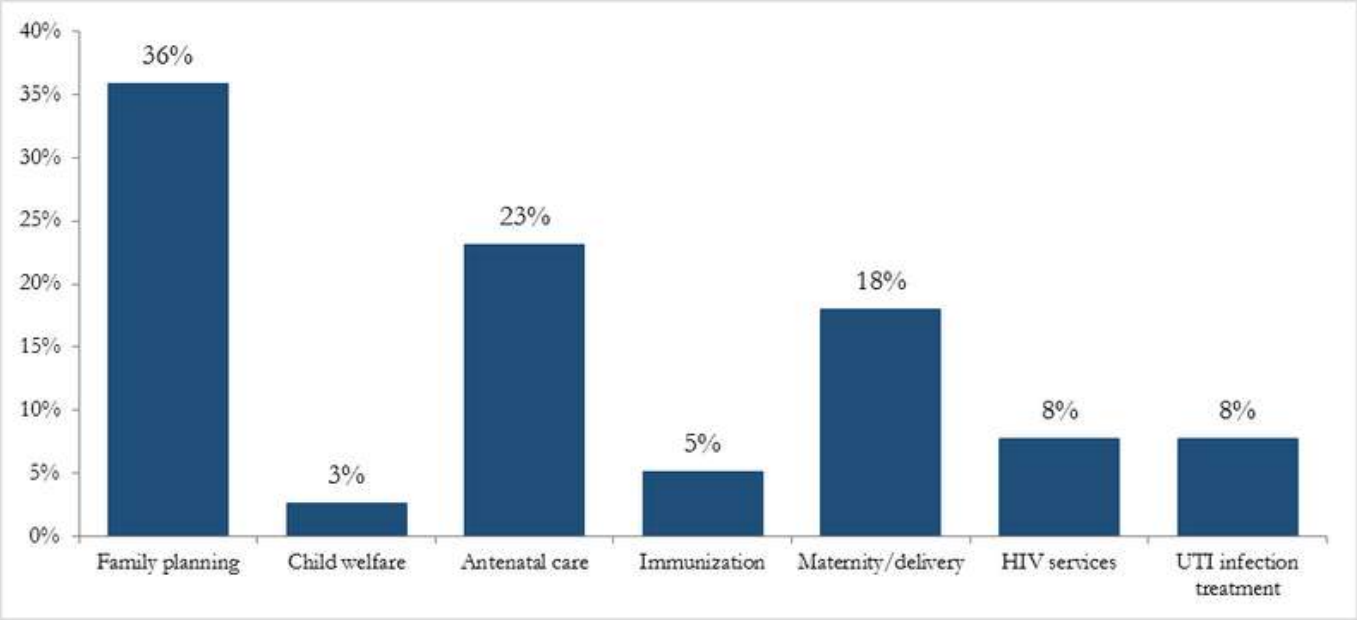


Figure 8: SRH services that are sought after by Adolescents and Youth

Those who sought FP services (36%) were the majority and they were mainly looking for contraceptives like pills, while one sought an implant (Jadelle). A further 23% and 18% were seeking antenatal services and delivery services respectively. Forty six percent (18) of the respondents were at the facility for the first time.

3.3. Effect of COVID-19 on access and utilization of services

The findings revealed that in **Kisumu County**, the COVID-19 outbreak had affected utilization and access to AYSRH services in several ways. Key facility respondents reported that the number of clients dropped due to the fear of contracting COVID -19 at the health facilities reducing the number of adolescents and youth visiting the facility. Utilization of VCT services and other contraceptive services reduced. Enforced curfew interfered with night services and accessing the health facility was a challenge due to restrictions.

"The number of adolescents and youth coming to seek RH services have decreased due to fear of contracting COVID19; the facility was restricting the number of clients at a time to maintain the prevention measures" KII, Kisumu.

Teen pregnancies increased at the beginning of the pandemic though cumulatively, the rates remained lower than 2019 according to an internal Kisumu County report on family health performance on priority areas (see figure 9).

The report demonstrates a declining trend in proportion of teen pregnancies from 2019-20 to 2020-2021 financial years, contrary to the popular belief that teenage pregnancies skyrocketed.However, it is important to note that this is facility-based data and may not provide a full picture of the situation in the community.

"We all know early pregnancies have really increased during the COVID period because of the fact that they are idle and feared to visit to the health facilities for the commodities" KII, CSOs National.

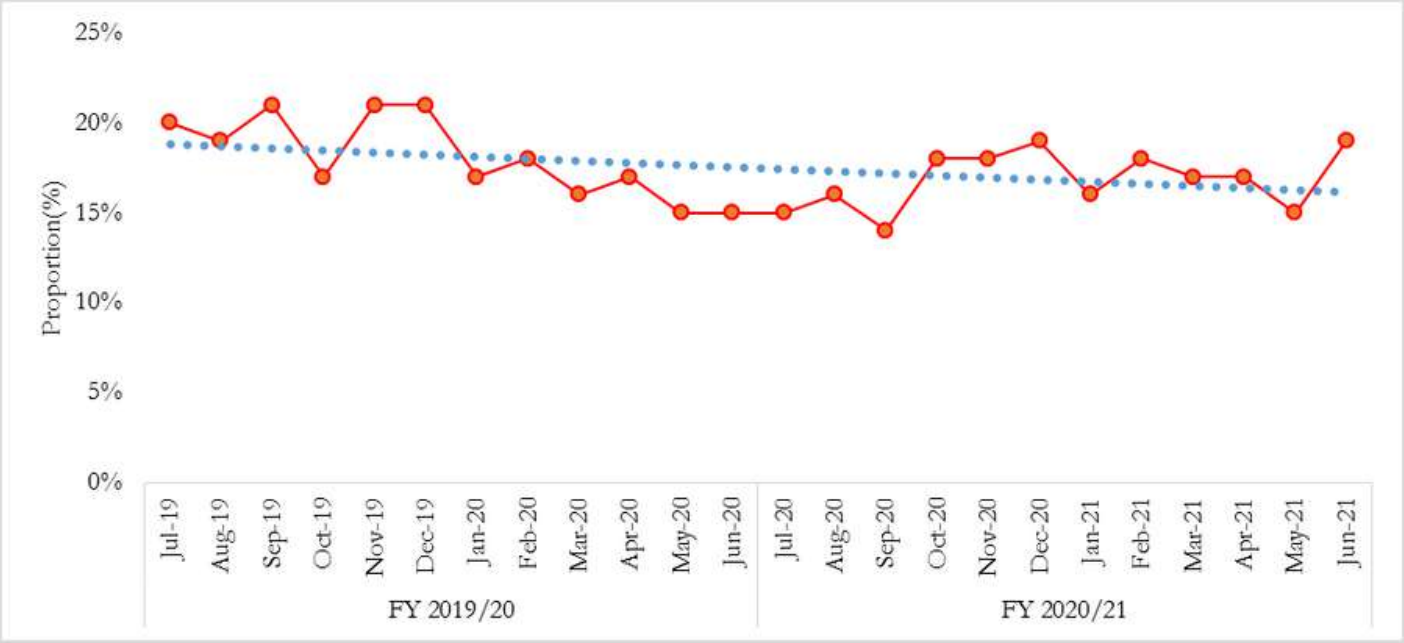


Figure 9: Percentage of adolescents' pregnant women (10 - 19 Years)
Source: RMNCAH+N review workshop presentation by Kisumu County AYSRHR focal person.

Service utilization in Nairobi County was also affected by the COVID-19 pandemic, where mitigation guidelines forced health facilities to reduce the number of people being attended to at a time. An ongoing health care worker strike led to crippling of services and the prioritization of the pandemic only and little concentration on RH affected and continue to affect service delivery.

There was closure of some of the health facilities due to either effect of COVID-19 or the health facility was set apart as a treatment or isolation centres. Some of the drop points where some of commodities, like condoms would be put were also affected because providers and users retreated. Fear of being infected by COVID-19 at the health facilities led to apathy in seeking services.

Some of the drop-in-centres (DICE) that are manned and used by community as safe spaces where vulnerable populations such as the adolescents and youth access services such as HIV testing and counselling, STI screening and treatment, cervical cancer screening, pre and post exposure prophylaxis, CCC services including HIV treatment, contraceptives, and GBV response were affected at the outset of covid due to lack of PPE and fear among the community health volunteers.

"Insufficient provision of PPEs making it inaccessible to seek RH services due to less staff" FDG, Nairobi
"A number of clients dropped off follow-up e.g., VCT and CCC" KII, Kisumu

The respondents reported a perceived increase in teenage pregnancies which were suggestive of increased unsafe sexual encounters during the onset of the pandemic. This was however disapproved by an internal report by Nairobi County health department which demonstrated declining trends Figure 10.

There was a disclaimer however raised by the county key respondents that the data may only represent adolescents seeking ANC services within the facilities, whereas there could be others in the community.

"We need to ask ourselves whether this data is representative. There could be pregnant teenagers in the community who have not showed up at the facilities either due to fear, the pandemic or other reasons" KII, Nairobi

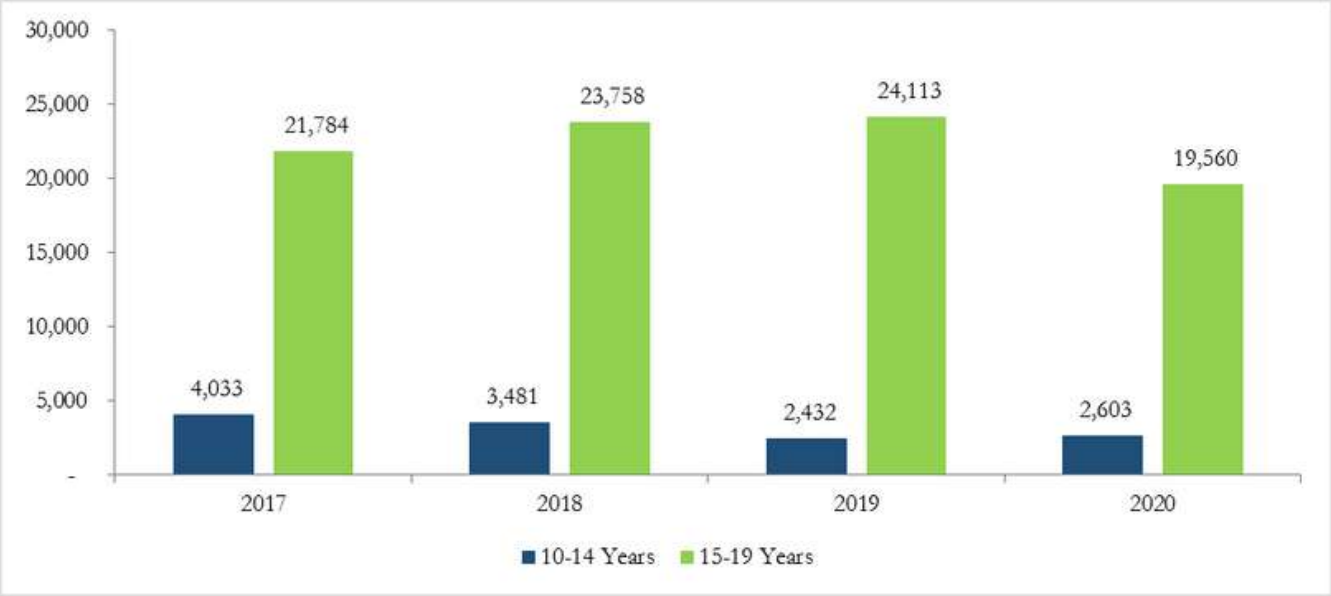


Figure 10: Adolescents presenting with pregnancy at 1st ANC Visit in Nairobi

High incidents of rape cases and other GBV were reported by the respondents. The pandemic also affected the youths economically due to loss of jobs, reducing affordability of commodities (pills and condoms) from the chemists or drug shops.

"Kazi iliisha, kuenda hosi ni hard juu hatuna fare so tunabuy mtaani" FGD, Kisumu (We lost jobs so it hard because we have no fare so we buy in the neighbourhood)

The assessment revealed that counties such as Nairobi attempted to mitigate the situation by using younger CHVs to distribute condoms and contraceptive pills to those in need. The county also used local radio stations to keep the adolescents and youth informed. The MOH also launched a campaign called TUJULISHANE with a toll-free number 08000722022, where youth could ask any question regarding RH and maternal health services.

"We started a social media campaign called TUJULISHANE where anyone who wants to access services is able to call in and get a doc, counsellor to talk to on issues of reproductive and maternal health. If we feel that they have not been assisted we refer them to the nearest health facility". KII, Nairobi.

3.4 Adolescents, Youth SRH service users and community perspectives

3.4.1 Community support

Strengthening community health systems is a key component in ensuring that parents, guardians and other community members and organizations recognize the value of providing health services to adolescents and support such provision as well as utilization of services by adolescents. The study assessed the systems being implemented by health facilities in relation to strengthening community health systems to support delivery of community level SRH services.

All three facilities in Nairobi and one in Kisumu reported that the community is informed on the benefits and availability of AYSRH services. Some respondents in **Kisumu** said that adolescents and youth are engaged through parents, guardians and gatekeepers when need arises. This happens through community outreaches, dialogue days, and chiefs' barazas. This is done with the coordination of the CHEW/CHA and the facilities-in charge often made possible with the collaboration of RH partners through projects like AFYA HALISI, MWENDO and DREAMS, since the county government of Kisumu does not fund community engagements.

"There was a collaboration with MWENDO project which was supported by JIU PACHI in sensitization of better health care services for the adolescents. There is also an ongoing dreams girl project which supports the young female adolescents." KII, Kisumu.

Demographics of Adolescents and Youth exit interview respondents

A total of 39 exit interviews were carried out, of which 24 were carried out in 3 facilities in Nairobi County, while the remaining 15 were carried out in 3 facilities in Kisumu County. All respondents apart from one from Kisumu County were female. The average age of all respondents was 21 years. Ten of the respondents were single while 29 were married.

Table 8: Age Distribution of the exit interviews respondents (15-24 Years)

Age bracket	Frequencies
(No response)	1
15-19	9
20-24	29
Total	39

The exit interviews showed that 82% (32) of the respondents in Kisumu and Nairobi counties, 75% (18) and 93 % (14) in Nairobi and Kisumu respectively, usually receive information of some sort when they visit the facility (Figure 11).

The information that the youth received at the facilities varied depending on information need. Common information themes received were contraceptives, RH, HIV prevention and safe sex. 73% of respondents in Kisumu and 92% in Nairobi said that the health care provider clarified all concerns that they had.

However, a discordance was noted in that while health care provider spoke of being friendly and receptive to all AYs, some of the clients indicated that they were not. Only 27% respondents in Kisumu and 33% in Nairobi reported that they felt free to discuss everything regarding their health concerns with the health care provider.

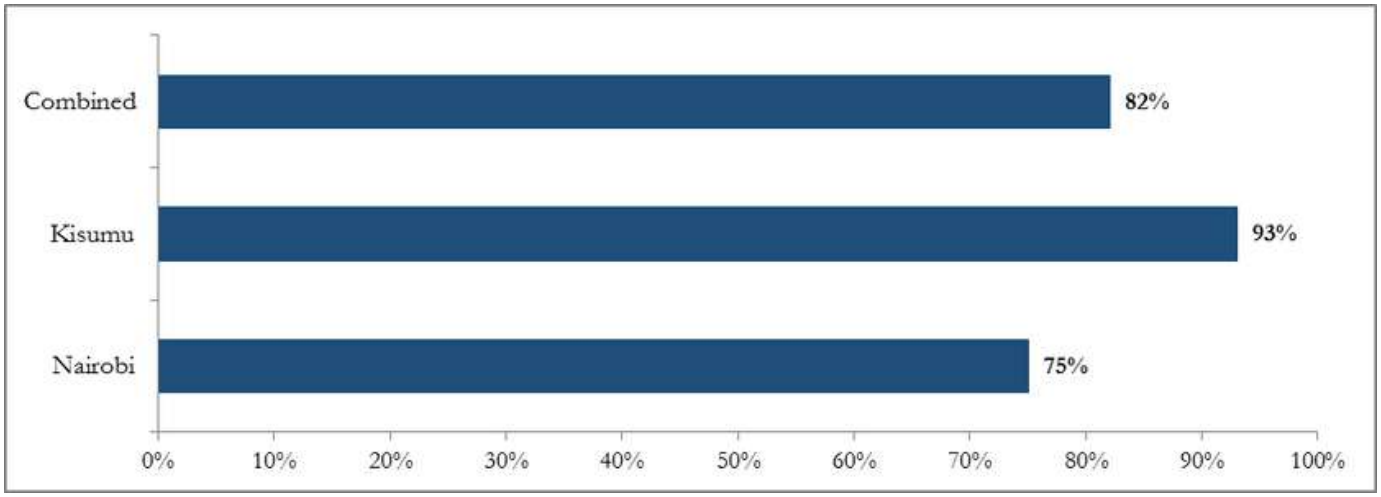


Figure 11: Proportion of AY reporting receiving AYSRH information

The national and county KIIs expressed optimism that despite the systemic challenges, the adolescents and youth are informed of AYSRH services. "For RMNCAH services, one is that in Kenya, the youth to a good extent, have access to information regarding reproductive, health issues" KII, CSOs National

Kisumu County: Respondents felt that there was limited knowledge on existence of AYSRH policies and guidelines among the adolescents and youth. Health facilities had digitalized platforms for enhancing SRH literacy, which were supported by partners whose funding has since ended.

"Youths are not aware of the policy that is being implemented, the policy is not 100% clear". "The county decided to come up with digitized platform to enhance the literacy but partners pulled out in the process" KII, Kisumu.

It was however felt that health seeking behaviour was still poor among adolescent and youth, and had resulted in an increase in teen and unplanned pregnancies, STI, HIV among others. Different adolescents and youth perceive SRH needs differently where, for instance those in rural areas may not have access to the right information because they get information from the social media platforms or peers, while those in schools may not have enough knowledge of existing SRH services due to poor access.

"Adolescents in especially in rural areas are not well equipped with knowledge on SRH and as a result there is an increase in teen pregnancy and in STI's among the young people" FGD, Kisumu

COVID-19 regulations were seen to have affected sensitization among AY's, though the media was being used to reach the adolescents and youth.
"There is use of the television to pass information on education programs" Facility in charge Kisumu.

Facilities in both counties are accessible to the AYs and majority of the AYs are aware of the availability and the timing of the services.

However, there is need to improve outreach services especially to the marginalized such as those in rural areas who have little access to information.

It was noted that during COVID-19, both counties adopted innovative ways of reaching adolescents and youth, using digital platforms, especially radio. Nairobi county for example used local radio such as Ghetto, Hope FM, and Koch radio to send AYSRH related information targeting the youth.

Community perception towards SRH services for AYs continue to affect access to services, where some services such as contraceptives and abortion are termed as unacceptable by the community and religious groups.

"Mission hospitals; religion related issues limit the delivery and access to services for adolescents and youth" KII health care worker, Kisumu.

The effect of this societal construction, where talks on sexuality are seen as taboo, facilitates development of unhelpful myths on AYSRH information and services.

"The thought of guardians /parents that their children are using contraceptives limit them from accessing the RH services" KII, Kisumu.

The opinion leaders therefore indicated that community resource persons such as teachers, CHWs, subnational level policy makers, church leaders, youth peers, administrative leaders and AY's, need to be sensitized to demystify AYSRH in the community.

"Dialogues on AYSRH services are conducted with partners, assistant chiefs, CHEW, facility in-charge and youth representative in the community when funds are available" KIIs, Kisumu.

Nairobi: Access to services among adolescents and youth is generally good, with them having access to sexuality education and a wide range of SRH services, including participation in advocacy initiatives.

Some religious institutions have set up initiatives that disseminate information and education among adolescents and youth. Preferred sources of adolescents and youth information include peers-to-peer, chemists, social media and youth networks.

"Young people often visit the chemist or drug shops due to the privacy they can't get from the facility. They don't ask us for advice but prefer advice from peers" FGD, Nairobi.

"Through organized peer- to-peer spaces in our circles, we talk about our SRHR needs, it is accurate, factual" FGD, Nairobi.

Door to door sensitization is also done by CHVs in the slums, although adolescents and youth prefer other sources of information, especially social media due to anonymity. Parents were not mentioned as a preferred source of SRH information.

The community opinion leaders expressed concern that young people shun the recommended sources of SRH information such as CHVs in the community, ending up in risky experiments. For example, most are more concerned about pregnancy than STI transmission. However, the MoH is currently exploring ways of addressing the information gaps.

"There is a big gap in information. As MOH we have been championing for Age-Appropriate Sexuality Reproductive Education. We are not 100% there, but we know information is power and currently we are running a campaign called TUJULISHANE, where the youth access information online." KII, National

Most of the AYs are educated; they get information from our outreaches, the internet, media and posters" KIIs, Nairobi.

Despite Nairobi County experiencing limited support among the community members especially religious organizations on AYSRHS, there has been some progress reported on religious institutions promoting minimal AYSRH services. Although data shows that the youth are sexually active, abstinence narrative is the main focus for religious organizations.

Many parents are not readily available or free to offer SRH information to their children, though some AYs mention that if they got pregnant, their parents would dictate the FP method they should take. Community engagement is better where AYs are engaged through CHVs, peer educators, champions and community health assistants (CHAs) who use promotional materials such as branded t-shirts in DICE set ups.

"Partners are able to reach the young people through peer educators, Adolescent girls, young women champions and through the CHA who organizes and links them with other youths" KII, Nairobi.

"We engage youth as trainers after sharing information at the facility since some young people are shy to approach the facility" KII, Nairobi

The county health management respondents confirmed that they prioritize adolescents and youth in their community outreaches.

"In Nairobi we had a budget and often had community dialogue days before COVID-19, where we engaged the community on AYSRH issues- this has been very helpful" KII, Nairobi.

It is clear that most of the community engagement activities are supported by RH partners and this is not sustainable in the long run. There is need for the counties to not only allocate funds in their AWPs but to actually implement so as to keep sensitizing adolescents and youth and gatekeepers for sustained demand creation.

3.4.2 AY access to AYSRH services, user perspectives

Availability of Services

some users felt that the services were not yet appropriate to some such as PWDs and key populations such as LGBTQI, who do not get special attention. Services such as Voluntary Medical Male Circumcision (VMMC), female condoms, and mental health were found not available in most primary health care facilities.

"*We need to include mental health services due to the increase of suicide cases*" FGD, Nairobi

The key health services to me and my peers that are lacking include products such as VMMC, female condoms and cancer screening services" FGD, Nairobi

Preference for chemists or drug shops was reported in the two counties, as an alternative provider of health care due to perceptions that they were faster, accessible and that they offered confidentiality. Other alternatives cited were private facilities, traditional healers, churches, CHVs, herbal clinics/vendors and some NGOs, such as LVCT. The respondents rated the alternative services as excellent because they felt they were treated very well, and felt accepted.

They also felt that the alternative services were faster and follow-up is easier because one sees the same provider, creating a relationship. However, some said that the alternative services were substandard and are not safe, giving an example of those performing cheap illegal abortion, which young girls were thought to prefer, as they cannot access the service in public facilities.

"There is no queuing in Chemists, providers don't lecture or ask many questions and common products are cheap e. g. pills" FGD, Nairobi.

"Private providers are good, because the clients are being treated well because they use their money, and there is not too much waiting in the line for service" FGD, Kisumu.

There were noted gaps in seeking health care among young males, despite the availability of services.

"Boys don't feel the need to seek these services since they're not sensitized rather girls alone are sensitized" FGD, Nairobi

The user perspective survey findings indicate overall positive rating of the service providers, with a majority of respondents indicating they were happy with the adequacy and understanding of information provided as illustrated in the figure 12.

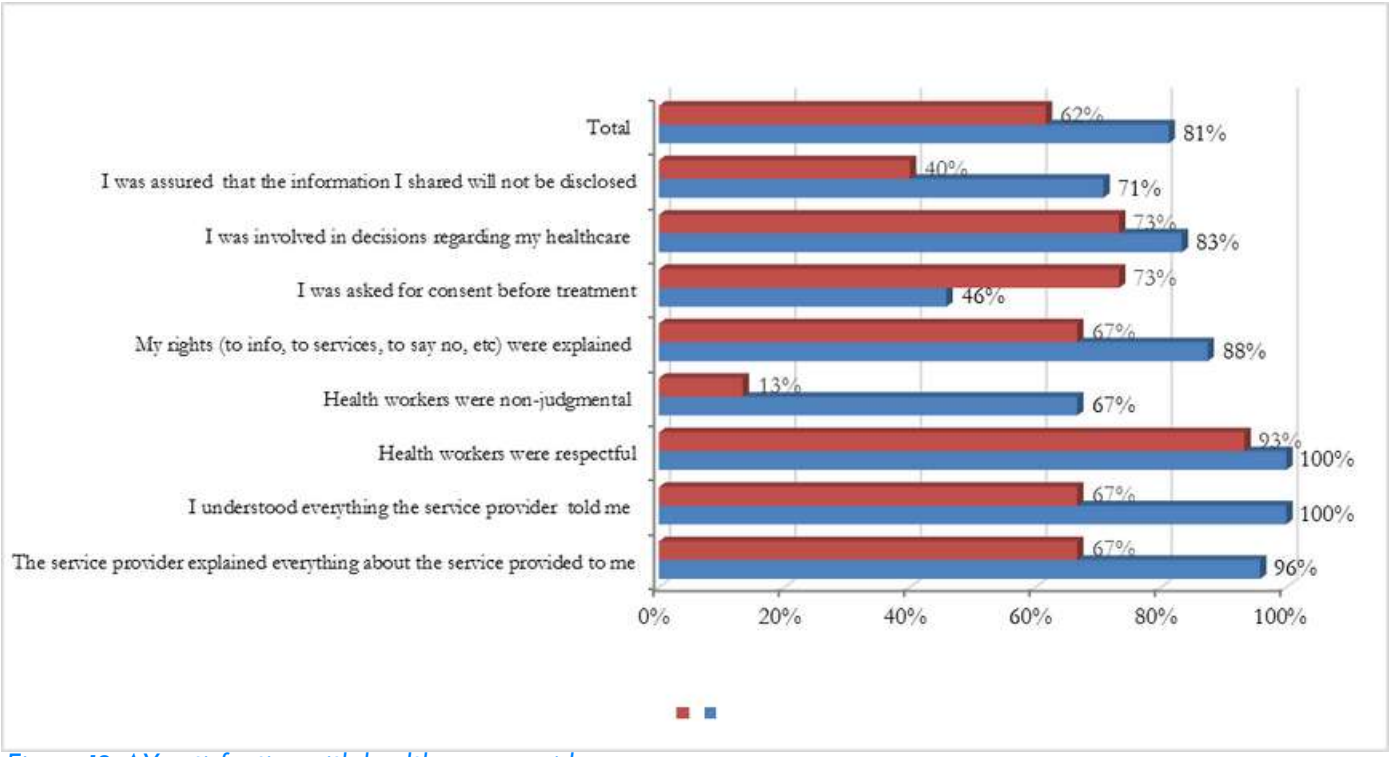


Figure 12: AY satisfaction with health care providers

Some of the adolescents interviewed in both counties felt that the health care providers' attitude was different if a girl walked into a health facility alone compared to one who was accompanied by a spouse, whereas the latter was served faster.

The health providers were perceived to be unkind and harsh towards girls who had early pregnancy, and especially during birth. The adolescent boys interviewed felt that the attitude of the healthcare workers favoured girls over them.

Adolescent Youth Friendly Services (AYFS) facility characteristics

While the health care workers reported that the waiting rooms were comfortable and had fun activities for the adolescents and youth to engage as they wait to be attended to, 64% of the adolescents and youth clients in both counties said they were boring.

They cited lackof privacy, insufficient sitting capacity with uncomfortable seats, and congestion. The adolescents and youth s confirmed that health talks are normally conducted in the waiting rooms. However, some spend their time chatting with other clients while others read educational materials. Majority (74 %) of the respondents said it was easy to access the facility.

To help improve the waiting period, the respondents felt that facilities could increase the number of health workers, provide internet services, increase the seats to make the space more comfortable, while 77% of the respondents agreed with the facilities that the hours of operations are convenient, but could be better and accessible if expanded to weekends.

"It would be good for us if services are offered 24/7 so that we can come after school" FGD, Nairobi

In terms of affordability, the AYs were in agreement with the facilities and shared that they received services for free. Only a few indicated having incurred other costs related to the services they received including for laboratory tests, medicines and indirect costs associated with transport to and from the health facility. Majority of the respondents revealed that they seek services 3 – 4 times a year.

"Kuonekana ni free lakini lazima uende test zingine nje ya gate na lazima ulipe. Ni ngumu" (consultation is free but you must get some tests outside the facility and pay. It is difficult) FGD, Kisumu.

The respondents were asked if they received the services they had wanted at the facility on the day of the interviews. Eighty-five percent (33) of respondents (88% from Nairobi and 80% from Kisumu) said they got the health services they had gone for.

Five respondents said they did not, and one was non-responsive. Most of those who did not get the services were appropriately referred to other higher-level health facilities. Fifty nine percent (23) of respondents said they felt safe or were happy with the services provided, and indicated they did not experience any challenge receiving services.

However, 14 respondents were either not satisfied with the services or were unhappy about the quality of the service. While all the health facilities reported that they practice high levels of privacy, 36% (14) respondents, (11% from Nairobi and 73% from Kisumu) did not feel there was privacy while receiving physical examination.

There were either other people in the room or nearby, making them uncomfortable and so this made them withhold some information that could have been useful in their treatment.

Almost all respondents (97%) indicated that they would recommend the services to their peers, while 90% said they would go back to the same health facility for similar services if the following were present; good and free services, professional, respectful and friendly service providers, short waiting period, availability of service providers, confidential management of client information, accessibility of needed services, cleanliness of the health facility and availability of commodities.

"I am satisfied with the services and I will come back and if my friends are in trouble, I will refer them here" FGD, Nairobi

The study sought to establish the aspects of the services the AY clients mostly found satisfying and the results were as below. Almost half of the respondents were happy with the quality of the health services and the fact that they were free figure 13.

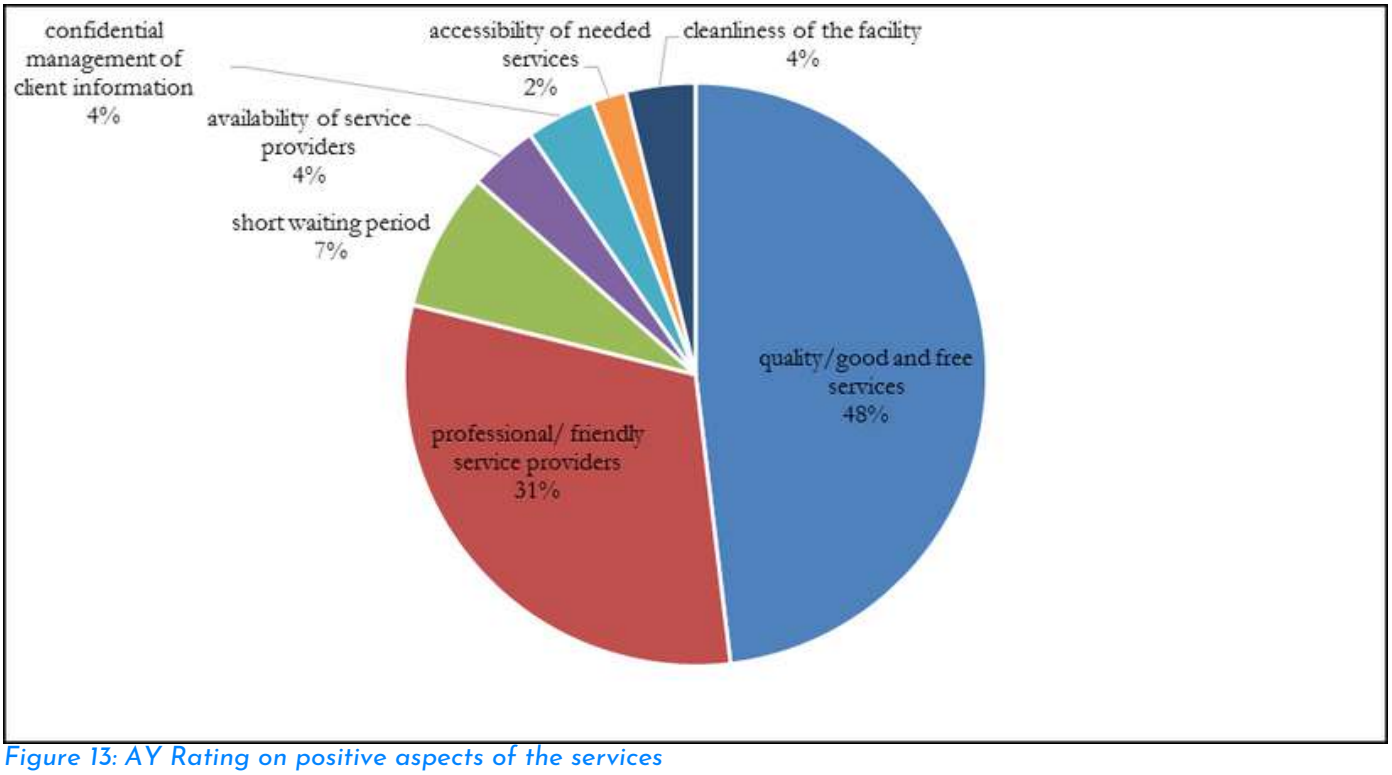


Figure 13: AY Rating on positive aspects of the services

Rating of the overall services received was mainly positive with 62% of the respondent's expressing satisfaction with the services. Only 3% were dissatisfied with the services as illustrate figure 14.

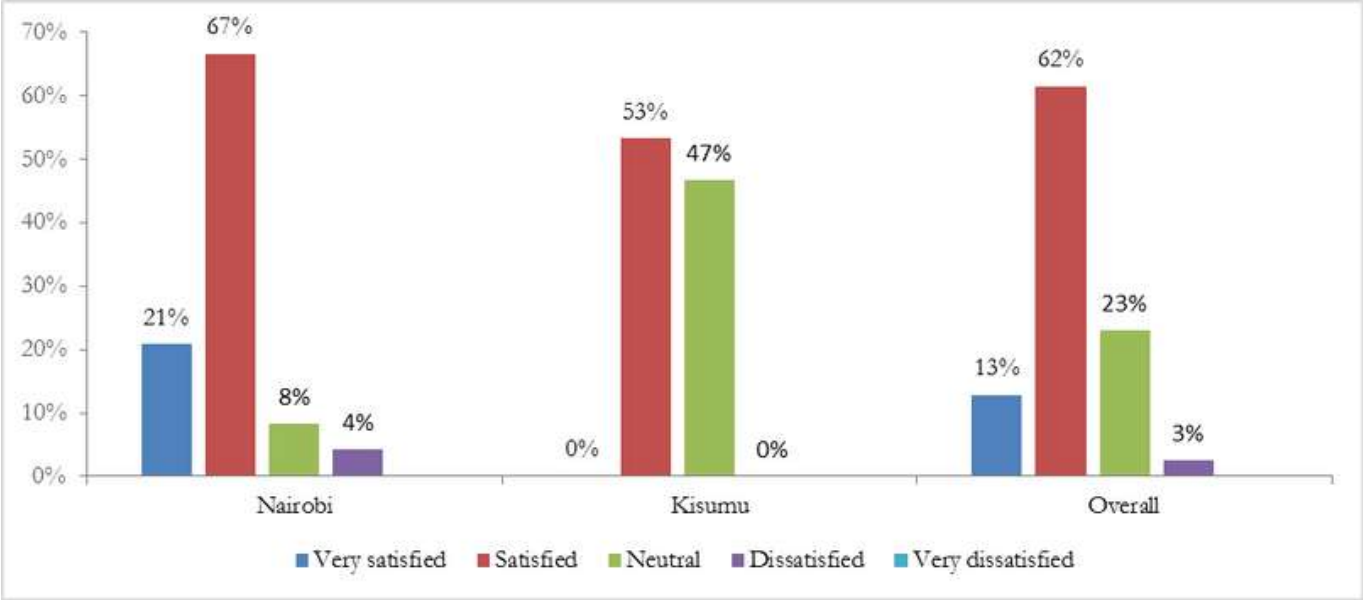


Figure 14: Adolescent and youth level of satisfaction with the services offered

3.5 THS-UCP (GFF mechanism) on responsiveness of AYFS and AYSRH services and information

Though there were reports that THS-UCP has helped in reducing teenage pregnancies and improved the initiatives that empower AYs and communities to demand for healthcare, it was not very clear how this is measured and most health workers expressed lack of knowledge on this stream of funding and its management.

"Us we are not funded by THS I hear they give funding but somehow I do not know if it is at the county level that those funds are not adequate for them to implement, I do not know or is it from the donor, but somehow, they are struggling with that. I get stories like we have funds but they are not enough" KII, National.

Respondents cited other programs besides THS-UCP that improve access to adolescent and youth services in both counties. In **Kisumu County**, the government health programs which are helping to improve access to AYSRH services, include UHC, MARWA and LINDA MAMA, which were said to have led to improvements such as having a maternity wing for the adolescents, improvement in commodities availability and laboratory services. Partners also run the few youth friendly (YF) corners in different health facilities. RH partners include KEFEADO and META Kenya.

There is a Kisumu UHC alliance that includes youth-led and youth service organisations. Respondents from the county health management knew about THS-UCP and believed it worked well in the county.It is assumed that THS-UCP improved access to SRH services and has helped in the reduction of teenage pregnancies in the county.

"We have several partners supporting programs that include provision of services, community sensitization, advocacy to empower young people and community to demand AYSRH services. I don't know about THS" FGD, Kisumu

In **Nairobi County**, there are supportive programs that exist impacting on AYSRH with activities such as capacity building advocacy forums. Some of the organizations in Nairobi include; - AYAREP organization, AHF, AMREF, FEBA, LVCT health, Our Voices Initiative, RHNK Alliance, MWENDO- IGA for young mothers who are HIV positive, BEACON OF HOPE (BOH) that supports school placing and school fees.

The county developed an AYRH implementation framework for 2019-2023, in a process that was led by young people and supported by partners. With the support of YACT, and IYAFP, Nairobi County has peer-to-peer youth friendly (YF) services that started being provided in February 2021. Additionally, the peer-to-peer manual on YF services can be used by young people to understand the basics of what SRH services are available. Nairobi County also has 2 funded projects by Bill and Melinda gates, through the CoG and another through UN-Women, both focus on vulnerable girls to address the policy issues

The two counties' department of health shared that the quality of AYSRH services has improved since the introduction of THS-UCP, though attribution is indirect due to lack of adolescent and youth specific indicators. However, overall health system strengthening is believed to have a positive cascade effect to AYSRH. The THS-UCP grant is seen as a big boost to RMNCAH services.

The finances allocated for specific AYSRH activities are prioritized for community dialogue and outreaches and a small amount included for needs assessment. However, in Nairobi for instance, it was noted that although there is prioritization of AY in the THS-UCP AWP's, the money is sometimes not released or delayed from the county treasury affecting implementation.

"We can make THS more responsive by having budget lines and monitoring the same. In FY 2019-2020 there was AY budget for community engagement and community dialogue only 2.7M, but the money is still held up by Nairobi country treasury, and so not implemented" KII, Nairobi

The results -based GFF mechanism has been viewed as supportive towards improving performance and use of the grant. The mechanism enhances, strengthen or calls for transparency, accountability inclusivity to ensure youth are included. Collaboration of various CSO towards the AYSRH agenda and especially prioritization and accountability has been especially helpful, although there is still a call for better coordination and collaboration.

"The GFF mechanism has been very helpful because you have to report what you have done for you to get more funding. It has helped CSOs to work together. We are now better coordinated and we're able to act together than before. So, coordination is improving. The GFF mechanism enhances, strengthens or calls for transparency, accountability inclusivity so the youth should be included in the UHC agenda". KII CSOs National.

"Funding is very minimal. Even research there is basically zero budget. I do not know much about grants. Most of the funding goes to partners then they come to support us. It would be nice if they are able to support the national directly. I think they do support counties. Counties apply. Like for us 100% we depend on partners. If we have direct funding for specific things then it can be much easier". KII, National.

Platforms, opportunities and spaces for MAYE in THS-UCP in line with the GFF Youth addendum

Adolescents' (and Youth) participation is one of WHO's standards of quality AYFS. It is important to involve adolescent and youth (AY) in decision-making in matters concerning their health and, in the planning, monitoring and evaluation of health services. This study assessed the extent to which this has been implemented in the two counties.

Nairobi scored 91% and Kisumu 81% (figure 15). Specifically, all facilities indicated that they include AY in their Health Facility Management Committees. Most of them reported involving AY, including vulnerable group(s) in the planning, service provision, monitoring and evaluation of AYSRH services. AY are also involved in decisions regarding their own services, including consent as well as being agents of change. They also take part in demand generation activities by sensitizing the AY in the community about available services including prevention of GBV, STI and early marriages. Confidentiality in collecting feedback from the AY was reported to be prioritized in all facilities assessed mainly by use of suggestion box.

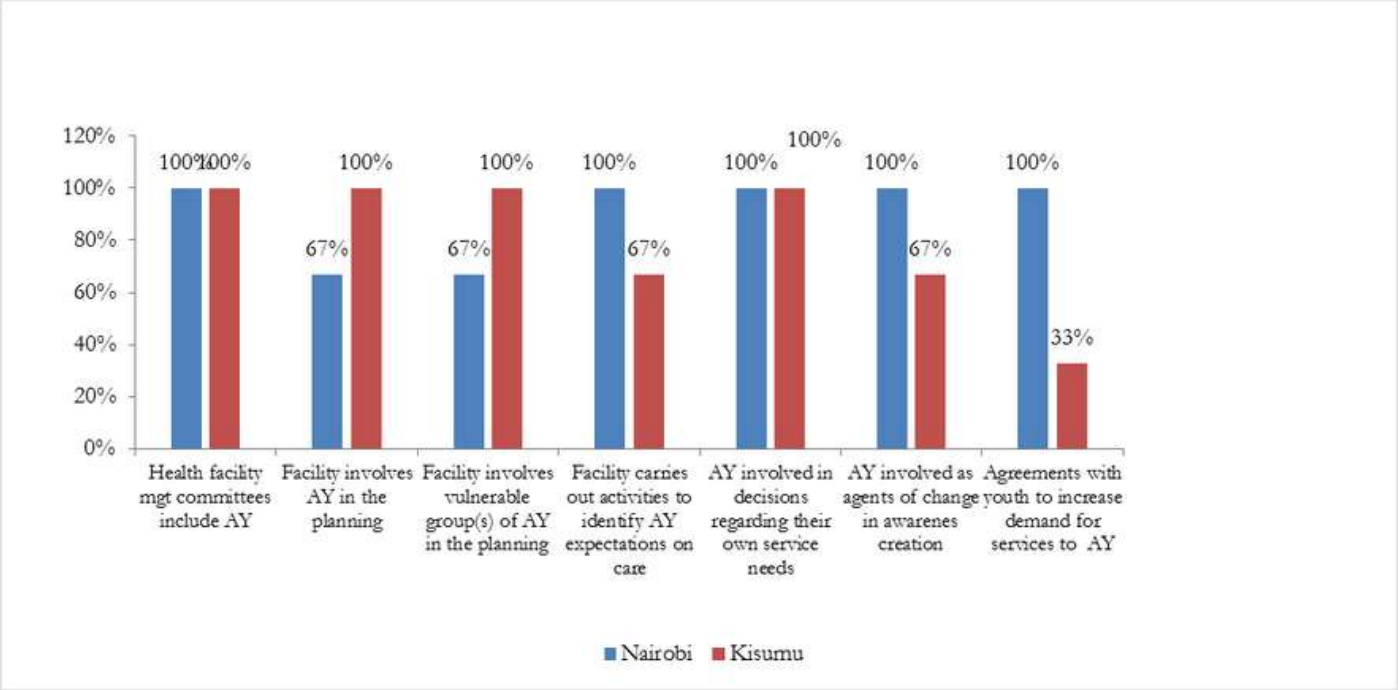


Figure 15: Meaningful Adolescents and Youth Engagement

Kisumu: Respondents from the local CSO's asserted that the tenets of the GFF youth addendum has helped them to advocate for more representation and resources. This means that in the future, youth-led organizations will have an opportunity to apply for engagement in the advocacy process at country level. They appraised organizations that have young people who are empowered to represent youth voices from other counties and advise on matters concerning health, such as UNFPA, which has a youth advisory panel.

IYAFP too has a Project called Sustaining Evidence Driven Advocacy, where they advocate for social accountability in budgeting. Further young people have been engaged as HIV counsellors, as CHVs and CHAs and have continued to support sensitization, referrals, and demand creation such as in the ongoing MARWA PROJECT.

"We are involved in mobilization of clients like during the MARWA PROJECT" FGD, Kisumu

"The young people are involved in AYSRH awareness creation and advocacy through sharing out IEC materials to the fellow youths" FGD, Kisumu

"Young people play a role in awareness creation and seeking for health care service" KII, Kisumu

"Yes, some of the health facilities have been engaging the youths in decision-making and in planning of activities" FGD, Kisumu

Nairobi: MAYE is very strong and vibrant in Nairobi County, where the youth are widely involved in AYSRH processes and programs. The youth are engaged in drafting policies and validation processes. There is a Youth Advisory Council (YAC) at the directorate of health that is strong and sits in decision making structures in the county. It is considered the official structure for youth engagement. The youth in the council are carefully selected from the sub-counties.

They develop their own AWP and take lead in any strategy development in matters of adolescents and youth.

"Oh yes we involve the young people a lot, in fact we can't do without them especially members of YAC who help on mobilization and demand creation. We also use them when collecting data in the county" KII, Nairobi

In the county's AYSRH implementation framework for 2020-2023, there is a whole priority area on MAYE with clear strategies for implementation. The county also uses a scorecard to measure how they are performing in their engagement of Youth. County Health departments of gender and youth are highly involved to see how they can strengthen MAYE between decision-makers and the young people in Nairobi County.

"Division of health working with groups of young people to produce some of the content that you see being aired, especially the animation things that would speak to young people, as well as to the rest of us" KII CSO National

Nairobi was viewed to be adolescent and youth responsive, having provided a platform to support MAYE by having AY focal person, and also a youth advisory council that is actively engaged in progressively implementing the AYSRH framework 2020-2023.

The role of the youth-leader desk in Nairobi County is to act as an overseer and organizing youth activities which include capacity building of the youth advocates and the youth volunteers.

The youth leaders act as advocates regarding key AY issues. They are seen as the representative of the young people's rights and work with like-minded partners in policy advocacy, in addition to working with decision-makers to influence change on what AY needs are and how they can be addressed going forward. They also facilitate community engagements.

At the health facility level, some of the youths are involved in the governance structures that exist, for instance at primary health care facilities, we have health committees while at the hospital level we have the hospital boards. For some of these health facilities, the youth are members of the committees or boards. Only a few are involved in planning, monitoring and decision-making. Mostly the youth are involved in implementing door-to-door initiatives.

Young people are also engaged as service providers in HIV testing and counselling. There is currently an ongoing activity of hiring young CHVs to be able to reach the AY in the community. Peer educators are involved in the local activities such as local sport activities, youth meetings at church, while other youths are used in mobilizing during the trainings that take place at the facility and with self-help groups.

The youths have been involved in advocating for SRH including use of social media to create awareness and do advocacy work (use of WhatsApp status) by health facilities close to them. Some GBV Clinics such as Tumaini are run by the youth. Some of the avenues used to engage youth include availability of a suggestion box at the health facilities, involvement in data collection and review through monitoring and evaluations, as well as peer to peer talk shows on local radio stations.

"Youth have always been involved in conducting monitoring and evaluation of their programmes to find out where the gaps are"- KII, Kisumu

"Some attend the implementation and mobilization meetings at the facilities" FGD, Nairobi
At the community level, the youth were found to be playing a key role as part of CHVs and CHA who help in sensitization, referrals and demand creation for services. They also volunteer as peer mentors, youth leaders, commanding for space for young people in policy implementation in budgeting and improving AYFS.

With support from partners some youth also provide and also benefits from training sessions for young people, capacity building and advocacy at community level. They are involved in needs assessment to identify advocacy priority issues then work with policy makers. They partner with CHVs to have health talks in schools and are engaged in mobilization and dissemination.

At county levels the community youth engagements are done through the CHA via youth groups/leaders. There is the use of the chief's office and the 'Nyumba Kumi' (elders) who help to reach out to households. Youth CBOs are also used for community outreach programs such as giving out sanitary pads, distributing condoms and linking young people to SRH care providers.

"Communities and county partners have given space to the youth groups to advocate because it helps the planner and policy-makers hear the voice and frame the issues the same way that the young people see the issues" KII, National.

"When we are developing our proposals or when we get a call for proposal that is geared towards youth, we share with the youth and support in empowering them. We make sure that they themselves speak for themselves, that they are represented. They are there, they have a representative articulating their issues". KII, CSOs National.

At national level there is a specific AYSRH TWG that is a standing committee in the Department of Reproductive and Maternal Health, where young people get involved. Young people have been engaged not just in communication through radio and TV, but also, in levels of partnerships to get the COVID messages and other services.

The Division of Health Promotion has been working with youth organizations and groups of young people to produce media content that is aired, especially the animations that would speak to young people, as well as to the rest of the population.

However, for effective advocacy there is need to enhance capacity of the youth not only to understand GFF mechanism, but other opportunities that can be used to address youth issues such as UHC. Using the HENNET platform, the CSO GFF/RMNCAH+N coordination group will work closely with OAY, to build the capacity of the appointed youth. There is a call to bring all youth led and youth organizations together to coordinate and align all advocacy efforts.

"*Because of being proactive, the youth are really giving their input and for us as a coordinating body, we are making sure that they are not left behind by building their capacity and being intentional about their inclusion"* KII, CSO National.

Improving Meaningful Adolescents and Youth Engagement (MAYE) Opportunities

Improving adolescent and youth engagement according to the respondents means creating a space for them to effectively engage across the entire health care system, including in monitoring and evaluation.

They expressed need for sensitization of stakeholders and policy-makers on the youth related issues and training the youth on what MAYE means to them to build a resilient movement as a sustainable model of ensuring youths are engaged. This may also mean identifying champions that can give back and engage youths. With regard to advocacy this may mean, public participation and strong collaboration between government arms e.g., MOH and ministry of education. Peer learning is not fully embraced and there is need to enhance the same at community level and wherever the adolescent and youth meet.

Opportunities and spaces which remain untapped include media engagements, training young people on leadership, civic education and how to engage in political processes; continuous engagement of the community on youths; economic empowerment and championing for rights.

Ensuring proper mentorship at all levels including school clubs and engaging young people in tertiary institutions, and out of school youth groups, including creation of work spaces that address their livelihood. The stakeholders interviewed also mentioned that media is not well tapped as an opportunity for MAYE given it reaches wider audience.

The youth leaders expressed a need to sensitize the government and other stakeholders on MAYE principles. They emphasised a need to have more AY indicators on RMNCAH+N investment framework to track progress of initiatives. However, they expressed a need for more funding and resources for youth organisations and youth initiatives.

"As a youth leader, I would engage opinion leaders to champion for AYSRH. Work with youth advocates to reach young people. Mobilise the community/young people on budget making process, policy and budget framework in influencing decisions at the community level, national, local and regional level. Implementation of evidence-based advocacy.

Planning and assessing the gaps in service delivery in a community and sensitize the government and stakeholders on youth issues" FGD, Kisumu

"So, with increased resources and actual representation of youth, the future is that there'll be more money where young people's organizations can apply for engagement in the advocacy process at country level" FGD, Nairobi.

The discussion with Chief Administrative Secretary (CAS), emphasized on GFF MCP platform as an important tool and opportunity available to mitigate challenges facing adolescents and youth health, by involving them especially on RMNCAH+N issues and tapping the opportunities in rolling as well as in implementing the UHC agenda in the country.

There is an open invite for the young people to attend meetings where the dashboards that include key health indicators and other conferences where discussions on the health matters and their needs are discussed to enable them be more responsive.

"Yes, we need to incorporate AY indicators in the next phase of the IC and data team should pay specific attention to data disaggregation to reduce duplication, create clarity on AY issues to ensure they are not falling behind. Further it is important for youth organizations to come together and advocate as one." KII, National.

The GFF strategy 2021-25 states that a top priority for the GFF will be to encourage and support partner countries to increase the diversity, equity and inclusion of their country platforms to ensure that the youth are included. The new global GFF strategy also emphasizes on the need for countries to engage the adolescents and youth.

"Between partners and other CSOs, we have committed to ensure that the youth CSO representatives to the MCP are able to access the meetings when called to participate in the events and activities" KII, National.

4.0 CONCLUSIONS

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Most of the global documents have some focus on adolescent health, however there is minimal focus on the youth 20-24 years, with an exception of the GFF 2021-2025 strategy, theAY Addendum to GFF CSES and the global statement on meaningful adolescents and youth engagement which substantially emphasises on inclusive and holistic MAYE - a huge step towards improvement of AY health indicators.

THS-UCP and PAD in Kenya prioritizes adolescents among the high impact interventions and posits to support ASRH strategies, however there are no AY specific indicators in the 6 project result indicators neither the mention of youth.

Adolescent health is included as part of the high impact interventions that are prioritized in the Kenya's RMNCAH+N investment framework. Strategies of optimizing service delivery targeting the youth, such as scaling up adolescent responsive and friendly health services, providing comprehensive sexual education and innovations to retain girls in schools are some of the highlighted interventions.

However, the reference of the youth (20-24 years) in the investment framework is sketchy. In terms of investment adolescents and youth are allocated 5% of the projected finances, however the results monitoring framework has only two AY indicators i.e., teenage birth-rate and FGM. The rest are aggregated in maternal health indicators

Kenya ASRH policy (2015) and the National guidelines for adolescent and youth friendly services (AYFS) 2016 focus on enhancement of the SRH status of adolescents. While the policy has no mention of youth, the guideline identifies MAYE as a key strategy for implementation of AYFS.

It also specifies key actions of engaging the adolescents and youth including their roles. Th two guidelines in reference fail to cover vulnerable populations such as sexual minority.

At the subnational level (County level), the County development integrated plans (CIDP) for the two counties highlight a need to focus on AY in their rationale especially on reduction of HIV prevalence and incidences though their implementation matrix. They however lack the specificity on expected deliverables.

A concern was raised in both counties that CIDP implementation is a challenge so are the Annual Work Plans (AWP's) such that even though funds are allocated for a few indicators, these funds are not availed to the health facilities, and neither are they ring-fenced for AYSRH.

Given the COVID-19 pandemic, the WHO's Maintaining essential health services: operational guidance for the COVID-19 has to a large extent prioritized adaptations to AYSRH services for the AY, including suggestions of innovative ways to reach them with information, products and services such as digital health and outreaches.

Though Kenya's COVID-19 RMNH guidelines does not specifically address AY, it outlines protocols for safe continuity of RMN and FP services.

Elements that may be helpful to improve AYSRH include use of telemedicine, longer (3months) FP refills for condoms and oral contraceptives, increase minimum stocks at facilities, as well as use pharmacies and drug stores to distribute the commodities.

In terms of funding, GFF in its 2021-2025 strategy promises to intensify support to help partner counties respond to COVID-19 (including vaccination) and get back on track with their result indicators.

Health workers, county and national respondents have good knowledge of the existing policy guidelines and frameworks.

They support adoption of the RMNCAH+N investment framework and the National ASRH policy of 2015, albeit with some scepticism with regards to sufficiency of funding and contextualization of the policies to local settings.

For AYSRH services, health facilities are accessible with clear signage. The AY respondents shared that they are able to access services and demonstrated sufficient knowledge of available range of services

Despite facilities reporting availability of educational materials in the health facilities, AYs awaiting services talk to other waiting clients, or spend time on their phones. Most facilities have a contact number but the use by AY could not be authenticated.

Education materials for PWDs or challenged literacy were not available in all facilities. MOH and County governments however trying innovative ways to reach the AY with information especially during COVID-19 on digital and media platforms such as TUJULISHANE toll free number and social media links.

Most facilities especially in Nairobi County were reported to have AYSRH education competent service providers, though only a few offered AY health talks in the facility or had active outreaches with Kisumu reporting that the digitalized platform had stalled after support by partner ended.

Knowledge of policy documents among AY, who these policies address was relatively low

One facility in Kisumu County claimed to inform community on benefits. Community engagement though singled out as key to improving community health, was less than desirable. This is because few health facilities were able to undertake community dialogues to create awareness in the community supported by partners.

There was however no record of collaborations between facilities and communities, as well as and no community outreach activities were going on during the assessment. Providers cited lack of funds or COVID-19 restrictions.

Cultural and religious beliefs continue to shape acceptability of AYSRH services, where community gatekeepers still held to misconceptions that adolescents should not seek them.

Capacity building has facilitated a good understanding and appreciation on the need for community engagement among health managers and health providers.

However, the assessed counties did not have allocated funding to support capacity strengthening activities implying that plans may not be fully implemented. Parents/guardians considered a big influence on access to SRH services by AYs were seen as opponents of use of AYSRH services, especially FP, post abortion care etc.

A majority of the health facilities offer a wide range of services targeting the AY and most have broad mixed contraceptives though mental Health, SGBV and Drug/substance abuse services were insufficient and had weak referral systems

It was clear that the inconvenient operating hours and long waiting hours were major barriers to AY access to health services, not forgetting infrastructural issues for YPLWDs, lack of diagnostic tests in primary health care facilities, frequent stock-outs and strikes leading to youth seeking alternatives.

Most popular alternatives were chemists/drug shops, peers and private clinics, increasing the vulnerability of the poor who are unable to afford.

Though majority of AYs exit clients stated they were satisfied and would recommend services to their peers, there was concerns around privacy and confidentiality of services as well as respect for vulnerabilities such as sexual minorities.

There are specific vulnerable groups that feel left out in service delivery and policy. These groups include but not limited to young boys, YPLWDs (physically disabled, deaf and dump) and sexual minorities.

There was a huge preference for chemists as an alternative that was quicker, and also AY preferred getting information from peers which though not fully accurate is considered confidential

Most facilities did not have a dedicated AYSRH staff for the day. While there are attempts to integrate youth friendly services in health facilities, there was evidence that though most experienced health care providers have been trained on AYFS, the newly recruited workers are not trained on APOC.

Health workers acknowledged receiving training in adolescent health care with emphasis on confidentiality and non-discrimination, and reported to be utilizing guidelines and job aides for counselling and clinical management of AYSRH services targeting the adolescents and youth.

Though facilities report that there are systems in place for adolescents and youth to provide feedback on services, none of the exit clients spoke to having been given opportunity to express their opinion regarding the services provided in those health facilities.

Majority were happy and satisfied with the HCW's conduct and almost all indicating they would go back or recommend the facility to their peers. However, a few AYs reported discrimination of very young pregnant or teenage mothers.

Very few of the facilities had an AYFS corners, and some missing services such as diagnostics and medicines affected affordability in some of the facilities, which sent clients to private facilities. Transport costs also affected access.

AY clients were satisfied with the cleanliness of the facilities, although they were concerned with the congestion, long waiting hours, uncomfortable and inadequate waiting spaces and lack of privacy in consultation rooms.

Both counties did not have youth friendly educational activities. However, all facilities attended to AY without needing parental consent. Health workers were respectful and non-judgmental, and they spent sufficient time with the AY clients.

In terms of supply chain management, several health facilities had a broad mix of contraceptives, although they also reported frequent stock-outs of some of the commodities.

On **reaching the vulnerable subpopulations** Nairobi County performed better, although it lacked facilities for YPLWD, especially the physically, visually and hearing challenged.

Most facilities tracked the referral of adolescents and youth as well as treatment data. However, most did not report cause-specific age disaggregated data.

Concern on the increase of STI's in all counties and increasing utilization of HIV care services was highlighted. There was also expressed concern on the negative impact of COVID-19 on AY behaviour leading to many unwanted pregnancies and STI infections.

Religious beliefs and gatekeepers continue to influence uptake of AYSRH services.

Counties expressed a disruption of services during the pandemic due to reallocation of personnel to the emergency, lack of drugs, closure of some facilities, which were set apart for COVID-19 isolation, infection of health workers, insufficient PPE's and minimising visits to facilities to reduce COVID-19 infections.

Demand side factors affecting utilization during the pandemic revealed fear of facilities and financial challenges, which may have led to plausible but unconfirmed reports of increase of teenage pregnancies, comprehensive care attrition and an increase in STI.

The effect of THS-UCP on the implementation of the RMNCAH+N investment framework and the utilization of AYSRH services, products and information was not very clear among the health care workers. While most national respondents hailed the achievements of GFF mechanism and THS-UCP at county and facility level, very few respondents were aware and expressed lack of knowledge.

One notable achievement of GFF was strengthening of transparency, accountability, inclusivity and advocacy including improvement of collaboration of various stakeholders towards the AYSRH and RMNCAH+N agenda in general.

MAYE was witnessed with youth citing engagement in decision-making, health promotion and providing feedback, though only a few facilities involved them in daily activities. Nairobi County facilities performed impressively in MAYE with a very active Youth Advisory Council.

At national level there was a call to engage the youth at the table beyond the MCP as the county transitions to UHC to ensure their agenda is prioritised including incorporating AYSRH indicators. Untapped opportunities and spaces that could be utilised include; schools, tertiary institutions, churches, markets, digital space, political arena etc.

Regarding what **an ideal and practical AYFS look like**, majority of the respondents advocated for a responsive service provision saying that anything that would make services be responsive to the adolescents and youth within the Kenyan context, would be helpful.

This means not necessarily following a blue print of having a youth friendly corner only. Some suggestions include; friendly and gender sensitive services; availability and affordability of a wide range of services, involvement of the young people at all levels of care, availability of multi-modal learning materials for different abilities.

Overall, there was noted improvement in the health care system at the county level, through the THS-UCP. Despite AYSRH services being integrated, the ripple effect is noted in delivery of the services that are mainstreamed within the essential services.

5.0 RECOMMENDATIONS

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- There is need to incorporate policy formulation and implementation in youth related capacity strengthening activities to increase literacy among the adolescents and youth health as well as enhance awareness of SRH rights.
- Integrate adolescent health, YFS and value clarification in the healthcare workers training curricula. This will result in creation of an enormous pool of competent and skilled health workers.
- Strengthen coordination among all the stakeholders on RMNCAH+N and particularly adolescents and youth (AY) to ensure a coordinated approach that focuses on improving health outcomes and health of this vulnerable population
- National and subnational health systems will need to significantly invest on data management, track progress and adolescents and youth indicators. Age and sex disaggregated data can provide more accurate age-appropriate services and information that enables continuous monitoring and decision-making.
- Explore opportunities within the THS-UCP RBF mechanism to incorporate AY specific indicators in the RMNCAH+N investment framework as an incentive to enable targeting of adolescents and youth and ensure they are not left behind.
- Strengthen health facility client feedback mechanisms for AY for improved quality of care and access to services.
- At the subnational level, there is need to sstrengthen referral mechanisms for services including for counselling on mental health, drug and alcohol use as well as sexual gender-based violence
- Stakeholders will need to ensure concerted efforts are made to advocate for increased funding allocations and corresponding disbursements, to ensure availability of equipment, diagnostics services and commodities that support delivery of adolescent's package of care (APOC).
- Intentional efforts have to be made to ensure direct targeting of the vulnerable AY during outreach activities at the county level, including targeting sexual minorities as well as YPLWD
- National and subnational health facilities governance structures such as the health facility committees and the hospital boards should include AY, to strengthen their engagement in decision-making structures including capacity building
- Private-for-profit drug shops or chemists that are managed by pharmaceutical technologists and pharmacists are key partners in providing care to AY and therefore will need to be included health provider trainings.
- In order to have a coordinated approach to advocating for the youth agenda, CSO and youth organizations will need to be strengthen to align efforts across all the youth constituencies
- Engage the AY in the review of the next phase of investment framework and UHC to ensure prioritization of AYSRHS.
- Strengthen advocacy capacity of young people at all levels of the health care system.
- Sensitize community and gate keepers such as teachers, opinion leaders etc. and have community champions for AY responsive parenting
- Have age specific interventions e.g., age-appropriate sexual reproductive health education in all settings such as learning institutions
- Use multi-modal avenues to reach young people and the community with information e.g., peer to peer, printed materials, social media, radio, community outreaches, explore innovative ways of reaching out to the youth through recreation centres, games, drama, draft, chess to support young talents and keep youth busy among others.
- Avail key services such as STI testing, cervical cancer screening, IUCD, SGBV support, treatment for substance abuse, VMMC and other SRH related issues for both (boys and girls) at PHC level
- Healthcare care providers will need to improve on the language and attitude towards the AY in the public health facilities.
- Intentional targeting of young men and boys who are unable to access services at public health facilities will need to be made by the counties.

"An ideal AYFS to me is not a special corner, but AY responsive services even if integrated. You can have a corner full of graffiti and entertainment with no services or have perfect AYSRH services integrated with other services" KII, Nairobi

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ANNEXES

Annex 1. Study sites

		STUDY FACILITIES	
County	Sub-county Nairobi Westlands Embakasi	Health facility Kasarani Kasarani Health Center Kangemi Health Center Mama Lucy Referral Hospital	Level of care
Kisumu	Muhoroni Seme Kisumu East	Nyangoma Sub- County referral Oriang Alwal dispensary Nyalunya dispensary	

Phase	Methodology	Data collection technique	Response to the assessment questions in line with OCED criteria
Data collection	Desk Review	To establish the level of prioritization of AYSRH services and MAYE in planning and implementation of AY, Literature review on policies and key documents relating to RMNCAH+N, THS-UCP/ GFF project and AYSRH policies was carried out. Annual work plans (AWP's), progress or performance reports and appraisal documents at national county and facility levels were assessed too.	Effectiveness Relevance Sustainability Impact Coherence
	KIIs	Semi-structured interviews were administered to each key informant. Questions were context-sensitive and relevant. **In-depth interviews were conducted face to face or virtually** with Key Informants selected for the study at county level, health facilities, and national level. *The data was collected by the PI and Specially trained research assistants (volunteers from OAY) using respondent specific KII guides. There was a moderator and note taker in each session.*	Effectiveness Relevance Sustainability Impact
	FGDs	Focus group interviews conducted. • 3 AY (15-24) per county (include PWDs, vulnerable, different ages etc., 5 males, 5 female) The groups will initially be disaggregated into male and female for gender specific information then aggregated for common issues. The content included health needs, awareness and challenges in accessing and utilizing RH services. FGDs were helpful tounderstand young people's experiences on availability and quality of the services provided by their health centers in line with GFF priorities and AYFS guidelines • 3 CHV/opinion leaders/peer counsellors per county- discussion focused on ASYRH access, youth engagement activities opportunities and spaces; Challenges, lessons, training received, Perspectives at community level *Data was collected by a moderator and a note taker in each FDG using an FDG guide. Notes were recorded verbatim and later transcribed in readiness for analysis.*	Effectiveness Relevance Sustainability Impact
	AY exit interviews Perception survey	Exit interviews (7-10) were conducted in each facility where young people between 15-24 years were interviewed on their experience on availability access and perceived quality of AYSRH services as they left the facilities. Trained RAs conducted the exits using a semi-structured interview guide	Effectiveness Relevance Impact
	Health facility observation /information analysis	Observation and physical check technique were used in the facilities to assess AY service utilization data and availability of Essential Package for AY friendly service provision *A facility checklist was used by the research assistants to observe and get information from the RH in-charge on services, HRH, infrastructure and commodities available for AYSRH provision.*	Effectiveness Relevance Sustainability Impact efficiency

No	Level	Target group	Type of Engagement	Type of information/Indicators
1	National	1.1. COG	KII:	1. Coordination at CoG and county level, including with AY 2. AYFS score card/indicator 3. RMNCAH resourcing and funding of specific indicators – funding RMNCAH vs GFF funding – conditional grant 4. Initially GFF was to focus on most vulnerable counties but now implemented in all counties 5. Transitioning to UHC especially for AY (likely to be left behind)
		1.2. GFF focal person – CAS-health	KII:	1. Sources of health financing 2..GFF funding progress 3. AY agenda in MOH planning and operations 4. AY agenda place UHC
		1.3 MOH – RH coordinator	KII, relevant reports	Performance indicators and what youth indicators are being tracked; Overall performance, effects of COVID-19 on progress made, inclusion of a youth indicator or disaggregation of data to enable tracking of youth ASRH – FP indicator, ANC, teenage pregnancy, AY maternal deaths; 1. Technical 2. Policy 3. Initially GFF was to focus on most vulnerable counties but now implemented in all counties – DID This affect quality especially for AY 4. Transitioning to UHC especially for AY likely to be left behind
		1.4 HENNET- (Non-state)	KII	1. MAYE 2. Prioritization of AYSRH in policies and scorecard- Indicators 3. Role of YSOs
		1.5 PATH (Non-state)	KII	1. prioritization of AYSRH in RMNCAH 2. Progress, lessons learnt, best practices
		1.6 Parliamentary health committee	KII, relevant reports	Accountability and prioritization, ring fencing? How do they monitor?
		WB GFF focal person Kenya	KII	Progress, lessons learnt, best practices
		Total National KII	7	Reports of interest- MOH AWPs, COG AY indicators report

No	Level	Target group	Type of Engagement	Type of information/Indicators
2	County	2.1. County Heath Director/Chief officer	KII	Progress of THS-UCP, Annual work-plans, prioritization in CIDP, Funding mechanism prioritization (ring fencing of AY funds), Supply chain. Identify the performance-based indicators and progress in the past three years. Opportunity and spaces for AY Adoption, dissemination and implementation of policies – ASRH Policy 2015 and Guidelines on Provision of AYSR Services (successes), THS-UCP progress,
		2.2 Adolescent Health coordinator	KII	1. Funding, Schedule of activities, how many done, who facilitates, are they trained. State of AYFS, reports and records, successes, challenges, lessons learnt what ideal AYSRHS looks to you
		2.3 AYSRH coordinator	KII	1. Funding, Schedule of activities, how many done, who facilitates, are they trained. state of AYFS, reports and records, successes, challenges, lessons learnt what ideal AYSRHS looks to you.
		2.4. County GFF/THS focal person	KII	Inclusion of youth activities in the work plan? If any What opportunities and how can this be enhanced. Data and records- youth access to AYSRH services AWP 1. AYFS activities – demand creation and uptake – do you have activities and who does them (CHWs) 2. Budget implementation (who funds activities- County or CSOs?) 3. Reaching marginalized, vulnerable and most at risk, hard to reach 4. Trainings on AYFS 5. Opportunities and spaces for AY and MAYE (same as up)
		2.5 CA Health or Budget Committee	KII	Accountability and prioritization, ring-fencing of funds
		TOTAL	5 KII'S	Reports required: Annual work-plans, prioritization in CIDP, APOC

No	Level	Target group	Type of Engagement	Type of information/Indicators
3	County – Health facilities	3.1 Facility in-charge	KII	AYFS Facility checklist, questionnaire, training, supply side challenges, Uptake of services by AY, Training on AYFS, Adequacy of infrastructure and commodities, AY involvement (in and out of facilities) in activities Challenges, recommendations and lessons
		3.2 Facility RH in charge	Facility checklist	Quality of services (Availability of key components) Avail utilization data
		Total	2 questionnaires	Documents required utilization records for the last 2 years
4	Non – state	4.1 Youth Leader	KII	MAYE, Prioritization of AYFS, MAYE & ACCESS to AYSRH and information since funding
		1.2CSO (NGO)	KII 2-3 each county	Perspectives on AYSRH services Impact of THS in improving RMNCAH,
		4.3 CHVs, Peer educators, Opinion leaders, Local administration	FGD Groups of 8 x 3 sub counties	Any ASYRH youth engagement activities, opportunities and space for engaging with them. Challenges, lessons, training received, Perspectives at community level
		TOTAL	4 KII, 6 FDG's	
5	AYSRH Users	5.1 AY	FDGS: 3 sessions per county (10) 5 female 5 male.PWDs, at school, out of school, marginalized etc.	Attitude, Knowledge and AYSRH practices, engagement trends, perspectives
		5.2 AY in health facilities	Exit interviews; 7-10 each facility	Uptake of services (minimum package), awareness, access, availability of services, Practice, experience? Satisfaction? Challenges?
		Total	6 FDG's, 60 Exit interviews	

Annex 2: Data collection techniques and OCED criteria

Annex 3. Target respondents and type of data collected

Annex 4. List of targeted respondents and response rate

Tools	Targeted respondents	Actual respondents	Response rate
1. WB GFF focal person	1	0	0%
2. KII guide for MoH	1	1	100%
3. KII guide for COG	1	1	100%
4. KII guide for GFF focal person- CAS	1	1	100%
5. KII guide for Member of Parliament in health budget committee	1	0	0%
6. 2 KII guide for non-state actors (HENNET & PATH)	2	2	100%
7. KII guide for Member of County Assembly health budget committee	2	1	50%
8. KII guide for county health director	2	1	50%
9. KII guide for County RH and AYSRH coordinator	4	4	100%
10. KII guide for facility in charge	6	6	100%
11. Facility checklist by facility RH coordinator	6	6	100%
12. Exit interview questionnaire for AY (15-24years)	42	39	90%
13. FGD guide for AY (15-24 years).	6	6	100%
14. KII guide for youth leaders (IYAFP/Y-ACT)	2	2	100%
15. KII guide youth led and serving CSO/YSO	2	3	150%
16. FGD guide for CHV's, opinion leaders and peer educators.	6	6	100%
17. Document Review			
Total	85	81	95%

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
1	THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN AND ADOLESCENTS' HEALTH (2016-2030)	• Highlights Adolescents as central to the success of 2030 agenda if supported to attain full potential as adults • To improve individual potential and support adolescents as agents of change; Ensure that young people achieve literacy and numeracy and have relevant technical and vocational skills for employment and entrepreneurship while expanding age-appropriate opportunities for social economic and political participation. • Highlights a need to remove barriers to realizing individual potential and protect from violence and discrimination including expanding civil registration and vital statistics systems to increase access and rights to services • Calls for evidence-based health interventions adolescents' health including comprehensive sexuality education, Information, counselling and youth friendly services for comprehensive SRH including contraception without discrimination or other obstacles. • Calls for sufficient and sustainable resources and value for money towards adolescent health and development within the larger goal of attaining UHC. • Roots for adoption of integrated and innovative approaches to financing at global, regional and national level. Highlights GFF as a dedicated financing response for the strategy.	The youth not mentioned in the document
2	GFF Business Plan	• As an innovating financing mechanism to bridge the financing gap required to achieve 2030 SDGs, GFF helps countries to prioritize, focus on results and tackle systems bottlenecks that impede achievement of UHC. • Supports the prioritization and expansion of coverage of High Impact Interventions (HII) for women, children and adolescents through the development of an investment case. • Kenya is a front-runner US $ 40 million from GFF TF and IDA/IBRD loan of US $ 150 m, Japan government US $ 1.1m over 5 years from FY 2016/2017 and has in place an IC. • Adolescents are explicitly mentioned and prioritized in the GFF business plan as one of the "specific target populations that have historically been neglected (e.g., adolescents), and uses equity analysis to ensure that disadvantaged and vulnerable populations are identified and focused upon" as key component of IC. • Focus on adolescents (10-19 years) especially in its appraisal for resource needs as a worthwhile investment • Adolescent health care singled out under the GFF age specific service delivery settings	No adolescent specific indicator; and this may affect the measurement of progress unless other RH indicators are deliberately disaggregated. Youth (20-24) not prioritized with only one indicator "Knowledge among young people about sexual and reproductive health" (The World Bank, 2015), that mentions young people assumed to include ages 10-24 years

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
3	GFF 2021-2025 Strategy	• Pleasantly captures a positive trend in most RMNCAH+N indicators including adolescent pregnancies and family planning (FP) coverage in the first 5yrs in most GFF countries • Strategically directs that GFF will place special attention on mobilizing demand for services among the most vulnerable populations through a result based catalytic funding to among others, incentivize families to keep adolescent girls in school as a way to reduce early marriage and pregnancy; providing comprehensive sexuality education and family planning services. • Further seeks to Protect and promote high-quality essential health services by reimagining service delivery including innovations that may better reach the youth such as community based and digital care. • Commitment to increase GFF support for capacity building for the youth to meaningfully participate in their country platforms as well as intensify engagement of youth groups, increase youth-led accountability for health service delivery and quality of care. (GFF and WB, 2020). • Commitment to advance equity, voice and gender equality by among others; supporting countries to be more precise in their targeting strategies to reach the poorest women, children and adolescents, as well as vulnerable and marginalized populations. • With financial barriers to accessing health services expected to increase the GFF commits to place special attention on mobilizing demand for services among the most vulnerable populations by investing in health. • The commitment to sustain a relentless focus on implementation and results by strengthening the casual chains between GFF-supported activities and improvements in the coverage and quality of services and health outcomes for women, children and adolescents has potential to improve AY outcomes if their indicators are incorporated in the country specific indicators.	
4	Civil Society Engagement Strategy	• Proposes that youth participate at the GFF global level governance where one of the two proposed civil Society representatives on the investors Group (IG) alternates is a youth representative. • Global CSO Coordinating Group (CSCG), is also expected to ensure adequate representation of diverse interests and perspectives, with special attention to those representing marginalized groups such as youth groups. • At the national level, the CSES proposes that governments ensure key principles such meaningful engagement key stakeholder groups including participation from youth are part of Country platforms.	CSES was found to be inadequate in terms of AY engagement giving rise to AY addendum to the GFF

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
5	Addendum to the Global Financing Facility (GFF) Civil Society Engagement Strategy (CSES	• The addendum to the CSES outlines a deliberate approach to ensuring youth representation in the processes led by the GFF -CSCG to ensure their meaningful and active participation in the design, implementation, monitoring and evaluation of their country investment case(GFF, 2016). The opportunities for inclusion of the youth included CS steering group, GFF IG, Youth focal person at the GFF secretariat MCPs. Other outcomes include the: • Consultation of the AY on all relevant GFF strategies and documents, particularly those related to AY and SRH, • Knowledge-Sharing and Capacity Building: with specific attention to youth engagement; • Framework for Integrating Youth in National CSO Action Plans & Coalitions: including having; a proportion of grants from the small grants' mechanism • attributed to activities that have a deliberate focus on adolescent health and wellbeing; • Ensuring CSCG accountability working group includes youth representative(s); particularly at the country level including access to GFF formal evaluation reports for feedback from youth-led organizations. • A recommendation that youth engagement across GFF countries be periodically reviewed and documented. • The addendum enhances the opportunity for inclusive and holistic approach to meaningful adolescent and youth engagement (MAYE)- a huge step towards improvement of AY health indicators especially AYSRH towards which a Technical Advisory Group (TAG) was formed in 2019 to provide an action plan to support AYSRH in GFF countries.	
6	Global Consensus Statement Meaningful Adolescent & Youth Engagement	• The global consensus statement on meaningful adolescent & youth engagement was a commitment by experts and leaders in international development, to affirm that young people have a fundamental right to actively and meaningfully engage in all matters that affect their lives. • The statement emphasizes that meaningful engagement of young people is central to the common vision of achieving the outcomes and targets of the SDG's, FP2020 goals, and the GSWCAH among others and recommends recognition and engagement of youth as equal partners in initiatives and not just consumers. • The statement was premised on the following principles, which enable a young people-centered approach; 1. Rights-based 2. Transparent and informative 3. Voluntary participation and free from coercion –4. Respectful of young people's views, backgrounds, and identities –5. Safe participation space. • It is without a doubt that the consensus has explicitly highlighted the agenda of youth involvement in health and development and despite the many existing barriers given existing power structures, deliberate adoption of the recommendations and constant evaluation of progress will lead to great milestones to this end.	

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
7	RMNCAH+N Investment framework (MoH Kenya, 2016).	• With the objective of shaping how resources are directed, the Kenya's RMNCAH+N IF, 2016-2020 has harnessed need to ensure that available financing is being targeted at a set of priority investments that will benefit women, children, and adolescents, and support the attainment of UHC. • The IC includes set of smart evidence-based interventions specifically addressing key RMNCAH-N challenges by harnessing and maximizing both foreign egg GFF, and domestic investments • Among the HII prioritized in the RMNCAH-N is Adolescent Health • In terms of responsiveness to adolescents the IC seeks to address and mitigate risks and vulnerabilities that face adolescents, particularly adolescent girls and has set out various strategies to optimize service delivery to them. • Youth friendly health services are highlighted in the RMNCAH as a key component of provision of AY responsive AYSRH. • In terms of investments to the different sub components of RMNCAH the AY were allocated 5% of the projected amount (274,546,000) • Overall service delivery improvement interventions (supply side and demand side) projected in the IC have potential to improve AYSRH services. • In terms of tracking performance, the IC results framework and monitoring has only two adolescent specific indicators; Teenage Birth Rate and female genital mutilation.	• AY indicators not explicit in the document's performance framework posing a need to disaggregate maternal indicators such as ANC, Skilled birth, access to modern contraceptives into age specific to tease out AY trend. • Prioritization of youth (20-24 years) is sketchy with only a few mentions with regards to contribution of the youth to new adult HIV infections a concern on lack of meaningful involvement of youth in ASRH programming. • There is need to include interventions targeting growing problems among the youth such as abuse of alcohol and substance, mental health etc.
8	THS-UCP	• Seen as the main operationalization vehicle for RMNCAH-N IC and Funded by the World Bank, THS-UCP is a 5 years project running from 2016-2021 with a Total Project Cost US$ 191.10 million with 150M going to counties • The development objective of the THS-UCP for Kenya is to improve utilization and quality of primary health care (PHC) services with a focus on Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) services. And comprises of three components. Component 1: Improving PHC results; Component 2: Strengthening institutional capacity; 3. Component 3: Cross-county and intergovernmental collaboration, and project management • It is under component one where the project seeks to support counties to scale-up evidence-based, county appropriate supply and demand side interventions identified in the investment framework i.e., to Improve functionality of existing health facilities to deliver essential PHC services and improving the demand for services at the community and facility levels. This has potential to improve AYSRH services • The approach allocation of resources to counties based on improved PHC results and Earmarking funding for RMNCAH strategic commodities has potential to improve AYSRH services only if there AY specific data.	• Unfortunately, THS-UCP does not have AY specific indicator. However, the MCH project indicators on ANC, Skilled birth, use of modern contraceptives, if disaggregated by age would show the trends in AY access to health especially for the girls. • It is hoped that the cascade effect of the envisaged general health system improvement would without doubt improve AYSRH services if access barriers are addressed.

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
9	Project Appraisal Document (PAD)	• A document of The world bank meant for the appraisal of the proposed creditof US $150 M, Proposed Grant of US$40M from GFF, proposed US$1.1 M by Japan Policy and Human Resources Development Fund to the Republic of Kenya for Transforming Health Systems for Universal Care Project (THS-UCP) running for 5 years from June 2016- June 2021(World Bank Group, 2016). Key for appraisal of envisages improvement of the Utilization and Quality of PHC. • Heavily focused on health system strengthening evidence-based interventions that are high-impact and cost-effective in addressing the key bottlenecks in service delivery in the counties such as (a) improving functionality of existing facilities to deliver quality essential PHC services; and (b) increasing demand for services at the community and facility levels. • Specific strategies that have potential to improve AYSRH services if targeted are expansion of the availability of quality Bemoans and CEmONC, improving a referral system, and ensuring RMNCAH strategic commodity security. • In terms of demand creation for AYSRH strengthening community units for delivery of preventive and promotive health care including having community dialogue days would be really impactful if targeted to AY. • There is a technical intervention for the continuum of care specifically for adolescents and women (no mention of youth). • The PAD envisages that the project will support the Division of Family Health (DFH) to: develop and/or disseminate RMNCAH-related strategies and guidelines, including improving adolescent sexual and reproductive health (ASRH), newborn health and nutrition to address high teenage pregnancy, neonatal morbidities and stunting; and conduct operations research. • In terms of social safeguards the PAD recognizes the need for inclusion and informed participation of the Vulnerable and marginalized Groups (VMG's) and asserts that "A key focus of the Vulnerable and Marginalized Groups' Framework (VMGF) will be to propose proactive steps for VMGs to participate and benefit from the Project as most of the impacts anticipated will be positive for all communities including for VMGs and minimal, if any,negative social impacts are anticipated from the Project" PAD, pg,70. . • The PAD envisages increased demand for and utilization of PHC services through improved knowledge, attitudes, and behaviors of communities towards the continuum of essential care services including ASRHS; improved access to PHC services by strengthening the county's capacity (for example, financing, workforce, products, information and governance) to deliver effective and efficient integrated interventions at the communities and facilities; and improved quality of PHC services by ensuring constant availability of essential inputs (for example, human resources, equipment, commodities, water, and so on) and enforcing quality of care standards for improved client experience, patient safety, and effectiveness of care. • This would increase responsiveness and hence demand creation for AY.	• It is noted that PAD lacks an AY specific indicator despite ASRH strategies being highlighted in the document. Like the IC and THS-UCP, AY MCH may be addressed in HII related to ANC, skilled delivery and PNC. • No mention of the youth though

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10	National Adolescent Sexual and Reproductive Health Policy, 2015	• The aim of the ASRH Policy is to enhance the SRH status of adolescents in Kenya and contribute towards realization of their full potential in national development. • Highly prioritizes the adolescents given its main policy intention: to bring ASRHR issues into the mainstream of health and development. • Its priority areas demonstrate great responsiveness to adolescents which in turn creates demand for AYSRH services. They include; Promoting ASRHR, Increasing Access to ASRH Information and Age-Appropriate Comprehensive Sexuality Education, Reducing STIs including HPV and HIV, Reducing Early and Unintended Pregnancy, Reducing Harmful Traditional Practices, Drug and Substance Abuse, Reducing Sexual and Gender-Based Violence (SGBV) and Improve Response, Addressing SRHR needs of Marginalized and Vulnerable Adolescents.	• The policy fails to cover specific vulnerable populations such as SRHR of lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) LGBTIQ adolescents who face unique challenges (Kenya Human Rights Commission, 2020) • The policy does not include youth in the age cohort of 20-24 yet they may have different needs. Thus, need different interventions from the 10-19 old.
11	National Guidelines for Provision of AYFS in K	• The goal of the guidelines is to improve Availability, accessibility, acceptability and use of quality SRH services by AY seeking services (MOH, 2016). • The objectives of the guidelines are appropriate and key to quality AYSRH services (i)To define the essential package of health services to be provided to AY at service delivery points; (ii)To standardize the provision of quality AYSRH Services at all levels; (iii)To increase access to comprehensive SRH information and services among AY (iv)To strengthen collection and utilization of age and sex disaggregated data on SRH among AY. • The 5 stipulated characteristics of AYFS: Equitable, accessible, acceptable, appropriate and effective and the 8 Standards for quality AYFS: Adolescents' health literacy, Community support, Appropriate package of services, Provider's competencies; Facility characteristics; Equity and nondiscrimination; Data and quality improvement and Adolescents' participation reflects an important facet of responsive quality services. • The guidelines identify MAYE as a key strategy for the implementation of YFS and recommends Key actions and activities to include: *Engage adolescents and youth as partners in the design, planning, implementation and evaluation of AYFS programs, Involve adolescents and youth in health care worker trainings, Support networks of adolescents and youth health peer educators and champions, Identify and involve marginalized and vulnerable adolescents and youth on AYFS, Develop dialogue platforms for adolescents and youth that will utilize current technological advancements, Engage young people, as appropriate, in service delivery, including: as facility-based adolescent client-advocates, HIV care coordinators working with young patients, CHVs, and appointing youth and adolescent members of Health Facility Committees, Referral, linkage and follow-up- to ensure access to holistic health.* • The guidelines further address responsiveness and demand creation by recommending AY specific Service delivery models to include: Community - based: Clinical based: School based and Virtual based.	• Again, Youth interventions not prioritized besides an emphasis on MAYE.

	Document	Prioritization of AY (Prioritization, investment, responsiveness of services, demand creation/generation of AYSRH)	Areas of improvement
12	WHO's Maintaining essential health services operational guidance for the COVID-19 context	• Has explicitly prioritized adaptations to AYSRH services for the adolescents including suggestions of innovative ways to reach them with information, products and services such as digital health and outreaches. • It responds to evidence suggesting that during the pandemic, children and adolescents are at a greater risk of depression and anxiety, online harassment, and SRH problems, such as unintended pregnancy and intimate partner violence. Further, school closures have also had dramatic impacts on adolescents' access to preventive services given exclusively in school setting such as counselling and school meals. • The need to rethink the SRH services is emphasized with a recommendation to prioritize digital health services, self-care interventions, task sharing and outreach to ensure access to medicines, diagnostics, devices, information and counselling. • Some of the specific AY responsive adaptations include; use of alternative outlets for service provision e.g. schools, colleges, community outreaches; adoption of alternative information strategies for RH education e.g. digital media, providing telehealth mechanisms such as help lines, provision of safe houses for response to intimate partner and sexual violence, extension of distribution of essential products such as menstrual products, FP commodities such as condoms and oral contraceptives using community groups/ volunteers. Increase self-testing for HIV, information on changes in service provision (where, when, what), post rape care etc.	• No emphasis on youth in general
13	Kenya's COVID-19 RMNH guidelines, 2020	• Though Kenya's COVID-19 RMNH guidelines do not specifically address AY, it outlines protocols for safe continuity of RMN and FP services. • Elements that may be helpful to AYSRH include use of telemedicine, longer (3months) FP refills for condoms and oral contraceptives increase of minimum stocks at facilities and use of pharmacies and drug stores to distribute the same. To come back again staggered and scheduling done by telephone to avoid congestion. Every encounter with WRA must consider contraception needs. And recommendation for 24 hr. RH outlets to reduce workload. (MOH, 2020)	

Annex 5. Prioritization of AY on the RMNCAH+N IF and associated global and national documents