

Outlets for Sexual Health Services Amongst Youth in Public Secondary Schools in Mukuru Slums, Nairobi

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Abstract:

Outlets for sexual health services are increasingly becoming a global public health concern in sexual reproductive health of the youth as they struggle to balance their pursuit and performance in education and the effect of their sexual behavior on their lives. Studies have indicated that access to basic sexual reproductive health services continue to jeopardize the health of the youth as they struggle to also cope up with the consequences associated with the growing health needs from emerging public health concerns. The Ministry of Health in Kenya is recording high prevalence of sexually transmitted infections including HIV amongst the youth. Urban residents have a significantly higher risk of HIV infections (7.2%) than rural residents (6.0%) A majority of annual new HIV/AIDS infections occur among youth aged 15-24 years, the majority of whom are in secondary school levels due to their high sexual activity. The main objective of this study was to determine outlets for sexual health services amongst youth in secondary schools in Mukuru slums in Nairobi. The study adopted a cross sectional descriptive design that utilized both quantitative and qualitative techniques of data collection. The study was conducted in three purposively selected secondary schools in Mukuru slum, Nairobi County amongst the youth aged 15 to 24 years. A sample size of 335 was determined and stratified sampling procedure was used. Data was collected using semi structured questionnaire and 6 focus group discussions which were both administered and conducted amongst the study population. This study received scientific and ethical approval from the Scientific Steering Committee at the Kenya Medical Research Institute. Participants were taken through all the consenting processes prior to their acceptance to participate in the study. The results show that there were more females (57.8%) respondents than males (42.2%). Many of the female respondents (81.1%) indicated that they had first sex before they turned 10 years than few male respondents (12.2%). About 50% of respondents visited private facilities to seek medication services. Among those who visited public hospitals, 27% of the respondents sought services for consultation, lab, and medicine while 13% of the respondents indicated that they visited traditional healers. There were many females (21.8%) who indicated that they visited private hospitals for STI treatment. However, the type of outlet or facility (p-value 0.000<0.05) significantly influenced the services that the respondents sought at the outlet or facility. This study concludes that despite the many outlets offering SRH services, many youth in schools engage in sexual risky behaviours that exposes them to harmful consequences such as early pregnancies, abortions and STIs. There is a need for the Ministry of Health to develop a working partnership with the outlets for SRH to develop and monitor youth friendly essential packages that will meet the most pressing SRH needs of youth in schools and young adults in slum settings.

Keywords —Put your keywords here, keywords are separated by comma.

I. INTRODUCTION

Sexually transmitted infections are huge socio-economic and health concerns that have threatened health systems and service provision in many developing countries. The World Health Organization estimated that there were 340 million

new infections of trichomoniasis, gonorrhoea, chlamydial infection, and syphilis, the four main STIs that are curable, every year with about 75% to 85% detected in developing countries[25]. A study by Newton-Levinson, Leichter and Chandra-Mouli estimated that most of the infections occur

among individuals aged 15-49 with nearly 70% of those being aged 15 to 24 years[17].

Globally, the youth account for about half of all new HIV infections. For example, in 2007, an estimated 12 million people aged 15-24 years were living with HIV and 60% of this population was in sub-Saharan Africa. A UNAIDS report in 2020 revealed that AIDS-related illnesses remained the leading cause of death among women of reproductive age (15–49 years), and they are the second leading cause of death for young women aged 15–24 years in Africa[24][24]. In Sub-Saharan Africa, the report shows that HIV/AIDS was the leading cause of death for both men and women of ages 15-29 years.

While there is a significant need for sexual and reproductive health information and services among the youth, there has been a lack of adequate facilities and more importantly, there exist barriers in accessing such services. These barriers include physical locations that are not convenient to youth, costs, or policies that restrict the youth to access services [14]. Abortion as an SRH complication is among the leading cause of admission to the emergency gynaecological ward at Kenyatta National Hospital's in Nairobi. Specifically, about 60 percent of the gynaecological admissions are due to abortion-related complications, a majority of which are youth [11].

While most adolescents are expected to complete junior secondary schools and progress into senior secondary schools, or other forms of secondary education, only 18% of the 101 out of school young people had completed senior secondary school. Dropping out of the formal educational tier was largely attributed to pregnancies among girls. Furthermore, the study revealed that teenage pregnancy, its termination, and unwed motherhood are not uncommon (29% of the sexually active female adolescents reported that they had been pregnant at some time [1]).

Girls are more likely to engage in premarital sex if they attend schools where considerable pressure to have sex is reported[13]. Moreover, schools characterized by girl-friendly teachers and a gender-neutral atmosphere, a home containing female role models, and the support of two parents, reduce the risk of premarital sex. The study further indicated that the school environment appears to have an impact on whether sexually active boys choose to use contraceptives. FAWA estimated that about 6.6% of girls who entered form one of the secondary schools was to drop out by form two; and out of these, pregnancies was projected to have the highest index as a cause of dropout[3].

STIs are a common public health problem worldwide, with developing countries particularly low-income countries accounting for the majority of cases. Infectious agents that cause STI can be classified as either viral, bacterial, protozoal, or fungal. Besides, STIs can result in serious long-term complications including pregnancy complications, fetal and neonatal demise, cancer, infertility, sexual dysfunction, and enhanced HIV transmission as well as serious physical, psychological, and social consequences, negatively impacting on the social and economic well-being of affected persons[9].

According to the Ministry of Health, HIV&AIDS estimates show a dramatic difference in HIV prevalence between 15-19-year-olds (2.3%) and 20-24-year olds (5.2%). This difference suggests that many young people are infected during adolescence. Female youth are significantly more likely to be infected than their male peers. For instance, among 15-19 years old, 3.5% of females and 1% males are HIV positive, while among 20-24-year-olds, 7.4% and 1.9%, respectively, are infected [16].

A study by Beguy *et al.*, shows that in the slums, adolescents make up a considerable proportion and they face several challenges in these slum areas such as higher levels of unemployment, crime, poor sanitation, substance abuse, poor education facilities, and lack of recreational facilities[2]. All these increases chances of the predisposition of

youth as it conforms to an earlier study by Zulu et al. [27] which suggested that the extreme deprivation that is associated with high unemployment and low wages of slums traps residents into engaging in high-risk sexual behaviour for economic survival.

The overall HIV prevalence in slum settlements was estimated at 12% higher than the national average of 7.1% and the overall prevalence in Nairobi (7.0%) [15]. Moreover, the HIV prevalence amongst 15–24-year-olds was 2.3% and that young women aged 15-24 years are more than twice as likely as men in this age group to have HIV [10].

II. MATERIALS AND METHODS

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A. Study Site(s)

This study was carried out in three (3) out of eight (8) purposively selected secondary schools in Mukuru slums, Nairobi County. This included a (one) girls' school, a (one) boys' school, and a (one) mixed school. Mukuru slum is situated within the Nairobi Industrial Area in Nairobi city.

B. Study Design

This was a cross-sectional descriptive study which used both quantitative and qualitative data collection techniques.

C. Study Population

The study population were youth aged 15 to 24 years attending the purposively selected secondary schools in Mukuru slums, Nairobi County.

D. Sample Size Determination

This was determined using the Fisher sample size estimation technique[4]. When the population is to be drawn is less than 10,000, the size of the population must also be taken into account. Thus, for a population of more than 10,000, n above is the final sample size. For populations less than 10,000,

as is the case with this study, the following adjustment must be made.

$$nf = n/1 + n/N$$

Where,

nf = the final sample size when the population is less than 10,000

n = the sample size for populations of 10,000 more

N = the size of total population (the total number of youth in secondary schools within Mukuru slums is 2600)

$$nf = 384.16/1 + 384.16/2600$$

$$nf = 334.56$$

Hence, 335 youth (secondary school youth) were be selected for the study. The study participants were shared from all the three (3) purposively selected secondary schools in Mukuru slum (112 pupils from each school including yielding to 168 girls and 168 boys in total.

E. Sampling Procedure

This study used two stages to get the study population:

Stage 1: Stratified sampling procedure to ensure participation of both males and female youth in Mukuru slum secondary schools.

Stage 2: Purposive selection of homogenous groups who participated in focus group discussions and in-depth interviews.

F. Data Collection

Data was collected using a semi-structured questionnaire. The tool captured issues such as socio-demographic characteristics, practices and attitude on seeking sexual health as well as outlets for sexual health services and choices about seeking sexual health care services.

Data was also obtained using Focus Group Discussions and Key Informant Interview guides. A minimum of six (6) FGDs were conducted in the selected schools amongst purposively selected students. Informed by the saturation limit, 2 FGDs were conducted in each school. They were organized based on sex and each included 8 to 12 participants. Key Informant Interviews were also conducted amongst representatives of students (school prefects), school heads, and guidance and

counselling teachers in the three selected schools. A total of 24 interviews were conducted. The main issues in the guides included attitude and practices on seeking sexual health outlets for sexual health services for youth and their choices about sexual health care services. Both the discussions and the interviews were moderated and tape-recorded by the researcher.

G. Data Analysis

For data from questionnaire, coding and analysis were done using Statistical Package for Social Sciences (SPSS) software version 19. Descriptive statistics was used to analyze continuous variables (age, sex, class) while percentage frequencies were used to describe categorical variables. Pearson’s Chi-square test was used to determine the association between categorical variable(s) and the dependent variable. Depending on the distribution of the continuous variable(s), the T-Test or chi-

square test for independence was used to test for the difference between the levels of the dependent variable (health-seeking behavior outcome).

Qualitative data (from FGDs and KIIs) was transcribed and manually processed through the six-step process of thematic and context analytical framework. Findings are described based on themes and verbatims.

III. RESULTS

H. Outlets for seeking medical attention for Sexual Reproductive Health

The table below shows that many females (21.8%) indicated that they visited private hospitals while 19% of the male respondents visited the same facilities. About 50% of the male respondents indicated that they had visited other places other than conventional facilities that offer health services.

Table 1, Outlets for Seeking Medical Attention for SRH.

Variable	Factor Level	Sex		Age Group		Form		
		Male	Female	15-19	20-24	Form 1 & 2	Form 3	Form 4
Where do you find sexual health services?	Private	26(19%)	41(21.8%)	57(20.9%)	7(21.9%)	26(19.4%)	14(19.4%)	27(22.7%)
	Public (GoK)	41(29.9%)	42(22.3%)	70(25.6%)	10(31.3%)	27(20.1%)	18(25%)	38(31.9%)
	Traditional healer	3(2.2%)	4(2.1%)	4(1.5%)	3(9.4%)	1(0.7%)	3(4.2%)	3(2.5%)
	NGOs	8(5.8%)	9(4.8%)	15(5.5%)	1(3.1%)	9(6.7%)	2(2.8%)	6(5%)
	I don't know	53(38.7%)	85(45.2%)	115(42.1%)	10(31.3%)	66(49.3%)	33(45.8%)	39(32.8%)
	Others	6(4.4%)	7(3.7%)	12(4.4%)	1(3.1%)	5(3.7%)	2(2.8%)	6(5%)
	Total	137(42.2%)	188(57.8%)	273(89.5%)	32(10.5%)	134(41.2%)	72(22.2%)	119(36.6%)
Where did you go for treatment for STI?	Medical clinic	13(46.4%)	14(56%)	21(55.3%)	5(35.7%)	5(38.5%)	11(68.8%)	11(45.8%)
	Pharmacy	10(35.7%)	6(24%)	10(26.3%)	6(42.9%)	6(46.2%)	3(18.8%)	7(29.2%)
	Traditional medicine	4(14.3%)	5(20%)	6(15.8%)	3(21.4%)	2(15.4%)	1(6.3%)	6(25%)
	Others	1(3.6%)	0(0%)	1(2.6%)	0(0%)	0(0%)	1(6.3%)	0(0%)
	Total	28(52.8%)	25(47.2%)	38(73.1%)	14(26.9%)	13(24.5%)	16(30.2%)	24(45.3%)
Have you visited any place for health services?	Yes	56(65.9%)	51(50%)	87(55.1%)	17(77.3%)	32(47.1%)	24(60%)	51(64.6%)
	No	29(34.1%)	51(50%)	71(44.9%)	5(22.7%)	36(52.9%)	16(40%)	28(35.4%)
	Total	85(45.5%)	102(54.5%)	158(87.8%)	22(12.2%)	68(36.4%)	40(21.4%)	79(42.2%)

During the FGDs, many participants pointed out several individuals and institutions that they seek help from when they need or are about to seek SRH services. Some went to their friends, parents’ others to small government facilities and VCTs. Further, herbal clinics and traditional doctors were also identified as sources of help when the participants sought help for SRH services. Some observed:

“...Friends really help a lot when consulted” (FGD, male)

“...these small hospitals and clinics within this slum really help us a lot” (FGD, female)

“... even the herbal clinic like the one in green and white tents that charge shillings

50 also help us when we have problems”

(FGD, mix, boys / girls)

Sexual Reproductive Health Outlets against sex, age and class

The table below shows that across the age group (p-value 0.105>0.05) and class (p-value 0.094>0.05) of the respondents, these categories were not statistically significant in determining whether the students visited other places other than conventional facilities that offer health services. However, there was a statistically significant difference across the gender (p-value 0.029<0.05) at a 5% level of significance which implied that the responses of male and female respondents varied significantly on whether they sought health services at conventional or non-conventional facilities.

Table 2, SRH Outlets against sex, age, and class

Inferential Statistics					
Variable		Statistic	Value	df	Asymptotic Significance (2-sided)
Where do you find sexual health services?	* Sex	Pearson Chi-Square	3.143	5	.678
	* Age	Pearson Chi-Square	15.023	10	.131
	* Class	Pearson Chi-Square	12.788	10	.236
Where did you go for treatment for STI?	* Sex	Pearson Chi-Square	1.985	3	0.576
	* Age	Pearson Chi-Square	3.243	6	0.778
	* Class	Pearson Chi-Square	7.642	6	0.266
Have you visited any place that offer health services?	* Sex	Pearson Chi-Square	4.778	1	0.029
	* Age	Pearson Chi-Square	4.504	2	0.105
	* Class	Pearson Chi-Square	4.732	2	0.094

Services at Sexual Reproductive Health Outlets

Findings from the study reveal that 50% of respondents visited private facilities to seek medication services. Among those who visited public hospitals; 27% of the respondents sought services for consultation, lab, and medicine while

13% of the respondents indicated that they visited traditional healers.

Table 3, Services at SRH Outlets

Variables	Factor Level	Where do you find sexual health services?					
		Private	Public (GoK)	Traditional healer	NGOs	I don't know	Others
What services did you receive?	Consultation, Lab & medicine	3 (17%)	4 (27%)	1 (14%)	1 (100%)	1 (10%)	2 (100%)
	Prescription only	3 (17%)	0 (0%)	0 (0%)	0 (0%)	2 (20%)	0 (0%)
	Medicine only	9 (50%)	8 (53%)	5 (71%)	0 (0%)	5 (50%)	0 (0%)
	Lab & medicine	2 (11%)	3 (20%)	0 (0%)	0 (0%)	1 (10%)	0 (0%)
	Others	1 (6%)	0 (0%)	1 (14%)	0 (0%)	1 (10%)	0 (0%)
	Total	18 (34%)	15 (28%)	7 (13%)	1 (2%)	10 (19%)	2 (4%)
Are there charges (fees) for the services?	Yes	44 (70%)	27 (39%)	7 (100%)	4 (25%)	0 (0%)	6 (50%)
	No	19 (30%)	43 (61%)	0 (0%)	12 (75%)	2 (100%)	6 (50%)
	Total	63 (37%)	70 (41%)	7 (4%)	16 (9%)	2 (1%)	12 (7%)

Many participants indicated they went to the outlets to seek services offered at VCTs relating to HIV/AIDS testing and counselling. However, some participants noted that they visit outlets whenever they suspected they are suffering from STIs especially gonorrhoea and syphilis. They observed the following;

“There are also others who want to visit the hospital for treatment but they are scared and want to be encouraged” **(KII, male, 17years)**
 “...VCTs also provide treatment to youth like us especially when we are suffering from STIs like gonorrhoea and syphilis

alongside counseling on the same” **(FGD, male)**
 “.....if you visit the dispensary here they will prescribe for you medicine” **(FGD, female)**

Support Services at School and SRH Outlets

From the table below, 56% of respondents especially in mixed day schools identified guidance and counselling as the type of support services they received and 42% receiving their contraceptives from medical clinics. In girls’ boarding schools, majority (70%) noted to source theirs from pharmacies.

Table 4: Support Services at School and SRH Outlets

Variable	Factor Level	School Type			Sex of respondents	
		Mixed Day	Girls Boarding	Boys Boarding	Male	Female
What sexual health support services exist in your school?	Guidance & counselling	116 (56%)	62 (70%)	19 (68%)	70 (51%)	127 (68%)
	Peer education	8 (4%)	21 (24%)	0 (0%)	5 (4%)	24 (13%)
	None	78 (38%)	4 (5%)	9 (32%)	60 (44%)	31 (16%)
	Others	6 (3%)	1 (1%)	0 (0%)	1 (1%)	6 (3%)
	Total	208 (64%)	88 (27%)	28 (9%)	136 (42%)	188 (58%)

Source of Contraceptive	Pharmacy	11 (25%)	7 (70%)	2 (50%)	7 (26%)	13 (43%)
	Medical Clinic	18 (42%)	2 (20%)	0 (0%)	11 (41%)	9 (30%)
	Other sources	14 (33%)	1 (10%)	2 (50%)	9 (33%)	8 (27%)
	Total	43 (75%)	10 (18%)	4 (7%)	27 (47%)	30 (53%)

Findings from qualitative arm of this study shows that majority of participants identified local retail shops, government hospitals, public toilets, and friends as sources from which they could access contraceptives especially condoms.

“We only get partial guidance and counselling services in schools which sometimes may be an avenue for a relationship with some teachers...This is tricky for us girls...Some of us get condoms from friends in the dormitories or from staff working in the school” **(FGD, girls)**

“You see...those contraceptives are not anywhere provided by the school administration for us to pick for use but we easily find them from friends” **(FGD, boys)**

“The group of youth which is out of school is the one that goes to hospitals to collect free condoms for those in schools” **(KII, male, 38 years)**

However, there was some mixed reactions regarding who carries condoms from those sources.

“...Free condoms can be sourced from hospitals, toilets in some public places or even from friendsbut we don’t pick them as girls” **(KII, female, 19years)**

“Young people like us are not given condoms in those public places that are kept inside offices...You must gather enough

courage to ask for them from nurses. That is why most of us would rather collect them from older friends or engage in sex *hivyo tu*” **(FGD, mixed, boys / girls)**

“Some students have informed us that their single mothers would also pick condoms for them daughters who, in turn, give to their sexual partners...This happens mostly when the daughter brings home something at the end of the day” **(KII, female, 40 years)**

Further, most female participants were unanimous in pointing out stigma that exist when they are found carrying or heard asking for condoms either in schools, shops or selling outlets as noted in the discussion groups;

“It is not really difficult for us girls to pick condoms from anywhere...you are quickly branded as morally loose or malaya” **(FGD, girls)**

“There are girls who pick or steal condoms from their elder brothers and keep them far away moreso from their parents” **(KII, female, 38 years)**

Regarding the type of sexual health support services received in schools, most participants had mixed reactions on this;

“Yes, we get some counselling in the school relating to many issues such as getting disturb in class or when experiencing some unfamiliar irritations in the private parts but it depends on who is in charge of that department as most of us girls won’t feel free to open up to men teachers in that regard” **(FGD, girls)**

“There are no sexual health support services that exist in our school. Our Head teacher is

a no nonsense Christian person who doesn't entertain those things" (FGD, boys)

"We used to invite some health personnel from the nearby health facilities to talk to our students when we noticed that some of them had had their learnings interrupted as they go for long getting treatment for sexually transmitted infections but we stopped it as they demanded to be paid money" (KII, male 48 years)

"If we got Sex Education back to schools probably that could be the only avenue to empower our students with some skills and knowledge on sexual matters...for now we have our matron who tries to attend to those matters like giving painkillers to girls with menstruating pain" (KII, female, 45 years)

".....The school also takes us to Mukuru dispensary whenever we are sick" (KII, female, 15 years)

"....We have guidance and counselling in our school, *lakini iko weak, ni spiritual sana*" (FGD, male, 18years)

IV. DISCUSSION

Socio demographic characteristics

National governments, including Kenya, have been prioritizing enabling the youth in the provision of health care services through various programs. Health facilities provide an important setting for adolescents to access services such as SRH preventive information, testing and treatment services. However, studies have not only shown that the youth utilisation of the services has remained low due to myriad of issues such as fear of being stigmatised, negative attitudes of health care providers and a lack of age - appropriate and youth - centred services, among others but also some association between socio-demographic characteristics and uptake of those services [18].

The study determined that the class in which the participant was significantly influenced whether they attended school when they were menstruating. From qualitative arm of this study, behavior associated with menstruation came out as largely informed by personal reactions and experiences associated with it. Indeed, majority of girls in lower classes pointed out that they feel lots of guilt and discomfort during period-days especially for those who are receiving it for the first time and therefore with limited knowledge on menstruation. Many of that group would therefore choose to stay at home or in the dormitories as they don't know how to react to that situation in school or class.

Most girls in upper classes even with various experiences on reacting to menstruations too abscond classes as menstruation makes them uncomfortable and are unable to concentrate sufficiently in classwork. Periods are associated with some pains to some girls which push some of them to stay away from school or classes for the entire period days. This study noted that most of the girls who are disturbed by menstruation are those who don't have enough sanitary pads (either their parents / guardians didn't buy them enough or were not given enough money to buy them or both). This finding concurs with that of Hennegan et al., who further observed that infrastructure required to support menstruation individual menstrual factors such as pain and flow also, ordinarily, affect concentration of girls in whatever they are doing[7].

Further, the presence of male figures in the school environment (teaching and non-teaching staff on the one hand and boys, classmates of girls, on the other hand) brings another dimension to education of girls in schools. According to Mason et al., menstruation is a proxy indicator for adulthood and a traditional announcement of a girl's sexual availability that in turn may result in indicating series of negative practices, including sexual harassment even from teachers, withdrawal of economic support from parents, and sudden pressure to marry, among others[12]. The situation in mixed schools (with both boys and girls) leads to more girls in all classes using all manner of ways to

conceal their experiences for fear of the above especially in societies where 'menstrual etiquette' is lacking. Hiding menstrual blood flow or stains in dresses invoke some fear of girls from being bullied by boys. This is a primary factor that informs the decision of many girls to miss school [8].

The study found that age was a significant factor influencing the places where they sourced the materials they used during their menses. This finding concurs with a study by Sivakami et al., [22] who established that poor access to sanitary pads, a non-facilitating school environment, and the associated shame and embarrassment related to poor menstrual hygiene contributed to poor performance in school and absenteeism. On the one hand, the young ones especially in the lower classes (Forms 1 and 2) and who may have begun menstruating may not have various sources of getting menstrual materials except bought for them by their parents / guardians (for day scholars) or from teachers / matrons (for boarders). Some of the young day-scholars particularly those from poor backgrounds use materials such as clothes, cotton wool and parts of mattresses while few of them use pads.

On the other hand, old students in upper classes (form 3 and 4) are more matured whose experiences on handling / reacting to menstruation vary depending mainly on the environment they live in. Many of such students get their materials from their own social networks that range from peers, boyfriends, performing some social tasks. Most of this group use pads that are mainly bought from shops. The few students have their materials for use bought for by their spouses as majority of them (60%) were married.

Age and class in which the respondents belonged significantly influenced their age of sexual debut, the prospect of having engaged in a sexual encounter, and their chance to have a sexual partner. A study by Olufemi, Paulin and Akinbode argued that understanding the practices and attitudes of adolescents and young adults towards sexual encounters was vital because of the social concerns

associated with the subject, such as early and unwanted pregnancies and the transmission of STIs[20]. According to the study, age, type of family, peer pressure (across the classes) and use of drugs were predictors of the early age of sexual debut among adolescents and young adults. The findings are also in tandem with those of Peltzer [21]who determined that about 27% of study participants reported a first sexual encounter before the age of 15 in 8 African countries, with the percentage of boys (38%) being higher than that of girls (16%).

Moreover, respondents' age, gender and class had a significant impact on the respondents' use of a condom during their last sexual encounter. However, there was no significant difference in the reasons for condom use across the respondents' age, gender, and class. Among the demographic characteristics, the study established that gender was the only factor that significantly influenced the person who initiated condoms in the respondents' last sexual encounter. The results align with those of Yosef and Nigussie that found that the gender of the respondent, a history of having sexual intercourse, area of residence, and knowledge of STIs significantly influenced the practices and attitudes of condom use among the respondents[26]. The slum, as an environment where the respondents live, was observed by the majority of them to have played a key role in informing the decision on who to initiate use of condoms.

A study by Zulu et al., [27]shows that extreme deprivations (associated with urban poverty, high unemployment, and low wages, among other issues) traps residents into engaging in risky sexual behaviours for economic survival. It is in this regard that older male populations, married or otherwise, engage young women and girls including those in all levels / classes in secondary schools in sexual activities. As the main source of survival, young girls, either in day or in boarding schools, have multiple sexual partners, a behaviour that exposes them to starting sex early, early child-birth, abortion, commercial sex, sexually transmitted infections and HIV / AIDS, among other consequences. From the qualitative arm of this

study, majority of girls observed that to be able to thrive in such behaviours, and for fear of getting pregnant, young girls are increasingly learning to initiate use of condoms with their sexual partners.

Outlets for sexual health services

The study found that outlets such as public and private facilities were more popular among the students in schools as they sought for their reproductive health services. Though both provide those services, private facilities are more preferred by girls than boys. Overall, this study found that there were many females (21.8%) who had visited private hospitals compared to few male (19%). Students in boarding schools have very limited options in choosing the outlets as school matrons are the ones that decide on where the students should either be taken or referred to whether the students like it or not.

The qualitative arm of this study found out that most girls treat their reproductive concerns with lots of secrecy and very personal which can only be addressed in hospitals of their choice especially in private facilities due to their high level of privacy and the overall approach of care. Many participants observed the following;

“Most of us fear visiting public hospitals for our reproductive health issues as many nurses there look old, not interested and tired handling our issues unlike in many private hospitals where you find relatively active young men, women or girls who will heartily receive you and address your concerns in a friendly manner in the shortest time...Bleeding from private parts for some reasons is a private affair us...before you accept to be examined you look at the attitude or approach of the nurse first” (FGD, girls)

Though perceptions of the youth vary from individual to individual and between sexes, general approach of staff offering reproductive health services is came out strongly. This finding is similar with that of a study by Gausman et al., that found that attitude of healthcare workers in general services delivery has been observed as one of the

barriers to uptake of health services in public facilities, a practice that has made such services underutilized[5]. However, the finding in a study by Godia et al., shows a different perspective that girls seeking antenatal care and family planning services in public facilities characterize the services as good and helpful staff but boys perceive the same services as designed for women and children and not them[6]. The later finding was supported by the finding of this study that shows that about 50% of the male respondents indicated that they had visited other places other than conventional facilities that offer reproductive services.

There were other outlets that this study found to be used mainly by girl students in day-schools. For general guidance on managing monthly periods and acquiring pads and drugs for stopping excessive bleeding or abdominal pains associated with periods, many of the day scholars showed preference to peers, mothers and chemists while boys prefer their peers and chemist to purchase condoms or private hospitals for treatment and management of STIs.

“...we consult our friends whenever we need some guidance on reproductive health, for instance, where to get information and treatment for STIs” (FGD, mix, boys / girls)

“...those small hospitals and clinics within this area really help us a lot whenever some of us have STIs... There, you are treated and left to go home unlike in public hospital where you can be asked to inform or look for your sexual partner to accompany you for treatment” (FGD, female)

However, this study found that service provision regarding sexual health of the youth in private facilities has been jeopardized by the ever-changing individual demands of some healthcare workers whose approach and understanding of sexual health leave a lot to be desired. Cases of certain staff engaging in risky habits like rape or taking advantage of the naivety of young girls out on sexual issues to selling not authorized sexual

boosters to boys were found to be one of the common practices in private clinics. Girls observed;

“Some of us have found ourselves being raped by healthcare workers in those clinics after examining our private parts following some abdominal pains or whenever we need FP injection...you may find a male nurse inserting a drug inside your private part and begin to push it in using his penis! If it’s your first time, you won’t know how it’s done!” (FGD, girls)

“Other than getting the normal treatment for treating STIs, for example, some of us are advised to also buy the blue tablets to boost our sexual activities” (FGD, boys)

The above has further resulted into unintended consequences such as exposure to pregnancies, sexually transmitted infections, or sexual relationships. Though there are no studies on the student-nurse sexual harassment, the Ministry of Health policy guidelines makes it an offense for healthcare workers to either take advantage of the conditions or knowledge of patients to have sexual activities.

The findings have indicated an unmet need to have adequate outlets to provide medical care to adolescents and young adults. Further, the study established a need to reform the delivery of services to adolescents seeking SRH services to improve the services offered and the accessibility of these services. The findings concur with those of Newton-Levinson, Leichliter, and Chandra-Mouli who found that many youths still did not seek timely care for STIs due to taboos, anxiety, and the related fear of approaching parents or community members who could help[17].

There was a significant difference in the type of outlet that was sought across the different facilities. However, the kind of outlet did not significantly influence whether services sought by the adolescents were charged. These findings indicate the existence of barriers to accessing quality healthcare in SRH outlets. The determination of the

study is in line with the results of Odo et al., [19]who found that the efforts to provide and promote access to quality healthcare were constrained by inequitable distribution of SRH services and inadequate access to these services. Generally, the study supposed that SRH outlets were physically available for adolescents to utilize the SRH services, but they were financially limited to access the services.

The findings of this study also revealed a lack of sufficient programs that coordinated the provision of support services for adolescents. This has led to the underutilization of SRH services, resulting in poor reproductive and sexual health among this cohort of the population. This finding conforms to that of Thongmixay[23]. This study determined that improvement of access and utilization of SRH services by adolescents and young adults, a multi-component strategic approach was needed. This includes promoting adolescent-friendly SRH outlets, incorporating sexual education in schools, community support interventions, and establishing a formal referral system between the youth-friendly clinics and the schools attended by adolescents.

V. CONCLUSIONS

Most youth, on the one hand, do not optimize available outlets that offer SRH services. Access to these services depends on the existence of barriers that influence access to high-quality SRH services at the outlets, including issues on privacy, parental consent, stigma, and lack of knowledge on the importance of SRH services. On the other hand, youth in schools in slum-settings faces serious challenges in seeking SRH services especially, treatment and management, as many of the schools offer guidance and counselling.

Despite the many outlets offering SRH services, many youth in schools engage in sexual risky behaviours that exposes them to harmful consequences such as early pregnancies, abortions and STIs.

VI. RECOMMENDATIONS

The Ministries of Health and Education together with partners should establish feasible health education and promotion strategy school-settings in slums to continually enable the youth with sexually reproductive health skills and knowledge. This can be realized by having Special Curriculum or other tools or materials to sensitize the youth on SRH issues emphasizing on good social and health practices.

Adolescents' friendly outlets within the communities around schools in slum settings be expanded to offer key health services such as HIV preventative interventions like the voluntary medical male circumcision, condoms, pre-exposure prophylaxis, HIV testing and counselling. It will also be a strong linkage for follow-up and monitoring of youth who may turn positive to any of the sexually transmitted infections.

There is a need for the Ministry of Health to develop a working partnership with the outlets for SRH to develop and monitor youth friendly essential packages that will meet the most pressing SRH needs of youth in schools and young adults in slum settings. These efforts will enhance access to services, uptake, and utilization of SRH health products and create an environment where adolescents and young adults are provided with better and efficient care.

VII. CONCLUSIONS

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