THE REPRODUCTIVE HEALTH NETWORK ABSTRACT JOURNAL

June 2018

The Adolecent Sexual and Reproductive Health and Rights Conference

THEME

Amplifying the voices of Adolecents and Youths in SRHR

27th to 29th June 2018 - The Boma Hotel, Eldoret

Key Organisers:

Reproductive Health Network

Reproductive Health and Rights for All

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Contents

Abstract Review Committee

The RHN- 2nd Annual Scientific Conference on adolescent SRHR - Amplifying the voices of adolescents and youths in SRHR received more than 124 abstracts.The selection was made through the blind peer reviewed process by a national panel of reviewers.The time and expertise of all reviewers to ensure that the abstracts selected are of
the highest scientific quality is acknowledged.

Denis Otundo - Chair
Kagwiria Kioga
Muthoni Ndung'u
Stephen Njoka
Geoffrey Rugaita
Eunice Muthoni
Nelly Munyasia
Graham Nyabei

SEXUALITY EXPERIENCES OF SECONDARY SCHOOL STUDENTS IN NAKURU, KENYA:

Tammary C. Esho, Arun Datta, Samuel K. Muniu

BACKGROUND: Globally, reproductive health of adolescents is a matter of great concern. Adolescence is a transition stage where major developments take place and one of the most complex processes is sexual maturation and onset of over sexual behaviour. At this stage the adolescents gain autonomy from their parents, develop a network of peers and begin to pursue romantic connections. The experimentation tendency of adolescents leads them to engage in risky behaviors such as having unprotected sex, multiple sexual partners, and sexual debut at a very early age and having sex under the influence of drugs. It is these risky behaviors initiated during adolescent that predispose adolescents to health hazards such as contracting sexually transmitted diseases and contribute to increased cases of unintended pregnancies. Kenya is home to 10.5 million adolescents aged 10 – 19 years representing 22.5% of the total population. Considering that a good proportion of adolescents in Kenya are in secondary schools, it's important to elucidate their sexual experiences.

DESCRIPTION: The findings of this study indicate that peers play a significant role in providing information to adolescents on sexuality matters. However, majority of the students reported that they wish that their parents had been the source of sexual information. This is a realization attributed to the fact that as they grow older they realize the importance of getting accurate education on sex, hence the wish that parents could have provided more factual information to them. It is therefore important that parents should consider being at the forefront in conveying sexual information to their adolescents children. The students also provided important information concerning the use of internet and its influence on their sexuality. The internet is mentioned as a source of sexuality information which may not necessarily provide accurate information for these adolescents. The students reported using the internet to access information on masturbation, pornography, among others. With regard to general understanding about sexuality, the students seemed to relate well with the concept of 'love' and showed dislike on the concepts of pornography, masturbation and homosexuality. This may indicate that the students may be coming from families where they experience conservative upbringing, may be through strong moral, ethical and religious orientations. This indicates that parents should be at the forefront in providing sexuality education and information. This may have the consequence of prolonging the adolescents' sexual debut, reduce the propensity of risky sexual behavior, as well as providing moral and ethical grounding with regards to sexuality.

METHODOLOGY: A cross-sectional study utilizing stratified sampling to enroll 68 students who had attended a mentorship program organized at a secondary school in Nakuru County, Kenya. A questionnaire with open-ended questions was used to collect data. The questionnaire captured demographic information such as age, gender and religion. It also captured information on sexuality. The students were informed about the study and they signed informed consent before data collection. Students who consented to participate in the study were each given a questionnaire and requested to respond to the questions appropriately. For confidentiality purposes, the names of the respondents were not captured during data collection. The obtained data were entered and analyzed in Statistical Package for Social Sciences (SPSS®) version 22. Numerical data were analyzed into mean and standard deviations while categorical into proportions and summarized in a table. Chi-square test of independence and Fisher's Exact Test were performed to test for associations. A p-value of 0.05 was considered statistically significant.

RESULTS: Nearly half (48.5%, n = 33) of the respondents indicated that the first person who talked to them about sex was one of their friends. Internet was indicated by a high number (41.2%, n = 38) of the respondents as a source of sex information. Fisher's Exact Test revealed a significant relationship ($p = 0.005$) between gender and source of sex information. More male students were likely to use internet as the source of sex information. Of the 44.1% (n = 30) respondents that had engaged in sexual behavior, more than half (53.3%, n = 16) had engaged in kissing. It was noticed that gender is significant ($p = 0.034$) in so far as the type of sexual behavior is concerned. More females engaged in kissing. It was further noticed that it is the males who engaged in intercourse. Ethical and moral grounds were cited for non-indulgence in sexual activity by a high proportion (44.7%, n = 17) of the respondents that had not engaged in sexual behavior. Interestingly, virginity was reported to be of no importance among the respondents. The respondents used the internet to access information easily on the concepts of; love (58.8%, n = 40), marriage (17.6%, n = 12), pornography (36.8%, n = 25), masturbation (7.4%, n = 5) and homosexuality (13.2%, n = 9). Chi-square test of independence revealed a significant ($p < 0.001$) relationship between gender and use of internet to search for information on pornography. More males reported using internet for pornography.

Victor Rasugu , Network for Adolescents and Youth of Africa

BACKGROUND: The constitution of Kenya guarantees the right to the highest attainable standard of healthcare including reproductive health for all. However, despite this provision, and the right to non-discrimination, many young people particularly the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer do not enjoy these rights. According to a report by UHAI - the East African Sexual Health and Rights Initiative, about 4 out of 10 LGBTI persons in East Africa were denied health services on account of their gender identity with 46% responding that they were denied services due to their sexual orientation. Further, about 4 out of 10 confirmed staying away from health services due to their sexual orientation. The National Adolescent Sexual and Reproductive Health Policy (2015) and The Kenya Health Policy 2014-2030 stresses the importance of inclusiveness and non-discrimination in provision of health services. However, LGBT communities still face discrimination in their access to SRHR. Destigmatization linked with depathologization is among the six underpinnings identified by the Independent Expert on Sexual Orientation and Gender Identity as a key focus for reducing violations and discrimination based on sexual orientation and gender identity.

DESCRIPTION: Utilizing International Instruments for National Level Accountability for LGBQTI Advocacy, a case of the use of the Convention on Elimination of all Forms of Discrimination Against Women (CEDAW).

METHODOLOGY: Kenya has committed to key international instruments including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Utilizing accountability mechanisms for advocacy is a key component of NAYA's Participatory Advocacy Model for Youths. NAYA identified the CEDAW Treaty and the CEDAW Committee as an opportunity for advocacy for sexual and reproductive health and rights including sexual orientation and gender identity and developed a roadmap for engaging with the committee. In 2017, in collaboration with partners, NAYA submitted a shadow report to the CEDAW Committee, highlighting the inadequate access to comprehensive youth sexual and reproductive health and rights services and information by LGBQT youth and called on the Committee to urge Kenya to protect, fulfil, promote and respect youth SRHR.

The issues addressed in the report included: Kenya's Penal Code criminalizing consensual same sex relationships, Inadequate access to non-discriminatory and comprehensive youth friendly services and Steps Kenya is taking to develop a comprehensive anti-discriminatory law based on Sexual Orientation and Gender Identity.

Further, the coalition also attended the actual review to brief the committee members one on one on the sexual and reproductive health and rights situation of young people including young LBT.

RESULTS: Following the submission of the shadow report and engagements with the Committee, the Committee issued a progressive concluding observation of their interpretation of the CEDAW Treaty and the sexual and reproductive health and rights situations of young people including young lesbian, bisexual, transgender, and intersex in Kenya. The committee underlined the role of state in protection and promotion of human rights for all through multisectoral coordination and participatory approaches. The Committee noted with concern the lack of comprehensive anti-discrimination legislation in the Kenya, including the absence of a clear and complete protection against intersectional discrimination in the Constitution, as well as the fact that consensual adult same sex acts remain a crime by law. The Committee called on Kenya to exercise due diligence to protect all women, including lesbian, bisexual, transgender, and intersex women, against discrimination and violence and further called on Kenya to adopt a comprehensive anti-discrimination law affording protection to all individuals, on all grounds including sexual orientation and gender identity in line with Article 2 of the Convention and the Universal Periodic Review Recommendation that Kenya accepted. The committee also called on Kenya to improve realization of sexual and reproductive health and rights and strengthen comprehensive sexuality education programmes.

LESSONS LEARNED: The engagement with the CEDAW Committee provided critical lessons on advocacy. There is need to strengthen the capacity of civil society organizations, LGBQTI organizations and young people on the different international and regional mechanisms and how they can be used for accountability on youth SRHR and sexual orientation and gender identity. There is need to collaborate with likeminded organizations to form coalitions to engage with these accountability mechanisms. This does not only ensure coordination and amplifying the messages but also ensures synergies, leveraging on experiences and capacities and effective use of resources. These coalitions are critical in developing roadmaps for engagement including the role division, development process, engaging the committee, harnessing support and clear post framework engagement. Following successful advocacy with these accountability mechanisms, it is of crucial importance to popularize and disseminate the concluding

observations and other outcome documents with partners, civil society organizations, government agencies and institutions and young people. It is also important to engage the government agencies responsible for the implementation of the recommendations and collaborate with them to develop plans of implementation. It is also important to link advocacy efforts at different levels of advocacy, from sub national, national, regional and international levels. This ensures that the momentum continues and that the urgency of the advocacy issue is not lost.

UTILIZING INTERNATIONAL INSTRUMENTS FOR NATIONAL LEVEL ACCOUNTABILITY FOR LGBQTI ADVOCACY

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PROVISION OF HIV & SRH SERVICES TO LGBQ+ITGNC PEOPLE IN NAIROBI

Ishmael Ochola

BACKGROUND: Article 27 of the Constitution of Kenya 2010, outlaws discrimination on the basis of one's health status, moreover, Kenya's HIV and AIDS Prevention and Control Act, 2006, provides the legal framework to address HIV providing for protection and promotion of public health, the appropriate treatment, counselling, support and care of persons infected or at risk of HIV infection. However, punitive laws for members of LGBTQ people such as sections 162 -165 of the Penal Code sections has been enforced in a manner that impact negatively on provision of health services to the LGBTQ people. Stigma and discrimination have been identified as a barrier to HIV prevention and uptake of care and treatment services. The socially excluded such as LGBTQ people who are living with HIV are unlikely to take up services and access sexual and reproductive health services for fear of being stigmatized and discriminated against by health service providers. LGBTQ people face stigma and discrimination in their families, communities and within structures and institutions in which they seek services.

DESCRIPTION: Increased access to HIV and sexual and reproductive health services to LGBTQ people though sensitization of health service providers on LGBTQ SRH needs and appropriate response mechanisms. Provision of key commodities including lubricants and condoms to LGBTQ people to their doorsteps to eliminate distance as a barrier to accessing health services**.** Scaling up of STI management at DICES in locations where LGBTI people live. Linking up LGBTQ people testing HIV positive to care and early ART initiation**.** Regular outreach and contact with LGBTQ people through peer based education, treatment and support.CWS has equipped and utilized peer educators and outreach workers with commodities to effectively deliver stigma free prevention and provide effective referral for services. Sensitizing and engaging faith leaders on LGBTQ issues and HIV to reduce stigma and increase service uptake through referrals and linkages and offering pastoral counseling and care. Delivery of integrated HTC packages to include TB screening, family planning services,cervical cancer screening, and other risk-reduction services (counselling, condoms with lubricants, STI screening) for LGBTQ people

METHODOLOGY: CWS recently did mid-term project assessment and employed a cross-sectional study design where the LGBTQ beneficiaries who had been enrolled in the program for over 6 months were interviewed to measure their knowledge levels on HIV prevention options, risk assessment on HIV prevention efforts, barriers to accessing HIV and SRH care. The survey team comprised of 5 CWS Peer Educators who administered the questionnaires in coordination with the Project Officer, HIV program and the Data Clerk and technical guidance of Design, Monitoring & Evaluation Coordinator.

LESSONS LEARNED: There is need to equip people with information on the use of PrEP and PEP this could be done through dissemination of IEC materials. Only 6.45% access sexual and reproductive health services at the government facilities, therefore an advocacy/training aimed at enhancing LGBTI friendly services would boost the uptake. 25% cited availability of condoms as a barrier to its use therefore; an increase in the supply would come in handy. GBV reporting &response mechanisms need to be strengthened since 25.81% have experienced IPV. 48.39% reported abusing alcohol and other substances. This has an effect on SRH. A BCC on the effects of substance abuse in relation to HIV, STIs and violence should be emphasized. Establish working relationship between public health facilities to improve access SRH services by LGBTQ people. Conduct awareness creation/ paralegal training for LGBTQ people on health and sexual and reproductive health rights. Increase supply of HIV prevention commodities such as condoms and lubricants to meet the needs of LGBTQ people.

CHALLENGES IN ADOLESCENT MATURATION

Peris Mwaka

BACKGROUND: Moving the Goalposts (MTG) has been using football as a tool to change the lives of disadvantaged girls and young women since 2002. At MTG, girls and young women become leaders by organizing and running annual league activities and peer education programs on reproductive health. MTG operates in the coastal counties of Kilifi, Mombasa, Tana River and Kwale where girls and young women face many challenges. All counties rate among the

poorest counties in Kenya with high illiteracy levels. The rate of girls dropping out of school due to transactional sex, pregnancy and early marriages is alarmingly high. MTG brings girls and young women together to play football, organize their own activities, become leaders and discuss issues that matter to them. MTG works with over 9000 girls and young women between 9 and 25 years.

DESCRIPTION: MTG works in most of the coastal counties and surveys have confirmed them to be the most counties affected by girls' school dropouts, early pregnancies, girls not given leadership opportunities, sexual gender based violence including rape, HIV/AIDS affecting the young people and care givers of people leaving with HIV/AIDS, male dominated counties, and many more issues affecting the girl child. One of the surveys done by Kilifi county hospital says that between January to June 2016, there were 20066 pregnancies, out of these 185 were mothers aged 10-14 years and 3671 aged 15-19 years. The girls seem to lack information on how to manage their menses with an alternative way apart from getting money from people. Once a girl gets a man who can buy her a packet or two of disposable sanitary towels, the girl feels more secure. The Kenyan government has been issuing the sanitary towels which are always not enough and so the girls go for other alternatives of getting the pads. This is done in exchange of unprotected sex which finally results into early and unwanted pregnancy. Once a girl realizes that she is pregnant, she again looks means of terminating the pregnancy of course in an unfriendly manner. This girl finally settles for unsafe abortion which in most cases the girl is faced by complications ie over bleeding and many other issues arise as a result of unsafe abortion. Other contributing factors to all these issues are lack of information, cultural behaviors and norms.

METHODOLOGY: The use of football drills has been effective in passing adolescent sexual reproductive health and rights (ASRHR) message to the young people. This has been done by girls to their follow girls through football leagues and tournaments in communities running from March to October on annual basis. Through interactive peer led sessions during the leagues and tournaments, young people have been able to acquire knowledge on puberty and adolescence, menstrual hygiene management, effects of early engagement of unprotected sexual activities, effects of unsafe abortion, and effects of using drugs including other ASRHR topics.

Apart from awareness creation, the girls and young women are also trained on making for themselves washable sanitary towels. This has helped in that this is one of the sustainable ways of managing menstrual hygiene. It minimizes cases of girls getting some money from boda boda riders in exchange of sex to purchase the disposable sanitary towels which they need on monthly basis which maybe the parents are not able to afford due to financial instabilities. This also minimizes the cases of unwanted pregnancies hence do away with unsafe abortion cases in the society. On the concerns around unwanted pregnancies, most reported cases are due to financial instability whereby the girls find their way out to source of for some money to cater for their basic needs eg accessing sanitary towels and all that. Majority of the girls realize they are pregnant when they are around five months pregnant. This is because no one told them about their body changes during adolescence and so they find it normal when they miss their menses. Some of them fear to disclose that they are pregnant due to stigma they get from the community. The information is also shared to parents, teachers and other stakeholders that MTG work with through trainings and meetings organized either by MTG or any other institutions e.g schools, chiefs, and others. Reaching the school going youths with the same information has also been successful with support from the ministry of education. MTG also train youth to reach out to youth with RH information and this contributes towards the reduction of unintended pregnancies and unsafe abortions.

RESULTS: Majority (80%) of the beneficiaries renew their registration annually. This is because MTG involves parents and entire community in that everyone gets to understand the programs well which has resulted to community owning MTG. Working closely with other partners strengthens the universal access of resources from within the community. MTG have been involving the ministry of health in training the peer educators, the ministry has also enabled us to have access to their resources since the resources are for the community and the fact that MTG is in the community, it is not an exceptional. The movement games have disadvantaged most of the girls with special needs eg those with hearing challenges the fact that not very many people are conversant with the sign language. Peer education program has created a platform for girls to understand their rights and claim them with focus on sexual and reproductive health choices.

LESSONS LEARNED: Peer education contributes to increase knowledge and information on amongst youth. Parents' empowerment to start dialogues on reproductive health talk with their children regardless of age or gender has not been reinforced much-This has dragged the reduction of early pregnancies from MTG girls. Customs and taboos are still majorly affecting girls decisions despite shared information. MTG should also consider marginalized groups eg girls living with HIV. Using sport as a tool to create awareness on sexual

reproductive health has been successful the fact that the sessions are youthful (peer led) and use movement and participatory facilitation methods eg video show, quiz competitions and many more. Young people really need fellow young people who they sail in the same boat (peers) to attain behavior change. Behavior change is brought by hearing and hearing and understanding the benefits of taking individual steps. Behavior change is brought by hearing and hearing and understanding the benefits of taking individual steps.

HOW AND WHY DO VOUCHERS INCREASE UPTAKE OF SEXUAL REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN KENYA

Alex Omari, Ziporah Mugwang'a, Roy Omollo, Edward Owino, Anna C Gorter - Marie Stopes Kenya

BACKGROUND : In Kenya, adolescents aged 15-19 constitute 24% of population. Many experience sexual and reproductive health (SRH) problems: one in every five is pregnant or has a child (Kenya Demographic Health Survey - KDHS 2014); they suffer high rates of unsafe abortions; and their maternal mortality rate is twice as high as older age groups (Ministry of Health 2018). Adolescents face a myriad of barriers accessing SRH services on both the demand- and supply side. Apart from lack of financial means, girls lack practical information, have insufficient knowledge of contraceptive methods; feel disempowered and have concerns about confidentiality. On the supply-side, providers are often unwilling to provide SRH services to adolescents, with fears of legal implications or parental disapproval. Providers have insufficient experience and knowledge on how to provide quality adolescents' SRH services and to make their clinic youth-friendly. Health vouchers are both a financing mechanism to improve equity, as well as a programmatic tool to reduce access barriers on both the supply- and demand-side and increase use of critical services. Vouchers – paper voucher and/or e-code or other token – can be distributed to target populations who exchange them for services at accredited health providers. Providers are paid for each voucher redeemed.

DESCRIPTION: In 2016 Marie Stopes Kenya (MSK) initiated a multi-component youth programme. In one component, providers from it's socially franchised (SF) private provider network ("AMUA") are trained in youthfriendly services. In selected AMUA clinics vouchers are implemented. Clinics are selected using a programme tool assessing youth-friendliness. MSK is the voucher management agency. The voucher package enables recipients to access multiple services including counselling, short- and long-acting contraceptives (STMs/ LARCs), pregnancy tests, STI services, follow-up consultations and LARC removal. Vouchers are distributed by community health volunteers (CHVs) who receive a performance based payment for each voucher used. Providers and CHW are paid monthly.

METHODOLOGY : The AMUA SF network currently comprises 338 clinics spread across Kenya, the majority being situated in peri-urban and rural areas. Vouchers are implemented in 124 AMUA clinics in Nairobi, Coast, Central and Western regions. After a small pilot in Nairobi the voucher programme started in April 2017 and quickly scaled to the 124 voucher clinics in four months. Distributors collect beneficiary data and send these to a web-based voucher platform using a smartphone and obtaining a unique e-code which is written on the paper voucher. At the service delivery point, the provider validates the e-code through SMS and after service provision reports services to the platform using SMS. Service data obtained from the voucher platform and the AMUA Information System were analysed using descriptive statistics. The average monthly proportion of adolescent clients in the 12 months preceding the voucher programme is compared with the 10 months post-initiation, and these data are also compared with the 214 AMUA clinics not participatin.

Use of implants by adolescents is also compared between voucher clinics and control clinics.

RESULTS: The monthly average proportion of clients being an adolescent in AMUA clinics participating in the voucher scheme quadrupled: from on average 8% in the 12 months before vouchers started to 34% in the subsequent ten months. In control clinics, these proportions remained almost the same, respectively 8% and 9%. Almost all increases observed in participating AMUA clinics were due to vouchers users: the number of fee-paying adolescents remained almost the same. In absolute numbers, the average number of adolescents making use of SRH services in the whole AMUA channel in Kenya increased from around 1,500 adolescent clients per month in the 12 months before the voucher programme started to 7,300 each month in the 10 months post-initiation. 84% of voucher users had never previously used contraceptives. Most voucher users were single (89%) and had no children (75%). Vouchers also expanded the contraceptive method choice. Implants are expensive for adolescents and while 61% of voucher users accessed an implant, in the control clinics only 32% choose an implant. However, both proportions are still high when compared with 6% use of implants among sexually active unmarried adolescents reported by KDHS 2014. Seven percent of adolescents used their voucher for IUD, again high when compared

with 0% reported in the KDHS; 11% to access injectables and only 2% to obtain pills.

LESSONS LEARNED: Vouchers successfully increased SRH uptake and enabled a new group – sexually active unmarried adolescents – to access services, a group which usually faces many access barriers. Vouchers are hypothesized to not only reduce financial barriers but also other barriers on both the supply- and demand-side. Results of Kenya vouchers support this assumption. Voucher-income motivates providers to improve quality and respond better to clients' needs, a process which is strengthened when combined with SF. On the demand-side, the voucher breaks down informational, educational, and cultural barriers and empowers youth to access services. In Kenya MSK identified factors for success: providers overcoming fear and gaining skills to counsel adolescents; motivated by voucher-income, facilities created youth spaces, expanded opening-hours, organised health talks at schools and youth events; trusted CHVs provided face-to-face counselling; performance-based payments motivated CHVs to involve community leaders, organise mobilisation activities and escort adolescents to clinics. The paper voucher itself empowered and was a discreet way to avoid explaining reason of clinic-visit (highly appreciated). In terms of sustainability, vouchers promoted sustainable change in healthseeking behaviour; when more adolescents experience contraceptive benefits, community awareness and acceptance increases; and unintended pregnancies reduce. While some research has noted potential fraud with vouchers the electronic voucher management system meant that fraud was quickly visible and controlled easily through an appropriate monitoring framework. Lastly, vouchers are a precursor towards health insurance; currently the national health insurance is looking at coverage of school-going adolescents, while MSK assists in developing youth-friendly accreditation criteria and an appropriate benefit package.

SEXUALLY TRANSMITTED INFECTION SCREENING IN A YOUTH FRIENDLY CLINIC IN A MIGRATORY COMMUNITY IN KENYA

Daniel Ronoh[1], Cosmas[1], Wesley Bor[2], and Moses Mokaya[2]

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BACK GROUND: There are about 1.8 billion young people (between the ages of 10 and 24) in the world. 600 million are adolescent girls between the ages of 10 and 19. Of the world's population, people aged 10–24 years, approximately 89% live in less developed countries ((UNAIDS, 2016). Sexually transmitted infections (STIs) are a major worldwide public health concern. The annual occurrence of STIs, including HIV, accounts for the loss of more than 51 million years of healthy life among men, women and children worldwide and in developing countries, STIs account for 17% of economic losses caused by ill-health ((Idele et al., 2014). Adolescents are the age group at greatest risk for nearly all STIs. STIs mostly found in adolescents include: gonorrhoea, Chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, HIV infection and hepatitis B infection ((Chinsembu, 2009). Qualitative survey conducted in Narok documented that the young people are sexually active and are under pressure to indulge in early sex and do not use condoms ("National Adolescents and Youth County," 2017) . The prevalence of sexually transmitted infections is a useful marker of unprotected sex which is also considered a co-factor in HIV transmission(KDHS, 2014) . The vulnerability of adolescents to STIs especially in Narok County is compounded by severe social stigma, inadequately informed young people and lack of youth Friendly facilities. These factors hinder access to critically needed health services and other HIV prevention, treatment, protection, care, and support interventions. The purpose of this intervention was to carry out STI screening, risk reduction counseling and treatment for all eligible adolescents in a youth Friendly clinic.

DESCRIPTION: KYC offered both static and outreach reproductive health services to the adolescents both at youth friendly clinic and at places of their convenience. Services were offered during weekends and evenings. The organization also used FDGs to create awareness and assess clients' needs. Clients were provided with hotline no. for inquiries, direction and information. The package provided included provision of RH information, risk reduction counselling, free STI screening and referral for treatment. Linkage was done using MOH referral and linkage tools. For appropriate linkage, clients called back the day they attended the facility and confirmed by providers in the said facilities.

METHODOLOGY: The Youth friendly clinic was located in Kilgoris town, Transmara West Sub County, Narok County. The data obtained was for the period May 2017 to April 2018. The data was obtained for program data tools as well as Ministry of Health tools such, Integrated Reproductive Health, MCH, Social Work, and Rehabilitation Summary (MOH711). This data was collected within a period of one (1) year (April 2017 –April, 2018). Data was analysed using Microsoft Excel 2016 and presented by use of percentile. The beneficiaries of the services were youth aged 15-24 years from both the general population and Key population. The total no. of

adolescents and young people (15-24) reached with the services was 686.

RESULTS:The result shows that STI infection is more common among the age group 15-19 years and it reaches its peak at the ages 20-24 years. The results also shows that HIV infection being a risk factor thriving where STIs are common is likely going to occur most in the ages 20-24 years. Risk reduction counselling session also documented report that most of the young people sexual contacts occurred without prior planning mostly in the informal setups where condoms may not have been available e.g. during school preps which mostly occur in the evening, in the bush or even crop plantations. Majority of the adolescents reported limited knowledge on the correct use of protections during sexual intercourse. The young people reported widely use of traditional medicine in treatment of STIs and this may not treat optimally the infection further increasing the spread during unprotected sexual encounters.

The adolescents' sexual partners were reported to be mostly older adults in other stable relationships which complicated treatment of both partners

LESSONS LEARNED: Youth friendly clinics help to promote access to reproductive health services and demystify myths and misconceptions about FP contraceptives. Therefore, there is need to equip the health facilities to provide youth friendly services that are sensitive to the special needs of young. There is need to strengthen collaborations between Ministry education and Ministry of health to help address the vulnerabilities among the adolescents in Transmara East and West in Narok County. The collaborations will strengthen the provision of SRH information and services and risk reduction counseling to youth in and out of school. In conclusion, In-depth surveys and research should be conducted to establish the causative factors in early sexual debut and its implications on young people in Narok County. This can help in designing appropriate and effective interventions.

COMPREHENSIVE MENSTRUAL HEALTH EDUCATION AS A LIFE SKILL FOR GIRLS AND WOMEN

Esther Mbugua-Kimemia

BACKGROUND: When a girl receives her menarche, she is not told how a menstrual period should look or feel or look like. Socialization from society causes her to hate her periods instead of viewing them as a monthly summary of her hormonal health. She is forced to figure them out as she goes, as a result many girls and women suffer in silence. Approximately one in ten women suffer from Endometriosis. It takes an average of 10 years to get a diagnosis, by this time the condition is in a progressive state. Endometriosis is a menstrual health condition where tissue similar to the lining of the uterus is found outside the uterus cavity. It is characterized by: painful periods, heavy flow with clots, pain during bowel movements and urination, headaches, backaches and pain during sex. The pain affects the quality of a woman's life.

DESCRIPTION: Timely access to comprehensive menstrual health education can reduce the amount of time it takes to get a diagnosis for a menstrual health disorder.

METHODOLOGY: Females in a whatsapp group hosted by Endometriosis Foundation of Kenya were invited to take part in a survey hosted on Survey monkey using the quantitative and qualitative research method. 50 women living with a menstrual health disorder responded over a span of three days. The age range was 15 to 49-year olds with 60% aged between 25 and 34 years old.

Results: 88% of the women said that comprehensive menstrual health education would have reduced the amount of time they took to get a diagnosis. The mean amount of time to get a diagnosis is 9.87 years, the mode is 10 years and the mean is 10 years. The shortest amount of time it has taken a woman to get a diagnosis is 2 years and the longest is 23 years. Other factors that prolong the time it takes to get a diagnosis are normalization of symptoms, lack of access to medical care, doctors not being well-versed in Endometriosis, and the high cost of treatment. 16% of the women have not gotten a formal diagnosis. 85% of the women wish that they knew what a normal period should look and feel like, that pain is not normal, how to deal with the pain, and the warning signs to look out for as teenagers.

LESSONS LEARNED: Many girls and women are suffering in silence. Diagnosis of menstrual health disorders is taking too long and the pain is interfering with girl's ability to work and lead a normal life. A major factor that drives women to seek medical attention is difficulty conceiving. The high cost of diagnostic tests and medication is a prohibitive factor. Societal pressure and stigma contribute to the negative emotional effects of living with a menstrual health disorder. Comprehensive menstrual health education should include: what a normal period should look and feel like, the warning signs that a girl and woman should look out for ways to deal with the pain that may come.

ASSESSMENT OF SEXUAL VIOLENCE AMONG TEENAGE GIRLS WITH DISABILITIES. A REVIEW OF LITERATURE ON AFRICA

Nicholas Mutiso, Marjory Githure and Wambui Kinyua

BACKGROUND: Accessing sexual and reproductive health has become a fundamental right in the 21st century. Africa and other third world nations are battling to ensure they provide sexual and reproductive health services to all as they also address other pressing issues [1, 2]. People with disabilities have historically been deprived of their sexual and reproductive rights. According to the WHO women with disabilities have been the most disadvantaged and alienated group when it comes to access to sexual and reproductive health services [3]. Although women may be the victim of sexual violence at any age, most studies report high number of offences against children and teenagers [4, 5,]. Very little is known about sexual violence among disabled teen girls in Africa [4, 7, 8, and 10]. With an estimated number of 150 million children living with disabilities globally [4, 6, 11], there is need to have information on this problem.The limited available studies have shown that teenage girls with disabilities face sexual violence because they are less able to defend themselves or seek help. Stigma associated with disabilities, social isolation, view of these girls as unworthy of dignity, respect and lack of sexual and reproductive information among other factors predispose these girls to sexual violence [4, 7, 8, and 14]. As a result of the sexual violation they are left severely scarred mentally and physically. Other challenges that arise are unwanted pregnancies, sexual dysfunction, sexually transmitted diseases. There is also limited information on how these violations and challenges are dealt with. [4, 7, 8, 9, 12, 14]

DESCRIPTION: The courage to report a sexual violation is dependent on various factors. Teen girls without disabilities face great challenges in negotiating for sex and equally suffer sexual violation. Teen girls with disability are a particularly vulnerable group faced with greater challenges. This review focuses on analysis of established literature in Africa of factors that affect teen girls with disability and how the violations are documented. This was an exploratory study that focused on the documentation of sexual violations of teen girls with disabilities. It also focused on what are the factors that influence continuous exploitation and abuse among the teen girls and how the reporting mechanisms of violations are.

METHODOLOGY: We conducted a review of the literature by searching PUBMED using a combination of various search terms such as “sexual violence”, “gender-based violence”, “sexual harassment”, “rape” , “teen girls”, “teenage girls”, “teenagers”, “ disabilities”, “physically challenged” and furthered narrowed down the search to geographical location of “Africa” and included other terms such as “Sub-Saharan Africa”, “East Africa” and “West Africa”.

The search was also confined to between 03/08/2018 and 04/20/2018. The search result had 17 papers that included 12 peer reviewed papers. The search and data analysis took a period of 15 days. The primary focus was on information that included knowledge, attitude, prevalence studies, reports on sexual abuse and policies protecting teen girls with disabilities against sexual violence. This created an overview of the predictors, antecedents as well as the social and health outcomes of sexual exploitation among teen girls.

RESULTS: It is clear that sexual violence against these girls is not only frequent but also rarely documented proving that young adolescents’ sexual abuse is under researched. [4, 7, 8, 10, 15]

Factors such as impaired verbal or motor skills which limit their defense especially since them highly dependent for support and care from other people. Other risk factors besides physical include but are not limited to societal or community and socio-economic status which contribute indirectly or directly to these sexual violence acts explaining the unreported cases. Most studies also suggest sexual violence acts meted against teen girls contribute towards multiple health effects like HIV infections, unplanned pregnancies, sexually transmitted infections and even lead to long term physiological effects. [4, 7, 8, 13]. Even where law exists to curb sexual violence, prosecutions of perpetrators is low [15]. There is lack of guidelines to protect teenage disabled girls from abusers especially since they heavily depend on caregivers and the family construct who form a significant percentage of the sexual violence perpetrators [17]. Worse still deeply embedded socio-cultural values that uphold male superiority and sexual entitlement while maintaining gender inequity have fueled this vice through unreported cases that are settled out of court using “hush’ money.[1,4,6,17] Thereby making it difficult to get concrete data on sexual violence prevalence in our countries. There is little awareness and use of available safe channels for teen girls to report violence cases without stigma or victimization. There is also a lack of clear understanding of own rights and what is acceptable behavior from their caregivers which is very important in helping to make use of these safe channels for reporting. [7, 12, 15]

LESSONS LEARNED: It is clear that there is a need for research on sexual violence of children and teen girls especially with disabilities across Africa. Studies also points to the importance of addressing the cycle of sexual violence early on, adolescence teen girls with disabilities, to prevent future cases and risk factors associated with sexual violence. Tackling violence against disabled teen girls, particularly

sexual violence, is central to an effective management of new HIV/AIDS transmission, unwanted pregnancies, spread and control of STI, psychological disorders among disabled teen girls. Strategies that need to be put in place include, coming up with an effective awareness and prevention training programme, to sensitize the caregivers and the girls on how to prevent and call out sexual abuse [15]. Training will provide education on their sexual rights and development while understanding what the risk factors are. The caregivers need to be impacted with training to observe behavioral changes that suggest sexual abuse and know how to deal with suspected se cases of sexual abuse. [10, 15, 16, 17]**.** It is also important to take a bottom up approach where communities are involved in bringing social change which will help promote effective health response programs that are able to adequately respond to sexual violence cases [13]. Successful protection of teen girls with disabilities from sexual violence requires strengthening of the institutional, structural and financial capacity of relevant stakeholders (Health services providers, students, children and adolescents). This will enable them to deliver basic services and provide a platform that provides clear guidelines that adequately respond to sexual violence.

UNPACKING MENSTRUATION

Jedidah Lemaron

BACKGROUND: Menstruation is a taboo topic that goes unheard and un-discussed in most African homes. When discussed either it's too late or too little is discussed. Growing up, most women now aged 45 and above never had the opportunity of using sanitary towels let alone access to menstrual health education and safe management. The modern world is considered a privileged but in matters pertaining menstruation we are still in the dark. In the past few years however, there have been numerous campaigns and lobbying for zero rating the tax on menstrual products and the providing of girls with pads to keep them in school. These efforts saw the government of Kenya pass an act to provide girls in schools with sanitary towels in 2017. While this is a step towards the right direction, the global society has failed in Menstrual Health Management (MHM), as there are many other key aspects concerning MHM that a girl needs to maintain her periods. I have continuously seen many articles and people depicting that the only problem facing girls is lack of absorbents during their menstruation. Lack of safe and hygienic disposal of menstrual waste, adequate water and sanitation, and lack of comprehensive education of MHM and reproductive health in general are key factors to be considered to achieve good menstrual health. I am concerned on the societal knowledge and understanding of menstrual health management. Perhaps if the government and society were well informed about menstrual health, management of menstrual health would not be a topic of discussion today.

DESCRIPTION: Schools are the key areas where menstrual health should promote but it is in these schools where menstrual health is devastating. Perhaps, this is because menstruation is a silent topic and not even teachers dare to speak about it and those who do, water it down, but are they to blame? The societal understanding of Menstrual Health Management, is wanting as they only associate it with sanitary towels. I therefore beg to argue that there is more to menstruation than sanitary products and safe spaces to talk in order to achieve good MHM.

METHODOLOGY: The activity being tested involved randomly selected 150 participants in face to face interviews and focus group discussion. The participants were students drawn from 10 schools in the rural and semi urban Kajiado. Open ended questionnaires were employed as well as peer reviewed articles from UNICEF/WSSCC. All this took two days and upon completion, the data was numerically evaluated to give the following results.

RESULTS: Majority of the participants said that they had no prior education/knowledge on menstruation before menarche. 89% of the participants said that they have never discussed menstruation in their homes and can only do that with their peers. On the question on what products they use, more that 90% use sanitary towels distributed by NGOs who visit their schools. On more in depth questions, 54% of the girls reported to miss class despite having sanitary towels, their queries revolved around lack of proper sanitation facilities, fear of stigmatization by their male counterparts, lack of water to shower and clean soiled clothes and menstrual cramps. Consequently, 73% argued that the lack of inclusion of men in menstrual discussions have made them less concerned about menstrual health management. Lastly, not even a single girl had any prior knowledge on menstrual health management and what it entails.

LESSONS LEARNED: We acknowledged the fact menstrual health has gained momentum and almost all girls have access to sanitary towels. However, the most vulnerable girls are still not benefiting from current advances in menstrual health and often face compounded risks to their health, wellbeing, and empowerment. Taboos related to menstruation are still common, and girls report feeling shame and embarrassment during menstruation. MHM products remain unaffordable and inaccessible to adolescent girls, especially those in rural and remote areas. Sanitation facilities are ill equipped to support girls and women to manage menstruation and dispose of the waste. There is also widespread gaps persist in water access and sanitation

across the country. Menstrual health stakeholders and efforts remain soloed, missing the opportunity to provide comprehensive intervention packages to address the interrelated barriers to and promote enablers of society.

A PERSPECTIVE ON PROVIDER ATTITUDE CHANGE TOWARDS CONTRACEPTION IN ADOLESCENTs

Dr Loice Luhumyo

Contraceptive use in adolescents is one of the strategies aimed at reduction of teenage pregnancies. A high rate of teenage pregnancies confers a social and economic burden to the country.

Approximately 24% of the total Kenyan population are adolescents (2009, KPHC). The teenage pregnancy rate is at 18% (KDHS 2014). As per UNFPA, 378,397 adolescent girls aged 10-19 years got pregnant between the months of July 2016 - June 2017. 28,932 of these girls were aged between 10 to 14 years. Most of these girls dropout of school after being impregnated eventually compromising on education attainment and the ability to secure decent economic opportunities in future.

With the age of sexual debut reducing, the risk of getting pregnant at an earlier age increases subsequently increasing the adverse effects of these pregnancies.

Programs that promote abstinence (as one of the strategies of reducing adolescent health) have been proven not to be effective in reducing teenage pregnancies. Some of the barriers to provision of contraception to adolescents is legislature and unfavorable provider attitude. Many healthcare providers have unfavorable attitude towards the provision of contraception to unmarried adolescents.

Most legislature has it that RH services provided to minors should be mandated by parental consent. An assumption is made that most teenagers would avoid seeking medical services for contraception or STIs if they were required to involve parents. Studies done have found out that about 60% of guardians know of their adolescent's involvement with contraceptive services. This did not hinder these minors from obtaining RH services nor did it deter teenagers from having sex.

The 2015 national adolescent sexual and reproductive health policy of Kenya promotes the provision of accurate information and services to prevent early and unintended pregnancies among adolescents. Contraceptive use is one of the crucial strategies in preventing unintended pregnancies in this age group.

Providers of adolescents' sexual and reproductive health services should take it upon themselves and change their attitude towards provision of contraception to adolescents to increase access to these services.

STRENGTHENING FAMILY PLANNING PROGRAM THROUGH DATA REVIEWS AND USE IN KIAMBU COUNTY

Caroline Mwangi, Kiambu County Government- Health Department (Primary Presenter)

BACKGROUND: Quality data is fundamental to health systems and their programs across the board and in all areas of care that ensure public health. Use of data helps health programs target services to areas and populations of high need, thus making the most of scarce resources. IPAS has been implementing a choice for change program in the county. During the initial quarterly data review meeting, IPAS after collecting the data from the 24 sites using the MOH standards analyzed and presented to all the facilities in a quarterly review meeting. The health facility staff would doubt some of the data and especially where there were queries on quality. Despite the facility staff participating in the data collection process they were still doubting their data. This prompted all the involved parties to go back to the drawing board and agree on the way forward. The next step was that all the facility to collect their data, analyze and present during the subsequent quarterly meeting using a guided template.

DESCRIPTION: Guiding the Health facility on the Template and involving all the actors in the facility. Visit the facility to guide them on what is expected and agree on the data sources for the various family planning indicators. A meeting is scheduled, time table is developed and health facilities are slotted for presentation. Facilities present their performance for the previous quarter other members present give both positive and negative criticism. All agree on what is working and what is not working and the county and the partner consolidate the facilities data to have the county perspective.

METHODOLOGY: This is being implemented in Kiambu county, through the support of IPAS the county has implemented the project which aims at improving FP access especially among the youths. This is the 3rd year of implementation of which in the first year IPAS was implementing the facilities' data. The facilities embarked on presenting their data with the main of promoting ownership and improving the quality. The facilities were provided with an opportunity to collect and present their data and in the process learn about their system in terms of what is working and not. The facilities were guided by the county, subcounty and IPAS team. Since all the data is eventually fed in the DHIS 2 system, during the presentation comparisons were made between the data presented and what had already been reported in the DHIS2. This motivated the facility since it brought out gray areas and inconsistences between source documents and the national system which prompted them to follow up the cause of the in consistencies

and ensure the correct data is in the DHIS2. The community health volunteers are also a major actor in all the stages.

RESULTS: Involvement of many staff in the facility, ownership of data, identification of various data quality issues at all levels, promoting data use amongst all players, identification of data needs at various levels, easier to see the impact of the program at the lower scales,facilities were able to identify their unique issues,determine the program needs at all the levels and facilities are able to identify the commodity needs. Using the data the Facility are able to identify the unreached population and thus involve the community health volunteers. Since FP doesnt occur in isolation other health programs are benefiting from the good practicei.e MCH services

LESSONS LEARNED: Data quality is pivotal in any program implementation,in order to promote ownership and improve on the processed there is a need to involve all actors, It is possible to improve data quality and in turn improve programs through strengthening collaborations, ownership plays a critical role in promoting sustainability, It is possible to improve the processes with scarce resources, Mentorship is very key if we expect good results

INCREASING ACCESS TO CONTRACEPTIVES AMONG ADOLESCENTS IN BUNGOMA COUNTY

Milsane Kiplai (MOH), Lorna Anjimbi (MOH), Nancy Aloo (IPAS)

BACKGROUND: Teenage pregnancy in Bungoma county remains unacceptably high at 14%**.** Most of the youth have limited access to FP information and methods of contraception**.** The unmet need for FP stands at 18% for general population and 25% for adolescents**.** IPAS has supported Bungoma county in making contraception more accessible to the adolescents and youth through its choice for change (C4C) project

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa.**:** Studies indicate that over 40% of pregnancies in Kenya are either mistimed or unwanted (Mumah et al,2014)**.** This is attributed to low contraceptive uptake**.** High rates of abortion among adolescents are due to stigma, possibility of dropping out of school and inability to support their children. The program targets adolescents and youths aged 15-24 years**.** Aims at increasing access to contraception, preventing unplanned pregnancy and averting unsafe abortion**.** Main focus is long acting reversible contraceptives**.** C4C launched in 2015 is implemented in seven counties in western region of the country, Bungoma is one of them. A collaborative venture between MOH, IPAS alliance, UNPF and Marie stopes Kenya**.** Funding is from the Children's Investment Fund Foundation a global foundation whose mission is to improve the lives of children in developing countries who live in poverty**.** C4C has employed innovative and cost effective strategies that give girls and young women true choice of contraceptive use and access, they include: Health system strategies**,** community focus strategies and policy and advocacy strategies

METHODOLOGY: Increasing adolescent contraceptive uptake through the public and private. Improve demand and utilization of reproductive health contraceptive services among adolescents through effective community mobilization and referral strategies**.** Enhance policy environment for ASRH at national and county levels and promote sustainability**.** C4C is a three year project implemented in 37 health facilities across the ten sub counties of Bungoma county**.** Strategies employed include health systems, community, policy and advocacy strategies**.** The project data is sourced from primary reporting tools at the facility and the DHIS. Community focus strategy which include: Mobilization using Peer Educators, CHVs and Community Based Organizations**,** Utilize Youth Peer Educators (YPEs) and youth groups to conduct social mobilization with focus on Adolescents**,**Train and develop the capacity of , Youth groups to effectively communicate with the adolescents clients**,** Develop and distribute adolescent focused IEC materials through existing youth groups and YPEs**,** Awareness creation & mobilization for referrals to services using community health volunteers**,**Conduct youth friendly community promotional events using mini-caravans, magnet theatres, social media platforms

RESULTS: IPAS C4C project has provided training opportunities for over 150 health care providers in the intervention facilities**,** equipment of the 37 facilities to enhance suitability to offer youth friendly services**,** support with family planning commodities to compliment the county government of Bungoma supply**,** Increase in the number of adolescents and youth accessing modern methods of contraception**,** efficient utilization of the community strategy to improve access to

ASRH services and help in reduction of cases of teenage pregnancy and resultant unsafe abortion,increased community awareness of the consequences of unprotected sex- unplanned pregnancy, unsafe abortion, sexually transmitted infections including HIV/AIDs and community more receptive to information about reproductive health

LESSONS LEARNED: Goodwill from key stakeholders is crucial for ASRH project, Adolescents and youth lack information to empower them make the right decisions in life, the health care system should strive to create avenues to facilitate this ,Inter -sectoral collaboration strengthens delivery of ASRH services ,each of the players have a cardinal role ,Adolescents and youth are very receptive of service providers sensitive to their unique needs for privacy, confidentiality and respect ,Public, private , partnership plays a very important role in delivery of not only ASRH but other key health services.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH ISSUES AND PREVENTIVE MEASURES

Dr John Nyamu, Simon Mwangi, Prof Joseph Karanja

BACKGROUND: To review sexual and reproductive health issues affecting adolescents in Kenya and other countries, to look at Reproductive Health Themes affecting adolescents and young people, to understand what adolescent health means and the class of age affected, to give some of the preventive measures and solution to adolescent sexual and reproductive health issues and to make recommendations for attaining good adolescent sexual and reproductive health

METHODOLOGY: This is a desktop review of studies and research conducted in Kenya related to adolescent sexual and reproductive health. Those documents reviewed include KDHS, Magnitude and complications of unsafe abortion in Kenya (ipas and MOH Incidence and complications of unsafe abortion in Kenya (aphrc and MOH 2013). Also reviewed was the Status report on SRH of adolescents living in urban slums in Kenya (APHRC 2013) and the National Adolescent sexual and Reproductive health Policy (MOH 2015). Preventive measures were discussed for each of the SRH theme identified and recommendations made at the end of the review.

RESULTS:A total of twelve SRH issues /themes affecting adolescents were researched on and recommendations made on how best to handle the health issue once it presents itself to the health provider. Adolescence is the period between 10 and 19 and most of these people are in the high schools and are reported to be the most vulnerable population as far as their health issues are concerned. The fact that sex education is not encouraged in schools and the parents are shy to educate their children this stage in life becomes an experimental one and most of the young people end up in the wrong hands and statistics can prove that. 11 % of female adolescents start sexual debut at 15 years compared to 8 % males and 12-14 years 3.9 % have started sex compared to 31 % in 15-19 age group. Those married adolescents using contraceptives were 36.8 % and unmarried adolescents who were sexually active ,49.3% (KDHS 2014).There was however unmet need of 23 % (married) and 59.3 % (unmarried). Adolescents are still the most vulnerable as far as HIV is concerned. However social platforms have played a key role to link young people to SRH,HIV and GBV. Another issue identified was the teenage pregnancy rate of 18-20 % between the age 15-19 years. Unsafe abortion also hits the adolescent hard as 45 % of women who presented to MOH facilities for Post abortion acre were aged 10-19 years (Aphrc & MOH 2013).Adolescents are also targeted in sex tourism and sex trafficking. Teenagers are mostly affected by hormonal imbalance regarding skin changes and irregular bleeding. To prevent reproductive health cancers it is best to start immunization s such as Cervarix or Gardasil at adolescence.

Lessons learned:There is need to delay child marriages and child bearing and reducing unintended childbearing ,arrowing gender disparities that put girls at risk of poor SRH outcomes and expand health awareness or enabling access to SRH services .Also it is good to Implement polices and programs for ASRH and advocate for use of contraceptive and safe abortion by adolescents. Training adolescents to use ICT and mobile technology by adolescents to access SRH services is worth doing.

USING HUMAN-CENTERED DESIGN TO DEVELOP AN ADOLESCENT PREGNANCY PROGRAM IN ELDORET, KENYA

E Apondi MMed, R Mogeni MMed, HC Millar MD MPH FRCSC, JG Thorne MD MPH FRCSC

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BACKGROUND: Adolescent pregnancy remains unacceptably high worldwide. In Kenya, where almost half of women have begun child-bearing by age 20, there has been no change in adolescent pregnancy rates over the past 5 years. Pregnancy in adolescence is associated with increased maternal and neonatal mortality and morbidity, including increased rates of obstetric fistula, anaemia, unsafe abortion, preterm birth and low birth weight. Young pregnant women are less likely to complete their education, obtain sustainable employment and, as a consequence, are less likely to lift themselves and their families out of

poverty. Strategies to prevent these pregnancies are vital to advancing maternal and child health. Equally important are strategies to optimize the care of such young women in order to improve maternal and neonatal outcomes.

There is a renewed call for evidence-based provision of adolescent-focused sexual and reproductive health (ASRH) services. This includes ante- and postnatal care to improve pregnancy outcomes as well as programs to prevent pregnancy in this age group. The current ASRH policies call for specific engagement of adolescents in the design, leadership and implementation of these programs.

"Human-centered design" methodology is emerging as an innovative, feasible and effective participatory approach to program design and implementation in health care. Human-centered design (HCD) is a discipline that has emerged from within design and management studies that involves keeping the human perspective at the forefront of all stages of the process of solving a problem and working directly with the users to develop and test solutions. Central to any of the approaches of design thinking is a design technique called empathy-building, the process of deeply understanding and engaging with users and their needs. This methodology allows the development of new care models that are based in the realities and priorities of the users and therefore have the potential to be more effective in achieving desired outcomes.

DESCRIPTION :We are proposing to improve adolescent pregnancy services in Uasin Gishu County with two objectives:

Develop an adolescent pregnancy care intervention to improve maternal, newborn and child health care using a human-centered, participatory, iterative design process.

Evaluate the impact of this adolescent pregnancy care program on uptake of services and pregnancy outcomes.

By employing a human-centered design strategy, local participation in and ownership of the design outcome will enable a more effective and sustainable approach to the development of a care program for pregnant adolescents. This program will address current barriers to care utilization and outcomes as they relate to the experience of pregnancy at the patient and provider level. In doing so, this approach will lead to overall improvements in antenatal care attendance, facility delivery, maternal and neonatal outcomes, postnatal care attendance, exclusive breastfeeding, and family planning uptake.

METHODOLOGY: This study will be carried out at Moi Teaching and Referral Hospital (MTRH) in both the current Maternal Child Health (MCH) clinics and at the Rafiki Centre of Excellence in Adolescent Health. To meet the study objectives we propose a mixed methods strategy. At the outset we will form a Community Advisory Board (CAB) comprised of key stakeholders who will serve as external reviewers of our study protocols, process, and interpretation of results. Objective 1 will include the formation of a design team. This team will have 8-12 members, including pregnant or parenting adolescents, clinicians, community health volunteers, and parents of pregnant or parenting adolescents. This design team will be led through a design training process in partnership with Idea Couture, a human centred design firm based in Toronto, Canada. The design team will then conduct a needs assessment using select empathy-building tools with both adolescents and clinicians/MCH care providers. The participatory analysis that follows will lead to the launch of a pilot intervention program (ie adolescent-focused antenatal care program), the collection of user feedback on the pilot, and refinement of the program. Objective 2 will involve 2 consecutive prospective cohorts, to compare key maternal health outcomes in adolescents using the current model of care and the new adolescent-focused model of care that will be developed in Objective 1. Adolescents ages 10 to 19 attending their first antenatal clinic visit will be targeted for recruitment. The primary outcome will be attendance at 4 ANC visits. Secondary outcomes will include number of adolescents who deliver in a facility, preterm delivery rate, Newborn Unit admission rate, rate of low birthweight infants, attendance to one postnatal visit at 6 weeks postpartum, rate of family planning uptake by 6 weeks and 6 months postpartum, and rate of exclusive breastfeeding for 6 months. Given an alpha of 0.05, to achieve 80% power, and accounting for 20% loss to follow-up, we will need to recruit a total of 224 participants (112 participants in each group).

RESULTS: government's commitment to engaging adolescents in the design, leadership, and implementation of programs that serve them by using a human-centered design (HCD) approach to build an Adolescent Pregnancy Program at MTRH. At present, there is no such program at MTRH or even in Kenya. HCD is an innovative, feasible and effective participatory approach that involves keeping the human perspective at the forefront of all stages of the process and working directly with the users to develop and test solutions. This project will (1) develop an adolescent pregnancy care intervention to improve maternal, newborn and child health care using a human-centered, participatory, iterative design process; (2) Use mixed methods to evaluate the impact of this adolescent pregnancy care program on uptake of services and pregnancy outcomes. Results will not only inform the implementation of a new care program, but also provide valuable scholarship in this emerging area of health services research.

THE USE OF MODERN CONTRACEPTION IN PREVENTING HIV INFECTION AMONG YOUTH IN UASIN GISHU COUNTY

Ruth Chelagat

BACKGROUND: The prevalence rate of HIV/AIDS in Kenya is at 6 %(KDHS) Uasin Gishu County is at 4.3% (KDHS). The median age for sexual debut in Kenya is 17years(KNBS 2014) this clearly shows that adolescents and youths are at a higher risk of getting infected with HIV as they are engaging in sex at a very young age. Abstinence not being an option for them hence the use of modern contraceptives is the best solution .However, there has been a low uptake of modern contraception of 56% which clearly indicates that at a very young age of 17 years they are at a risk of getting HIV infection .Therefore, there is the need to advocate for modern contraception uptake and create more awareness on proper use of modern contraception among youth as in only proper use of these modern contraceptives will bring down the HIV prevalence rates down and prevent the risk of getting HIV infection.

DESCRIPTION: Working with national, county executives and county assembly committees to build capacity, knowledge and get political will to ensure that there is increase in allocation of resources to health sector which specifically is modern contraception Sensitization of local communities which are the young people to ensure awareness of modern contraception which will aid its uptake and correct use also continued sensitization will attract civil societies that have same interests to push for increased resources allocation for modern contraception. Taking part in budget making processes at county levels to ensure our asks for increase in funds for modern contraception is captured so as during money allocation

METHODOLOGY: Through the implementation of SHAPE (Securing Health through Advocacy and People Empowerment) a three year project, whose main objective is: To mobilize funds from key European donors and also East African governments (Kenya, Uganda and Tanzania) to fund the use of modern contraception. From 2015 to date DSW has been able to build proven success in advocacy and capacity building to increase overall official development in particular modern contraception and reproductive health above all increasing domestic funding for family planning in East African our case Kenya specifically Uasin Gishu. In order to achieve DSW objectives we have been able to meet the county executive leaders including to present our asks; to achieve more allocation of funds to health sector especially modern contraception. As a youth champion I have participated in public participation forums for budget making where we advocated for increase in allocation of funds to health sector for modern contraception. To ensure sensitization of youth, social media; Facebook and what Sapp groups have been used where modern contraception and sexual reproductive health issues concerning youths have been discussed. Focused group discussion have been held at various youth centers also Comprehensive Sexual Education have been held in and out of school to educate youths on modern contraception.

RESULTS: There has been a significant increase of about 50% in funding for modern contraception from 69.6 million to 104.1 million in Uasin Gishu County from 2015/2016 it was at 69.6 million in 2016/2017 it went to 82.8 million and in 2017/2018 it hiked to 104.1 million(.This will largely help in reducing HIV prevalence rates. Through capacity building of leaders and advocacy there has been 90% political support which has been a major success ever since 2015 .More youths have been educated on modern contraception and sexual reproductive health issues .There has been an increase in number of youths using modern contraception thus reducing HIV infection.

LESSONS LEARNED : Engaging County policy makers is key in getting necessary support for modern contraception programs in the County. Access of information and services by young people increases uptake of modern contraception and other SRHR services. Implementation of comprehensive sexuality education program in schools has led to increase uptake of modern contraception among adolescents . Involvement of young people in public participations forums will be instrumental in prioritizing main concerns affecting young people on sexual reproductive health and rights. Look warm support from the political leaders in the County on Family Planning programs. Clergy members fear talking about sexuality issues. Parent youth communication on sexuality issues is still a problem

UTILIZATION OF COMPREHENSIVE CERVICAL CANCER SCREENING SERVICES AMONG HEALTH CARE WORKERS IN SELECTED HEALTH FACILITIES IN MACHAKOS COUNTY- KENYA

Agnes W. Nzioka

BACKGROUND: Cervical Cancer (CC) is the 4th commonest cancer in women in the world (50 incidents/100,000 women in Sub Sahara). CC is 2nd common cancer in Kenya but causes highest morbidity (2454) and mortality (1676) in Kenya. Early screening and treatment reduces morbidity and mortality associated with CC. In Kenya, 51.2% of estimated women population of 10.505 million aged 15 years and

older are at risk of developing cervical cancer. Research shows that screening a woman even once between the ages of 35 and 40 years reduces her lifetime risk of cervical cancer by 25–36%. However, the effective cervical cancer screening in developing countries is as low as 18.5%. Low levels of utilization of cervical cancer screening services among health care workers have been documented.

DESCRIPTION: What is the proportion of HCWs who utilize standardized C.C.S.S in selected health facilities in Machakos County? 2. Do individual factors influence utilization of standardized C.C.S.S. among HCWs in selected health facilities in Machakos County? 3. How does respondent's perception on quality of CCSS received influence utilization of standardized C.C.S.S. among HCWs in selected health facilities in Machakos County? 4. Do facility based attributes influence utilization of standardized C.C.S.S. among HCWs in selected health facilities in Machakos County?Null hypothesis: Utilization of CCSS in Machakos County among health care workers is not a function of individual, service provider and/or facility based attributes.

METHODOLOGY: This study sought to determine the utilization of cervical cancer screening services by HCW's in selected health facilities in Machakos County. It was also thought imperative to determine individual HCW and facility attributes influencing utilization of cervical cancer screening services as well as perceived quality of CCSS received by HCWs influence on utilization of CCSS among HCWs in selected health care facilities in the county. The study adopted a descriptive cross-sectional study design involving 272 female health workers drawn from all the level 4 and level 5 facilities within the county. Clinical and non-clinical HCWs participated in this study. Respondents were stratified according to level of facility and according to their cadres; within each cadre respondents were randomly sampled. Data was collected using self-administered questionnaires and a facility assessment tool.

RESULTS: Data analysis used SPSS version 21. Association was initially determined using Chi-square (x2) and those variables that were significant were then subjected to binary logistic regression. HCWs who had certificate (OR = 0.101, p-value = 0.008) and diploma (OR = 0.805, p-value = 0.002) were less likely to utilize CCSS as compared to HWCs who had attained graduate studies or higher. Also health workers aged 30 years and below (OR = 0.108, p-value = 0.009) were less likely to utilize CCSS as compared to healthcare workers who were aged more than 50 years. Respondents reported inadequate counseling and expert recommendation for CCSS (66.7% and 43.7%) respectively. None of the facilities under survey demonstrated the ability to conduct consistent CCSS or the HCWs due to frequent stock-outs. Only 25% of the HCWs had ever utilized cervical cancer screening services by the time of this study.

LESSONS LEARNED: This study concluded that HCWs, like other similar segments of female population are at risk of HPV infection responsible for causing cervical cancer Hence, Machakos County for health management should target the young female health care workers aimed at increasing their uptake of CCSS services, design policies and charters specifically addressing how cervical cancer screening services will be rendered among members of staff which essentially should be provided in more secluded staff clinics . The selected health facilities' administrators should improve quality of CCSS delivery for clients by ensuring consistent and adequate supplies of CCSS commodities for clients, Ensure intensive supervision of CCSS delivery and be more vigilant in addressing documentation gaps which was a big challenge during this study.

KNOWLEDGE OF CERVICAL CANCER AND ACCEPTABILITY OF PREVENTION STRATEGIES AMONG HPV-VACCINATED AND NON-VACCINATED ADOLESCENTS IN ELDORET, KENYA

Anisa Mburu[1], Peter Itsura[2], Hillary Mabeya[3], Darren Brown[4]

BACKGROUND: Primary prevention of cervical cancer with the introduction of the Human Papilloma Virus (HPV) vaccines is the next generation means to reduction of the disease burden in developing countries. Sexually active adolescents have the highest rates of prevalent and incident HPV infection rates with over 50–80% having infections within 12 months of initiating intercourse. From May 2012 to March 2013, through the Gardasil Access Program, Eldoret received 9600 vaccine doses and vaccinated over 3000 girls aged 9-14. During that project, ten public schools were selected for determination of uptake of the vaccine through the hospitalbased vaccination program. Parents were educated at the schools and asked to bring their daughters to the hospital for vaccination as well as further information dissemination on cervical cancer and the HPV vaccines. Despite this, there is little information

on the knowledge of cervical cancer amongst adolescents and their amenability to accepting cervical cancer prevention strategies.

DisCRIPTION: To compare the knowledge of cervical cancer and acceptability of prevention strategies among vaccinated and non-vaccinated adolescents after an HPV vaccination initiative in Eldoret.

METHODOLOGY: A Cross Sectional Comparative Study carried out in six of the ten public schools which were clustered into two groups of three. 60 vaccinated and 120 unvaccinated adolescents were randomly selected from each of the schools by proportionate allocation. IREC approval obtained and signed consent got from the parents. Data collection was carried out over a six month period using interviewer-administered questionnaires. Data analysis was carried out using R: A language and environment for statistical computing (R Core Team, 2017)

RESULTS: The median age of the participants was 14.0 (IQR: 13.0-15.0). Of 60 vaccinated adolescents, 56 (93.3%) had heard of the HPV vaccine compared to 6 (5%) of unvaccinated participants ($p<0.001$). Fifty-eight (96.7%) of vaccinated participants heard of cervical cancer compared to 61 (50.8%) unvaccinated participants ($p<0.001$). The participants were not different in their knowledge of risk factors for developing cervical cancer or its symptoms but overall, the vaccinated participants had a significantly higher knowledge score compared to the unvaccinated participants 14.4 (95% CI: 12.2, 16.7). Both cohorts identified the school as the commonest source of information for health matters as compared to social media or hospitals. The two groups also showed similarity in their selection of cervical cancer prevention strategies acceptable to them like delaying sexual debut until after the teenage years and frequency of using barrier method for protection against sexually transmitted infections. Similar proportions of participants from both cohorts showed high acceptability of screening modalities for cervical cancer (85% vs 86.7%, $p=0.940$). Of the unvaccinated participants, 63.7% expressed willingness to be vaccinated.

Exposure to the HPV vaccine was associated with a higher knowledge of cervical cancer. The adolescents predominantly rely on the school for their information. They show remarkable acceptability for cervical cancer prevention strategies but are limited by the dearth of information they have.

LESSONS LEARNED: Initiation of the proposed nationwide school-based HPV vaccination effort to increase knowledge of cervical cancer among adolescents. Collaboration between health workers and schools for provision of adequate information to adolescents about cervical cancer. Further studies to assess existing barriers to cervical cancer prevention through communityhealth service linkage for adolescents.

UPTAKE OF COMPREHENSIVE ABORTION CARE IN TIER THREE HEALTH FACILITIES IN NAIROBI COUNTY, KENYA

Jeremiah Mainah

BACKGROUND: Though there are safe and simple abortion methods over twenty million unsafe abortions are performed annually adding to the global burden of maternal morbidity and mortality (WHO, 2015). Globally one in every four pregnancy ends up in abortion (WHO, 2017). An estimated 464,000 induced abortions occurred in Kenya and about 120,00 women received care due to abortion complications(Shukri,2015). Comprehensive abortion care includes contraception, safe abortion, post abortion care and pain management, law reforms and referrals**.** While abortion remains controversial unsafe abortion is a public health concern and a major challenge affecting women. The most venerable women suffer the consequences of unsafe abortion because they cannot afford safe abortion services

DESCRIPTION: 47% of women aged 15-49 years in Kenya have no access to modern contraceptive methods (KDHS,2014). Despite

the lack of modern contraceptive many women are avoiding getting pregnancy (KNBS,2014). The projected number of women admitted to public hospitals with abortion complication is 20,893 with 182 deaths occurring annually.Young people between 15-24 years account for 70% of all pregnancies and since they are still in school they are most likely to end the pregnancy (MOH,2017)

24% of Nairobi women have unintended pregnancy (Ikimari, 2013). Abortion is second to normal delivery and 95% of Global Unsafe abortion occur in low income countries where Kenya is classified. Abortion remains top five leading cause of maternal death at 9% after Hemorrhage 34%, Hypertension 19%,Indirect causes 17% and other direct at 11% (MOH, 2012). According to Kenya RMNCAH investment framework access to quality CAC services remain a challenge at all levels of care due to supply and demand barriers.(GOK, 2016). Half (50%) of all maternal deaths are referral from another facility mostly level 4,5 or 6 (MOH.2017). Ministry of health is developing a roadmap for Universal Health Coverage and a health financing strategy (RMNCAH,2016). Nairobi county is the smallest county but the most populous county where 31% of maternal deaths are attributed to abortion. (Shukri, 2015).

METHODOLOGY: Descriptive cross-sectional survey conducted at Nairobi County, Pumwani and Mama Lucy Kibaki Hospital to a total Population was 360 Nurses. Only tier 3 hospital offering abortion services were included in the study. This was obtained through reconnaissance. Systematic random sampling was applied. The sampling interval of two was obtained by dividing the total number of nurses 360 by the desired sample size of 189. Semi-Structured questionnaires were used for quantitative data collection. Key Informant interviews were used for qualitative data collection and Pre Test was conducted in Kiambu Tier 3 hospital and corrections done before the collection of data. Qualitative data was analyzed using content analysis whereby, data was read to identify the main themes related to study objectives. Narrative and verbatim quotations were used to explain the trends exhaustively. Quantative data was analyzed by SPSS Version.

RESULTS: These findings resulted to the **rejection** of the null hypotheses in favor of the alternative hypothesis. There is a significant association between providers attitude and uptake of comprehensive abortion care. There is a significant association between policy application and uptake of comprehensive abortion care. There is a significant association between health facility resources and uptake of comprehensive abortion care

LESSONS LEARNED: Providers Attitude: Nursing Council of Kenya should review Nursing training curriculums to incorporate value clarification and attitude transformation. Reproductive Health Policies: Ministry of Health should disseminate existing reproductive health policies to health facilities and ensure health care providers adhere to them. Health Facility Resources: National and Country governments should increase in budgetary allocation for Reproductive health and ensure existing Health facility Resources such as service charters, Ambulances, finances are also utilized for comprehensive abortion care.

UNSAFE ABORTIONS AMONG THE ADOLESCENTS (MISUSE OF MISOPROSTOL, USE OF TRADITIONAL HERBS AND CONCOCTIONS). ADOLESCENT MYTH AND MISCONCEPTIONS.

Mickreen Adhiambo, Programme Coordinator, Gender Graduate

Phonsina Archane, Sexuality Programme Coordinator

BACKGROUND: With literacy levels at 86% according to the latest statistics from the World Bank in 2016[1], Kenya is a developing country in sub-Saharan Africa where 42% of its population live below the poverty line. It is estimated that in Kenya the average age of sexual debut is 12.4 years [2]with one in five youths aged 15 to 24 years reporting their first sexual experience before the age of 15. Adolescent girls and young women in Kenya accounted for more than 48% of post-abortion care patients in 2012. Kenya spent an increase of 100million Kenya shillings thus Sh533 million in 2016 compared to 433mllion Kenya Shillings [3]spent on post abortion care in public hospitals in 2012. Lack of proper information due to many adolescents relying on social media as a source of information on their reproductive health, Cultural beliefs that view unwanted pregnancies as a blessing and opposing contraceptives, prejudice from service providers, and lack of quality SRHR services has led many young women to seek dangerous abortion methods which include: use of detergents concoctions, hangers and pins, straws and syringes, traditional herbs.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers.

During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa.

METHODOLOGY: From the hotline, 8 out of ten callers mentioned that they got information about ways of terminating a pregnancy from the internet. Due to self and community stigma, adolescent girls and women are reluctant to seek proper information on the use of misoprostol for a safe abortion. Service providers and community workers also seem to have misconceptions on the use of misoprostol or do not know about it therefore they are unable to advice on safe abortion choices. Furthermore, the fear of being stigmatized in the society has led to young adolescents and women to seek clandestine abortion services in unkempt and medically unfit facilities often in the hands of unskilled service providers.

To be reduce the cases of unsafe abortions among young adolescents and women, the interventions will strengthen the communication channels to ensure that through a wide hotline number dissemination women make use of platforms available such as the Aunty Jane Hotline, ensure that proper information is being share in communities by training community representatives and using social media to put in place youth friendly sources for adolescents with the possibility to speak to counselors.

LESSONS LEARNED: Capacity building Values Clarification exercises for Pharmacists and Health care providers. This entails service providers, community members and other stakeholders undergoing Values Clarification sessions organized on 'Medical Abortion' and use of 'Misoprostol / Mifeprostone' as key when it comes to non-judgmental and quality service provision to the adolescents.

LEVERAGING ON INTERNET IN REACHING OUT TO YOUNG PEOPLE WITH SRHR INFORMATION.

Oliech Michael Okun, Youth Advocate NAYA Kenya

BACKGROUND: For millions of young boys and girls in Kenya, the beginning of adolescence not only brings changes to their bodies but also sets in new violations of their sexual and reproductive health and rights. Young girls and boys are often subjected to forced/ coerced sex and marriages and involve in risky sexual behaviors putting them at the risk of unintended pregnancies, sexually transmitted infections, unsafe abortions and dangerous child birth. Despite these risks that young people are exposed to, young people still face barriers to access the highest attainable standard of SRHR information to protect their health and well being and keep them safe and free from these risks they face. The internet has the excellent potential to promote good sexual and reproductive health outcomes among young people aged 12-25 who are its largest consumers (87%). In Kenya 2 out 3 youth either owns a smartphone or has access to one and will spend a minimum of 5 hours on the Internet 4 times a week. Unfortunately, the Internet has not been given a priority when it comes to disseminating SRHR information to young people despite being considered as the quickest and most convenient way of reaching young people with lifesaving SRHR information.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. In 2015 Network for Adolescents and Youth of Africa (NAYA) upscalled its use of Internet (Facebook and WhatsApp) to reach out to young people with SRHR information and to generate discussions. NAYA worked with a team of young people within the organization in reaching out to other young people through her Facebook page and WhatsApp group. This was to provide young people with the most preferred alternative in accessing SRHR information.

METHODOLOGY: Humorous Educative video clips: NAYA developed short educative SRHR video clips inform of animations, testimonials, interviews and dances which are attractive to young people and often attracted more discussions on SRHR in Facebook and WhatsApp ,

NAYA also used humorous memes to send SRHR information and messages to young people. Graphics Interchange format was also used in reaching out to young people with SRHR information in Facebook and WhatsApp platforms.

Quizzes: This was used to generate more discussions on different SRHR topical issues affecting young people and find different

strategies in addressing the issues in both platforms of Facebook and WhatsApp.

Campaigns: NAYA also carried out Facebook and WhatsApp campaigns to reach out to young people on important SRHR international days and to generate discussions among more young people.

RESULTS: Discussion of Sensitive SRHR issues: The internet platform (Facebook and WhatsApp) provided a platform where young people were able to freely discuss sensitive SRHR issues such as on abortion and LGBT without any fear and also get opinion of experts.

Increase in number of young people with SRHR information:

NAYA was able to reach 3 million young people (Facebook /Google Analytics) with SRHR information. NAYA was also able to reach 250 young people in the WhatsApp platform who with daily discussions with SRHR experts from different RH CSOs.

Willingness and openness to share experiences: Young people felt freer in the platforms and were willing to share their SRHR experiences challenges including generating different solutions to different SRHR problems.

Referrals and link to facilities: The young people seeking SRHR services in the Internet platform were referred to different young friendly health facilities.

LESSONS LEARNED: More young people prefer getting information from the Internet because it is more interactive, there is privacy, confidentiality and anonymity and one can express him/herself freely. It is often the first platform that young people will run to in seeking SRHR information. Young people also feel confident to discuss certain SRHR issues within the Internet platforms.

ENDING THE UNMET NEED FOR CONTRACEPTION AMONG ADOLESCENTS: WHERE THE SOLUTION LIES

Mark Gachagua

BACKGROUND : Worldwide, some 1.2 billion adolescents, aged 10-19, cover more than 16 per cent of the total population. About 15% of adolescent girls who are married or in a union are using modern contraception. In 2015, 12.7 million adolescent girls had an unmet need for contraception. This number will increase to 15.1 million by 2035 if current trends continue (UNFPA, 2016). SubSaharan Africa continues to lag behind the rest of the world, carrying a disproportionate burden of teenage pregnancy and maternal deaths. In 2012, the region continued to show the highest adolescent birth rates (ABR) at 118 births per 1,000 girls, slightly lower than the rate in 1990 of 123 births. In Kenya, the unmet need for contraception is highest among adolescents aged 15 – 19 at about 30 per cent. The level of unmet need continues to be higher in rural areas standing at 27% (Kenya FP-CIP, 2017). One of the main contributing factors to high unmet need for contraception is lack of adequate resources for family planning. Kenya is among the countries that have pledged commitment to FP2020. Translating this family planning funding commitment into action is one of the key solutions to ending the unmet need for contraception among adolescents in Kenya.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. DSW advocates for increased funding for family planning in Kenya under the SHAPE project (Securing Health through Advocacy and Peoples Empowerment). One of the primary outcomes of the project is to have clear budget allocations on family planning in key national and county health budgets in order to alleviate the unmet need for contraception among women of reproductive age, including adolescents. The organization works closely with the national government, 11 county governments (Meru, Laikipia, Mombasa, Kilifi, Nyandarua, Nakuru, Uasin Gishu, Trans Nzoia, Bungoma, Nandi and West Pokot), civil society organizations, youth and community members.

METHODOLOGY : In the past two years, DSW has been pushing for increased funding for family planning. In addition, the organization is supporting county governments to develop plans and strategies on reproductive health and specifically family planning. This has been done through: Establishment and strengthening family planning technical working groups, establishment of Civil Society Organization networks advocating for increased funding for family planning and or working in the reproductive health sector. Using both traditional and new media

to create awareness about family planning funding gaps and emerging issues in modern contraception and Joint costing sessions on Annual Work Plans for Health. Establishment of Civil Society Organization networks advocating for increased funding for family planning and or working in the reproductive health sector. Using both traditional and new media to create awareness about family planning funding gaps and emerging issues in modern contraception. Joint costing sessions on Annual Work Plans for Health. Development of Family Planning Costed Implementation Plans.

RESULTS: DSW has been able to work closely with the national ministry of health and 11 counties to develop five year costed family planning implementation plans. These plans both at the national and county level are used to: Ensure a unified country strategy for family planning is followed, define key strategies, activities, inputs and an implementation roadmap, determine demographic, health, and economic impacts of the FP programme, define a national and county budget for family planning, mobilize resources in order to secure donor, government and private sector commitments for the FP programming, coordinate activities and monitor progress of activities implemented by multiple stakeholders and finally provide a framework for inclusive participation by providing a clear framework for broad based participation of stakeholders within and outside of the ministry of health. Youth champions' requests or "asks" have been taken up by the county management team by committing to establish youth friendly centres in health facilities. In addition, champions have become the leading and authoritative voice in articulating sexual and reproductive health issues affecting adolescents in their respective counties.

LESSONS LEARNED: Kenya assented to the Family Planning 2020 goal and has defined clear objectives and made commitments related to programme and service delivery and finance/budget allocation and at the policy and political level to achieve its pledge. Translating government commitments on family planning funding into actions through implementation of plans developed is a sure solution to end the unmet need of contraception among adolescents. Meaningful involvement of youth in advocacy interventions helps youth better understand issues affecting their peers. This provides them with an opportunity to be part of the solution by providing sound feedback to policy makers and leaders. It is also worth noting that involvement of youth and adolescents is a sustainable strategy for guaranteed positive outcomes on increased modern contraceptive uptake among adolescents. This way, youth and adolescents become part of the much needed solution.

INCREASING ACCESS OF FAMILY PLANNING INFORMATION AND SERVICES AMONG ADOLESCENTS. (CASE STUDY OF UASIN GISHU COUNTY)

Frank Juma, Mark Gachagua

BACKGROUND: Globally SRHR issues affecting adolescents are largely contributed by lack of knowledge , agency or inadequate resources to enable them make informed decisions regarding their reproduction .this is according to international centre for research on women[ICRW]report 2017.WHO report 2017 indicates that improving adolescents access to contraceptive and ensuring their correct use is a major step and of great importance to global health. The report also indicates that 16 million adolescents aged 15-19 give birth each year mostly in low and middle income countries and many are mistimed or unintended. Adolescents comprise 24% of Kenya's population .This large population has implications on country's health and development agenda as it is likely to place increasing demands in provision of services. Contraception uptake is low with only about 26% sexually active adolescent girls using contraceptive methods. This is attributed to lack of access to information and services and existence of policy gaps and inadequate resources.Uasin Gishu county has an alarming prevalence rate of teenage pregnancy at 22% which is higher than the national prevalence rate at 18% (KDHS 2014).one in every five girls has begun child bearing hence there is need for clear cut interventions to address teenage pregnancy menace and unmet family planning needs in the county (AFIDEP).

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. Capacity building and trainings that targeted key county policy makers, adolescents and service providers. This helped a big deal in provision of quality modern contraception services to adolescents as

well as enhancing the knowledge level of duty bearers in the county. Implementation of comprehensive sexuality education in and out of schools to equip adolescents with relevant skills and information to enable the make informed choices on contraceptive use .Meaningful Involvement of family planning youth champions helped in dispelling myths and misconceptions associated with contraceptive use and public participation forums provided platforms for youth to advocate for increase in budget allocation to support family planning programs in the county.

METHODOLOGY: Advocacy on modern contraception has enhanced uptake and overcome barriers associated with contraception use. Methodologies used enhanced adolescents uptake of modern contraception through building capacity building of thirty family planning champions from the six sub counties namely Ainabkoi, Turbo, Soy, Kesses, Kapsaret and Moiben and this has led to creation of demand for contraception access.we participated in budget advocacy forums where we pushed for increase in budget allocation to support family planning programs in the county. Budget advocacy targeted key county policy makers. Their has been a significant increase of about 50% in the Uasin gishu county family planning budget and this is a major boost in adolescents quest to access modern contraception services. Imlementation of Comprehensive Sexuality Education [CSE] curriculum in and out of schools targeting adolescents has enhanced access to accurate information and informed decision making as well increasing access to modern contraception. Other methods used include use of online platforms to reach out to the adolescents audience with factual information on modern contraception. Engaging church leaders was very instrumental in reaching out to our target audience as they gave us maximum support and according us opportunities in churches and faith based institutions of learning to engage adolescents on modern contraceptive use. Male involvement was also key.

RESULTS: Family planning/ Contraceptive advocacy in schools and at community level is very vital in spearheading uptake of Family planning commodities/modern contraceptive among adolescents and will also help a great deal in making informed sexual decisions .Meaningful involvement of youth family planning champions in budget making process is very important as it helps in prioritization of pertinent sexual reproductive health and rights issues affecting adolescents. Civil society organizations and meaningful involvement of county youth family planning champions has helped in pushing for increased budget allocation to support family planning programs and establishment of youth friendly centres atleast one in the six sub counties to enhance access to accurate sexual reproductive health and rights information and quality youth friendly services. Implementation of CSE in and out of schools both in rural and urban setting has significantly reduced cases of teenage pregnancies and increased utilization of modern contraception among adolescents. Comprehensive information and knowledge about family planning can help us address the myths and misperception associated with access to modern contraceptive while refresher trainings targeting youth friendly service providers can make access to Family Planning much more friendlier and ensure quality services are accessible to adolescents and youth. Political support from national government and Uasin Gishu county political leaders is very key in facilitating family planning awareness campaigns and doing away with deeply rooted social and cultural norms thus enhancing uptake of modern contraceptive. Male involvement in family planning, contraceptive uptake is key in enhancing uptake of modern contraceptive.

LESSONS LEARNED: Based on the evidence base in regard to interventions that have worked directly or indirectly to impact on the contraceptive knowledge,attitudes and practices of adolescents in developing countries and most so in Kenya. Its important to understand the various advantages and limitations of the unique and diverse interventions implemented over the years, I feel there is a path forward which includes, creating an enabling environment that enables adolescents to overcome the demand and supply barrier that effectively and sustainably use contraceptive to reach their fertility desires in future years. Information acquired through advocacy on contraceptive can be used by policy makers to bridge the gaps in existing Sexual reproductive health and rights policies to enhance their full implementation. Donor partners with interests in sexual reproductive health and rights should invest in sustainable programs that are well tailored towards meeting the unmet contraceptives needs of adolescents more comprehensively. We should also consider multi component interventions like combining mass media programming and capacity building for local organizations. Monitoring and evaluation of all programs aimed at influencing adolescent sexual reproductive health outcomes. Building capacity of youth Family planning champions through trainings and refresher trainings will ensure a sustainable strategy of creating demand for access to modern contraceptives by adolescents in the county .Youth friendly service providers should be trained to effectively meet adolescents unique unmet needs when it comes to provision of modern contraceptive .Adolescents communication and negotiation skills related to adolescents reproductive desires should be enhanced to their reproductive desires.

AMPLIFYING MENSTRUAL HEALTH OF ADOLESCENTS AND YOUTH THROUGH POLICY CHANGE

Bridgit Kurgat

BACKGROUND: Historically menstrual issues have occupied the lower echelons of national priorities. However, international and national policy makers have increasingly recognized the impacts that menstrual health challenges have on the rights of adolescents' general development. Onset of menarche is a lifetime event of any woman yet few studies and interventions have been put in place to explore its impact. The country has taken interventions directly or indirectly to cater for adolescents' reproductive health. In April 22, 2014 the senate passed the Reproductive Health Bill, 2014 which is an Act of Parliament to provide recognition of reproductive rights. In an attempt to address menstrual issues, the government has undertaken three major interventions; In 2011, government policy allocated 240 Million shillings annually towards the provision of free sanitary pads to girls in public government schools through the National Sanitary Towel programme. The budget was later increased to 400 Million in 2015. The Kenyan government removed import duties and value added tax on menstrual hygiene products and solutions. Ministry of Health through collaboration has launched the Menstrual Hygiene Guideline.

DISCUSSION: Education and behavior change was the main intervention through: Menstrual Hygiene Management and Menstrual pain management advocacy in schools and communities to break the silence on menstruation, Awareness raising around the community to ensure that menstrual hygiene management is a concern to everyone, Training students and teachers by equiping them with information, resource mobilization through fundraising and identifying potential donors to buy menstrual hygiene products, participation of menstrual hygiene day, door to door visitations to create awareness on menstrual awareness as well collect information on community menstrual health practices and County budget lobbying for allocation of funds for sanitation.

METHODOLOGY: The intervention was carried out in Turbo Sub-County, Uasin Gishu County located North West of Eldoret town. The subcounty has a population of 208,583 as per the last census and an area of approximately 365.60[2]. This study took a qualitative approach and run between November 2016 to February 2018 in four secondary schools in the region targeting 1000 girls from form one to form four, guidance and counselling teachers of all the four schools and also interviewed a total of 50 women in the villages surrounding the school. During these meetings we administered interviews alongside focus group discussions with questions on demographics, schooling experience during menstruation in terms of access to sanitary pads, proper sanitation and menstrual pain management. We also asked questions on the level of support received from parents and the community at large.

Evaluation was based on the efficiency and nature of the process of implementation of specific policy programmes as intended, whether the programme is needed and the discernable impact it might have had.

RESULTS: Girls received sanitary towels from the National Sanitary Programme although it was not enough to cater for all students in the schools' therefore the pads were left in school offices to cater for the neediest students who had nothing to use. Girls who needed extra sanitary towels because of heavy flow were subjected to borrowing from friends while others opted using tissue paper as menstruation was seen as a personal affair and in fact regarded as a taboo subject and wasn't your neighbors' concern. Despite getting sanitary towels from the government programme, the girls did not receive and information on sanitary towel use and disposal.

Many girls cited menstrual pain discomfort as a major barrier to class attendance. Majority complained of extreme stomach pains accompanied by diarrhea, fever, fatigue, backache and vomiting. From the sample of girls interviewed, only two reported seeking gynecological help for the extreme pains reasons being extreme pain was normal and most of their siblings and mothers had undergone it. The girls expressed concerns on the lack of support during such moments with no provision of hot fluids or painkillers. Girls with disability were most affected as a result of proximity to the toilets especially at night. Lack of proper education on hygiene also led to infections as expressed by some girls who complained of itching in their private parts. Parents interviewed expressed lack of financial muscle to cater for enough sanitary towels and in regards to menstrual pain majority expressed it as being normal and was there from the olden days and medicine from hospitals cannot deal with menstrual pain. Most of their girls were treated with traditional herbs. They expressed concerns that using hormonal therapy would destroy their children's health as well as encourage promiscuity.

LESSONS LEARNED: There is need for collaboration from different sectors to continuously raise awareness on menstrual health to break menstrual barriers as well as demystify myths surrounding the topic. Menstrual health should be given more attention as an emerging issue in the field of Sexual and Reproductive Health and not assumed to be more of a water and sanitation agenda because of health impacts it has on women especially on cases related to secondary dysmenorrhea. Menstrual Policies should not only focus on sanitary distribution but look more into sociocultural barriers surrounding the issue. There is information regarding how menstrual issues were handled in the past

in terms of who should handle menstrual topics, which medicine to be given in order to manage menstrual pain and at what age should one be given medication. Menstrual policies and menstrual health issues are easy to implement and and talk about if community leaders in the society e.g. those in political and administrative posts talk about the topic unlike unfamiliar people. It was also easier for young people to talk to young boys and girls on sexual and reproductive health topics compared to parents and teachers. Sensitization should be done to parents, teachers and health practioners on how best to manage menstrual pain by providing a supporting mechanism to school going girls in order to reduce suffering and boost class attendance during menstrual periods.

EMPOWERMENT OF YOUNG PEOPLE AND ITS RELATION TO THE ACHIEVEMENT OF REPRODUCTIVE HEALTH AND RIGHTS

Judy Amina, Kenya SRHR Alliance

BACKGROUND: Often, young people do not realise their Sexual and Reproductive Health and Rights (SRHR) and their right to meaningful participation due to restrictions at societal, institutional and political levels that reinforce the taboos on young people's sexuality, leading to (among others), unintended (teenage) pregnancies, unsafe abortion and sexual and gender based violence (SGBV), and new HIV infections. Towards this the Kenya SRHR Alliance believes that having a generation of empowered young people who are able to voice their rights, willing to claim their rights and play a meaningful role in SRHR interventions is a necessity. Meaningful youth participation (MYP) and youth-adult partnerships (YAPs) are found to be crucial in enhancing SRHR for young people. Without involving young people in a meaningful way, it is impossible for SRHR and family planning (FP) programmes to adequately meet the needs of young people. For this reason, MYP and YAPs are key strategies of the *Get Up, Speak Out (GUSO) for youth rights* programme. GUSO aims to improve the SRHR of young people in seven countries: Ethiopia, Ghana, Indonesia, Kenya, Malawi, Pakistan, and Uganda. The GUSO consortium consists of Aidsfonds, CHOICE for Youth & Sexuality, dance4life, IPPF, Rutgers, Simavi and their in-country implementing partners.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. To investigate how empowered young people feel to contribute to changes on the target group (10-24) and social environment in which the GUSO programme operates, to evaluate the levels of youth adult partnership in relation to achieving GUSO programme objectives and to identify the different dimensions of youth engagement and empowerment in the GUSO programme. The research aimed to find out the level of confidence of young people working in GISO, whether they are being heard, if they can make decisions regarding GUSO and their interactions with adults in their organizations

METHODOLOGY: The Kenya SRHR Alliance through the GUSO programme in 2017 conducted a baseline research on the levels of MYP and engagement of young people in the Alliance and specifically in the GUSO programme. The research was conducted through an online survey with 29 young people in July 2017 and four follow-up focus group discussions (FGDs) with 23 young people in Kisumu and Nairobi Counties on September 14th and 18th 2017 respectively. Because of the aim of the research, the survey and FGDs focused on young people who are actively involved in the GUSO programme and not the beneficiaries per se.

RESULTS: The baseline research provides key insights and recommendations on how young people are being meaningfully involved in the Kenya GUSO program Young People at the Kenya GUSO programme feel that the adults in their organizations communicate to them regularly and in a transparent way but not as often or as clearly as they would like. The young people state that they can easily share their doubts about the GUSO program with the adults in their organizations and have positive interactions between one another. A majority of the young people indicate that they have responsibilities given to them however they would wish to have more responsibility than what they currently have. The young people share that their schedules should be considered when planning for activities involving them. (42%) of the YP feel that they can make decisions regarding the GUSO programme or activities with the support from the adults working with them and almost all of the young people in GUSO programme have adult coaches

who guide and mentor them. Young people agree that adults in their organizations communicate to them regularly and in a transparent way about GUSO however they still feel it's not as often or as clearly as they would like. The young people indicate that they are mostly involved in advocacy (65%), implementation (64%), reporting (58%) and Research/ M&E (42%). They feel that they are least involved in design (27%) and budgeting (19%).

LESSONS LEARNED: The GUSO programme has been able to reach and work with more young people as compared to other programmes. The young people report getting empowered and gaining skills that have helped them in the implementation of the programme at their specific implementation areas and the national level. The young people however require their capacity to be built in order for them to participate meaningfully in the GUSO and to confidently take up on the tasks given to them. Youth adult partnership should be encouraged for the programme so as to continue enhancing the meaningful involvement of young people, youth led advocacy and realization of better SRHR outcomes for young people. The involvement of young people in addressing issues that largely affect them like access of family planning services and commodities, access to safe abortion etc. gives a sure way of achieving set out objectives because young people are able to provide proper development of solutions to their own problems. Meaningful involvement of young people gives them a chance to speak better about their issues, their needs, preferences and make decisions for themselves which are realistic and sustainable. In addition, previous interventions that have been made for young people without involving them failed to make significant changes that benefited the targeted young people.

FROM SENSATIONALISTS TO CHAMPIONS: THE PLACE OF THE MEDIA IN SRHR ADVOCACY

Denis Otundo , Victor Rasugu, NAYA-Kenya

BACKGROUND: The mass media has huge prospects in reporting on sexual and reproductive health and rights. However, mainstream news outlets neither prioritize SRHR nor report accurately on it, particularly where young people are concerned. The coverage of such issues has been poor as a result of inadequate capacity and low motivation of media practitioners as well as lack of credible and consistent sources of information on SRHR. This paper therefore describes the experiences of the Network for Adolescent and Youth of Africa in building the capacity of the media in covering reproductive health on the basis of evidence, while at the same cultivating their interest on the same.

METHODOLOGY: This paper uses a case study approach based primarily on the personal experiences and reflections of the authors and documented evidence on media engagement at NAYA that has evolved over the years. NAYA's media strategy has moved from just the conventional techniques of relaying reproductive health information through press releases and newspaper stories to diverse approaches that seek to inspire journalists to not only report on SRHR based on evidence but also to provide for policy analyses on reproductive health issues facing the younger and youthful generation. The approach starts with establishing contacts and maintaining trust and mutual relationships between journalists and NAYA through regular meetings, field visits and enhancing formal relationships with media houses and individual journalists. It then moves to building the capacity of journalists in SRHR reporting and identifying credible sources of information that provide balanced coverage with regard to diverse voices including those of young people, service providers, SRHR advocates and policy makers. The approach includes enhancing the media's interest in and motivation for reporting on RH through trainings, regular technical assistance sessions and competitive awards for outstanding coverage.

RESULTS: Despite the widely held beliefs of inappropriateness of SRHR discussions especially in pubic discourses, NAYA continues through commentaries and analyses of the policy environment, to guide the media in finding the news value in SRHR without necessarily being alarmist. Our weekly radio shows, newspaper articles, blogposts, and once in a while TV talk shows provide insights that close the information gap on SRHR by providing to the media accurate information that is backed by laws and policies. To date, NAYA has published over 100 articles in the media on SRHR. The media then deconstructs myths on SRHR with the view of projecting it as a development agenda which, like any other issue in the public sphere, must be addressed though progressive laws and policies.

LESSONS LEARNED: From our engagements with journalists, we have come to learn that with a media fraternity whose grasp of SRHR issues is good, there is bound to be balanced information especially where forums for free deliberative discussions are allowed. And the media is poised to be better SRHR champions due to the wide reach they command.

GOING BEYOND SEX AND REPRODUCTIVE HEALTH EDUCATION FOR PRIMARY SCHOOL GIRLS IN RURAL AREAS: CASE OF BUTONGE PRIMARY SCHOOL IN BUNGOMA COUNTY.

Caroline Nekesa

BACKGROUND: The new school curriculum adopted in Kenyan primary schools has been identified as a significant platform where pupils receive basic Sex and Reproductive Health (SRH) education.

However, this initiative is not sufficient in dealing with matters on sex, sexuality and sexual orientation for primary school girls. Notably, the conservative approach towards sex, sexuality and sexual orientation in the society is a significant problem that hinders the intended effectiveness of school-based SRH education. Notably, the community considers sex topics a taboo and hence there lacks support in the community for SRH education practical adoption. Furthermore, conservative and gendered attitudes and beliefs to young girls' sexual activity by health practitioners and religious institutions worsens the poor awareness on sex matters for this cohort. Notably, rampant problems such as teen pregnancies, prevalence of Sexually Transmitted Diseases (STIs), and sexual exploitation for money within this cohort highlight the extent of the problem. This paper identifies that SRH education provided by the primary school curriculum is not sufficient in addressing sex problems affecting young primary school girls in rural areas. To this effect, this research intends to highlight the importance of creating awareness through the community and government initiatives. Creating awareness and the involvement of these stakeholders ensures that the root cause of sex-related problems for young primary school girls particularly in rural areas is addressed.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa.Sex awareness initiatives in the community that go beyond Sex and Reproductive Health (SRH) education are vital in alleviating sex-related problems for primary school girls in rural areas.

METHODOLOGY: The study's cohort is based in Bungoma County. This study adopts a case study design. The design is in line with the qualitative method used to collect in-depth data from the respondents. Interviews were conducted to obtain data from the respondents, which enables the researcher to obtain in-depth insights and views from the interviewe. Data source for the study is firsthand information collected using interview protocols containing information provided by the interviewees. Data collection time frame for the study is one month. A sample size of 12 pupils the age bracket 9-16 from Butenge Primary School in Bungoma County will be used. The sample size for the study is determined based on resources available, time frame and the objectives of the study. Content analysis method will be used as the method of data analysis for this study given the need to gain insights from textual data.

RESULTS: The study findings of the research fall into four categories, which are reproductive health challenges, lack of awareness on sex, sexuality, and sexual orientation, lack of appropriate communication channels in the society, and lack of adequate policies and facilities that discourage gender discrimination and promote effective SRH education in the community. Notably, reproductive health availability and awareness in this cohort is poor, a factor evident from unreported cases of sexually transmitted conditions and poor reproductive health management. Furthermore, the findings reveal that the target population lacks knowledge and a sound medium through which SRH education is supported in the community. Furthermore, public institutions, particularly the health care centers hardly adequately addresses SRH issues for young girls in the 9-16 age bracket. As a result, this target group suffers in silence given the multiple inefficiencies and problems surrounding SRH education and management for this group.

LESSONS LEARNED: This research identifies that there is a gap in society as pertains to SRH education, particularly for primary school girls in the age bracket of 9-16 years. The gap is fueled by lack of adequate mechanisms in the community that aid in the provision, implementation and adoption of SRH education. Additionally, basic SRH education provided in primary school doesn't effectively address the problems surrounding sex, sexuality, and sexual orientation in the community. The study highlights that stakeholders that is the government, health departments, and the community should support and facilitate adoption of SRH education by facilitating awareness and support programs. SRH education initiatives that go beyond the standard SRH provided in primary schools would help prevent, control, and manage sexually transmitted diseases among young primary school girls, support their SRH awareness, and improve their quality of life.

FRONTING FOR ELIMINATION OF FEMALE GENITAL MUTILATION/ CUTTING

Onyimbi Nelson, Youth Advocate NAYA Kenya.

BACKGROUND: Thousands of girls in this country yearn to be part of the cohort that successfully makes the transition from childhood to adulthood. In this way, priorities and responsibilities experience a shift. However, for some girls, this transition is marred by backward and outdated practices in some cultures that only end up posing life-threatening scenarios. A good example of such practices is female genital cutting (mutilation), or often referred to as FGM/C. In some communities in our country, this archaic practice is embraced as a form of initiation. Many times it is a forced practice, which is meted on a number of individuals without their consent. The larger picture indicates that a staggering total of 9.3 million women (constituting 27% of all women and girls population in Kenya) have undergone genital mutilation (UNICEF state of affairs, 2013), putting these girls and women at risk of infections, over-bleeding, physical harm and psychological disturbance. This practice is also a setback in the fight for achievement of the highest attainable standards of health, including reproductive health. It has been a major issue in SRHR over the years that needs to be tackled with the importance it deserves.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. The Prohibition of Female Genital Mutilation Act (No. 32 of 2011) "to prohibit the practice of female genital mutilation, safeguard against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes" is widely supported by The Constitution of Kenya, 2010, alongside other legal provisions such as The Penal Code and The Children's Act No.8 of 2001 (section 14). The sections of the Constitution with regards to female genital mutilation are Article 44(3) and Article 53(1, d) which are widely advocated for by NAYA Kenya alongside other organizations with similar intent.

METHODOLOGY: World Vision International has developed a concept of safe houses where young girls that escape the act of FGM can be housed, protected and provided for as solutions around their cases are worked on. Alongside other NGO's, they provide legal aid and education, medical assistance, training community service providers and psychological support. Through awareness campaigns and public forums, alternative methods have been introduced and preached. Nice Nailantei Leng'ete as a Champion against FGM has been able to save approximately 15,000 young girls from FGM in seven years, giving them an opportunity to go to school and start careers. Her advocacy platform campaigns to uptake alternative rites of passage while at the same time, maintaining culture without FGM. This enforcement of the Penal Code outlaws the deliberate infliction of "grievous bodily harm" including FGM. Medical Practitioners and Nurses are also bound by their legal bodies' existent laws against participating in FGM. Other laws include The Children's Act, 2001. **RESULTS:** Some participating communities in campaigns against FGM have little or no knowledge on the FGM laws and the National Policy which makes it a challenge in the struggle to abolish FGM. Some communities look down upon girls who take up alternative methods of initiation, as such, it takes a toll on some of these young girls who end up sneaking to undergo FGM in order to be validated by the society. A large number of young girls have the will to legally pass through school, have careers and have families without necessarily passing through the trauma associated with FGM. Culprits arrested and charged based on the existing laws sometimes get away easily after being fined subtly, which goes back to haunt the community in the form of continued FGM practice.

LESSONS LEARNED: FGM is a deeply rooted cultural practice in some communities. However, the campaigns and advocacy strategies should be intensified. The affected youth should be able to have a platform where they can voice their concerns. The fight against FGM is more of a change in attitude and cultural practice rather than a preaching to implement legislations and policies. These legislations and policies come as props and the best way to dispense this knowledge and information is through advocacy and voiced concerns on relevant platforms.

EFFECTS OF FGM ON ADOLESCENT SEXUAL REPRODUCTIVE HEALTH RIGHTS (SRHR) IN THARAKA NITHI COUNTY IN KENYA.

Lacton Mugambi, SRHR Project Coordinator, GRADIF-Kenya Foundation.

BACKGROUND: Sexual Reproductive Health Rights (SRHR) is one of GRAID-Kenya's key components under Social Protection thematic area. Consequently, one of the of GRADIF Kenya's interventions is to create awareness of the dangers of Female Genital Mutilation/Cutting (FGM/C) among adolescents and youths to minimize the dangers and effects of the same. GRADIF-K is implementing a systematic SRHR Project funded by the Planned Parenthood Global (PP Global) through the Youth Peer Provider Model (YPP) which is helping reach out to adolescents and youth with appropriate information and servicesincluding on FGM/C. Currently, GRADIF K is employing various methods and interventions to rescue girls and women from this retrogressive and rights violation practice in Tharaka Nithi County. We are also partnering with various duty bearers including the county government, development partners, Civil Society Organizations (CSOs), men among others to ensure that the practice is curbed.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. In TharakaNithicounty, just like globally, FGM/C is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health and education consequences (WHO, 2008). For example, babies born to women who have undergone female genital mutilation suffer a higher rate of neonatal death compared with babies born to women who have not undergone the procedure. The girls and young women who get the cut are likely to drop-out of schools and jeopardise their social-economic life and later live in poverty. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women (WHO, 2008). Women and girls in Tharaka Nithi are not valued like men and boys. The society is purely patriarchal Female Genital Mutilation/ Cutting (FGM) is nearly always carried out on minors and is, therefore, a violation of the Rights of the Child. The practice also violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruelty, inhuman or degrading treatment, and the right to life when the procedure results in death. In developing world especially Africa, the practice is so common and it denies equal opportunity to girls in relation to education and economic development. It also denies the victims enjoyment of their sexual and conjugal rights during marriage.

Women and girls are highly marginalized in TharakaNithi County both socially andeconomic terms due to FGM/C. FGM/C affect the physical and psychological health of girls and women; decreases their attendance and performance at school; fails to meet their gender equality rights; and risks their lives at the time of FGM/C, at marriage and during childbirth. FGM/CC also has a relationship with other issues such as girls not completing their education and having poor literacy; early or arranged marriage; the spread of HIV AIDS and poor access to physical health and psychological health care. The perceived benefits of FGM/C include Cleanliness/hygiene Social acceptance, Better marriage prospects, Preserve virginity/prevent premarital sex, more sexual pleasure for the man, religious approval, reduce promiscuity/reduce sex drive, reduce STI and HIV/AIDS. Most communities report differently on the importance of FGM/C although they fail to report the negative effects of the vice. The link between HIV and FGM/C is a complex and contested issue amongst researchers. The WHO multi-country study found that although no studies link HIV/AIDS and FGM/C directly, haemorrhaging subsequent to the operation, bleeding during sexual intercourse as a result of lasting damage to the genital area and anal intercourse where infibulations prevent or impede vaginal intercourse are all potential sources of HIV transmission (WHO, 2006). Using data from the DHS 2003 report on FGM/C in Kenya, one study suggested that circumcised female virgins were substantially more likely to be HIV infected than uncircumcised virgins. The authors concluded that HIV transmission may occur through circumcision-related blood exposure (Brewer et al., 2007). A further study reported that a plausible mechanism of HIV transmission for females was through the use of a non-sterilized ceremonial knife on several girls, where one of the girls was infected with HIV through a non-sexual mechanism before

undergoing FGM/C (Pépin et al., 2006).

Various development agencies, both National and international organizations have played a key role in advocating against the practice and generating data that confirm its harmful consequences in this County. NGOs leading the fight against the practice in the County include the United Nations Fund for Population Activities (UNFPA), Kenya Ant-FGM Board World Vision Kenya, Plan International-Tharaka Unit and GRADIF- Kenya Foundation among others. Others include; ant-FGM activists and supporters. The support they have provided is valuable in creating awareness about the dangers of FGM to girls and the entire communities at the grass root level to eradicate this culture of circumcising girls/women. However, their support is limited and does not empower girls fully.

RESULTS: Reduced school drop put rates among girls, Improved academic performance amongst girls, increased knowledge about FGM/C and other related matters among the community, parents, teachers and learners, increased reporting of FGM culprits to the relevant authorities, increased support of the project my men both and young, reduced incidences of school absenteeism reported by teachers, reduced incidences of superiority antagonism between circumcised and uncircumcised girls, increased demand for Ant-FGM/C campaigns in most regions in the county and beyond and increased transition rate among girls from primary to secondary schools.

ADOLESCENT SEXUAL RIGHTS: AN ANALYSIS OF SECTIONS 8 AND 43(4)(F) OF THE SEXUAL OFFENSES ACT

Victoria Nanjala

BACKGROUND: The social construction of adolescent sexuality has shaped how the concept of adolescent sexual rights has been construed over the years. The legal construction of adolescents as incapable of making decisions regarding their own sexuality limits the enjoyment of sexual rights by adolescents. This affects the availability, quality and accessibility of services and facilities required by adolescents to ensure that they are afforded the highest attainable standards of health, more specifically sexual and reproductive health. This paper is concerned with the legal disempowerment of adolescents as regards their sexual rights, autonomy and agency. Section 8 criminalises consensual sex between adolescents. Section 42 incapacitates adolescents from consenting to sexual activity, by applying a blanket provision for adolescents under the age of 18, and disregarding their evolving capacities. Apart from regulating sexual conduct, these provisions constitute 'a framework for expectations and norms for parents and professionals working with young people' that determines how they seek to shape and influence young people's health-seeking behaviour. While it is not in dispute that the state has the responsibility to protect adolescents from early sexual debut, it is also important to recognise the evolving capacity of adolescents to make certain decisions about their own sexuality and sexual health and to participate in the formation of policies that affect them.

METHODOLOGY: This paper is written against the background of the Kenyan society and the main reference point being the specific provisions of the Sexual Offenses Act of Kenya. The research was done by way of library study and use of online resources. The SOA was the main point of reference but a publication by IPPF was equally instrumental in the acquisition of data. The other materials include the National Adolescent Sexual and Reproductive Health Policy and the world health organization guidelines on adolescent health. Case law has also been of substantial contribution. The main reference case is the Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development, whose judgement on the sexual rights of the adolescents was outstanding.

RESULTS: That, sexual rights are indeed human rights and therefore they need to be respected, protected and enforced by the government and other stakeholders involved. Just like other human rights, sexual rights are inalienable and are interdependent with the other rights in such a way that once sexual rights are infringed upon, the general well-being of the victim is violated. The government and its institutions and other stakeholders are obligated to respect, promote, protect and fulfil sexual rights of adolescents. That the legal and social construction of adolescent sexuality in Kenya, like in other African jurisdictions, has been instrumental in disempowering adolescents; constructing adolescents as sexually passive defeats the aim of making adolescents partners in guaranteeing and enforcing sexual rights. For instance one of the consequences of such discrimination is the stigmatization of adolescents who are sexually active. Lastly, there is need for policy reform for instance to enhance the capacity of stake holders in the different organs that deal with adolescent sexual health to understand and recognize evolving capacities of adolescents and to support them to remain healthy, without judgement or discrimination from the judiciary to the health sector and to the education sector as well. There is need for policy provisions for adolescents to receive appropriate information to make informed decisions about their sexuality. Age appropriate information is a controversial topic and therefore provision of this information should be based on the evolving capacities.

LESSONS LEARNED: It is my conviction that the application of sections 8 and 43(4)(f) is a gross violation of the autonomy and agency of adolescents. It limits the adolescents' enjoyment of sexual health and sexual rights. Sexually-active children may not receive the guidance and support necessary for them to develop their capacity for sexual self-determination. Caregivers and parents may assume restrictive attitudes around adolescent sexuality and fail to provide this support. The consequence of failure to support children is unwanted or unprotected sex, unwanted pregnancies, unsafe abortions and sexually-transmitted infections, including HIV.

The case of Martin Charo v R illustrates the creation of a stigmatised subjectivity. In this case, a girl of 14 had voluntary sexual intercourse with an adult man. In the Appellate Court's opinion, a girl who voluntarily engages in sex behaved like a grown woman, and did not deserve the protection of the law. The Court effectively constructed the girl as a deviant child because she expressed sexual desire and agency. In Teddy Bear Clinic for Abused Children case, the Court addressed the question whether criminalising consensual sexual conduct between adolescents was necessary to achieve the aim of protecting adolescents from harmful sexual intercourse. The Court concluded that, criminalisation infringed on a host of rights, including the rights to dignity, privacy, bodily and psychological integrity and health care services, young people who are sexually active would be stigmatised, and denied support. Therefore, the process of reform should be less about making additional laws than about how to fashion better sexual relations laws that are more adolescent- centric. Laws that promote free access to quality goods and services that adolescents require for their sexual well-being. The first step to achieving this is by revisualising adolescent as sexual and as partners rather than passive subjects.

USE OF DIGITAL PLATFORMS TO REWARD ADOLESCENTS FOR ACCESSING SRH SERVICES AND INFORMATION

Renard, Benoit; Matikanya, Richard; Mwangale, Vanessa; Ribeiro, Admillo; Donjon, Nathalie-Ann; Kupfer, Marylou; Gitau, MaqC

BACKGROUND: In Kenya, adolescents aged 15-19 constitute 24% of the population (Kenya Demographic Health Survey - KDHS 2014). However, adolescents have little access to sexual and reproductive health (SRH) information and often face judgement when accessing services. This leads to high rates of teenage pregnancy and unsafe abortions; 15% of women aged 15-19 have already had a birth, and 3% are pregnant with their first child; only 49.3% of unmarried sexually active and 36.8% of currently married 15-19-year-old women are using a modern method of contraception; and there is 23% unmet need amongst this age group (KDHS, 2014). Notably, the proportion of teenagers who have begun childbearing has not changed since the 2008-09 KDHS (KDHS, 2014), highlighting a critical need for programs which focus on increasing family planning uptake amongst adolescents. While the field of behavioral economics has extensively studied the relationship between motivation and behaviour - and Triggerise incorporates these insights in developing its digital ecosystem - few researchers have studied the relevance of motivation to adolescent family planning uptake. Triggerise's digital platform provides us with the unprecedented ability to not only study motivation behind family planning uptake, but also allows us to analyze results generated in real time.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. In 2017, Triggerise implemented a youth program in Kenya, which centers around a digital platform to reward adolescents for uptake of SRH products and services. Tiko Miles are virtual reward points which are spent just like real money in the local market. This puts a real value on positive behaviour, making it desirable and aspirational. The platform sends out targeted messaging and reminders and includes a map showing locations of service providers as well as ratings provided by adolescents themselves. This ecosystem creates an enabling environment for improved communication and uptake of SRH services, with data available in real time.

METHODOLOGY: After piloting in Mombasa and Nakuru counties, the ecosystem was scaled up in December 2017 to 18 counties in Kenya including 1,604 agents and 269 health facilities. Agents from within communities engage with adolescents on SRH issues, refer for free services and register them onto the platform; a trigger is sent to a cloud-based platform which sends a code to the adolescent to validate

the interaction. Once the adolescent receives a service, which is again validated by a trigger at the facility, all actors receive Tiko Miles to reward the positive behaviour. Adolescents can access services including counselling, all family planning methods, emergency contraception and HIV, STI and pregnancy testing. Retailers and stockists are also registered onto the platform, in which Tiko Miles can be redeemed. Different solutions are available for high technology (smartphone application), low technology (SMS application) or no technology (Tiko card). This ensures that all adolescents can interact with the system irrespective of their access to technology. The system is monitored daily by a data analyst and configured with restrictions to mitigate the risk of fraud. If suspected of fraud, the system is blocked for the specific actor and a risk management strategy implemented.

RESULTS: As of March 2018, 17,696 adolescents have been enrolled onto the system since May 2017 with steady growth in both the number of girls enrolling, and accessing services. The current conversion rate from enrolment to service uptake is 45%. In total, 7,995 adolescents have accessed SRH services of which 4,863 are for family planning methods. Method mix includes 18% implants, 7% IUDs, 22% oral contraceptives, 6% injectable, 19% condom and 28% emergency contraception. Of the family planning services offered, 25% chose a long-term method. There is an increase in uptake of long-term methods from 16% in the first 6 months compared to 26% in the latter 6 months of the first year of the project, with biggest increases seen in implants (2063%). Injectables increased the lowest (6%), suggesting improved counselling on the benefits of using long-term methods. Of the adolescents who received a service, 4,282 provided a rating with an average rating of 4.5 (out of 5). The opportunity to rate the service creates a pressure and feedback loop to greatly improve the provision of quality services for adolescents.

LESSONS LEARNED: The use of a digital ecosystem to reward positive behaviour choices successfully leads to increased uptake of sexual reproductive health services by adolescents. The Tiko Miles rewards increase adolescent desire to uptake these services as well as increasing their purchasing power and financial independence. As the rewards are also offered to agents and service providers in the ecosystem, the agents drive higher demand for services, and the providers are willing to offer youth-friendly services. In addition, the opportunity to rate the service gives more incentive to providers to offer a quality, non-judgemental service. The ecosystem creates an enabling environment that addresses both demand and supply-side barriers, ensuring that adolescents have improved desire to access family planning information, services and products. In turn, the platform is a valuable resource for better understanding adolescent SRH needs, and can be used to send reminders for those on short-term methods, and offer them rewards for returning for a service or for taking a long-term method. Understanding that only 45% of adolescents in Kenya have access to a mobile phone, the availability of high, low and no technology solutions ensures that the rewards-based platform is accessible to all adolescents. Whilst traditional voucher programmes are subject to much fraud, the availability of real-time data from the platform ensures that issues are easily apparent and can be dealt with quickly using the risk management framework. Specific actors can be blocked from the system instantly, preventing any further fraud.

THE USE OF MOBILE APPLICATION IN ENHANCING HIV KNOWLEDGE AND REPRODUCTIVE HEALTH AMONG YOUTHS IN WESTERN KENYA

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(MTRH Rafiki Center program)

Brian Kwendo2; Edith Apondi2; Carole McAteer1, 2; Rachel Vreeman1,2; Winston Nyandiko2,

BACKGROUND: The number of young people in sub-Saharan Africa using smart phones is increasing, and most of them use mobile applications to get information and news. Mobile platforms can also provide information and autonomy for the user to engage in the information when needed, as well as marketing and personalized communication. A mobile platform targeted at improving HIV knowledge among youth in sub-Saharan Africa could provide needed information, even to those not currently accessing HIV services.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. The use of mobile application in enhancing HIV knowledge and reproductive

health among youths in Western Kenya

METHODOLOGY: "HIVFactSheet" is a youth-friendly mobile application, developed in western Kenya that can be downloaded from Google Play store. Once installed in an Android mobile device, the appworks offline to provide access to multi-media educational components on: HIV prevention, HIV testing, General HIV knowledge, Antiretroviral Therapy, Adherence, Disclosure & sexual reproductive health.Some of the application content including short films and narratives were developed within an NIH-funded study to develop a counseling intervention to improve HIV disclosure.

Support groups and bi weekly health talk forums at Rafiki center were utilized to reach the adolescents and young people. Appointment reminder in the app was also used during one on one sessions where the adolescent were helped to fix their clinic dates in the app to be reminded. Through the application young people were able to call, text or email, a counselor who offers counseling to them and referred them to clinics for further support whenever needed.

RESULTS: Since the launch on 1st December 2017 to 31st April 2018, 822 young people have accessed comprehensive HIV information including the reproductive health messages using the HIVFactSheet application. 84 counseling services were offered by the online counselors, while 128 referrals from the calls, text received were made in various clinics. Youth development of this resource enhanced both cultural relevance and appropriateness for the youth population.

LESSONS LEARNED: The use of mobile platforms tailored to youth in sub-Saharan Africa can help us improve access to comprehensive HIV information and bridge the gap for access to resources and care, which can be utilized by youth and other key populations. We also learnt that the provision of factual information is key in enhancing access to health services, positive living and eliminating stigma & discrimination among young people. It also facilitates informed decision-making and enables community members to understand HIV and reproductive health better, potentially improving access and reducing stigma.

USE OF MOBILE PHONES TO ENROLL ADOLESCENTS INTO AN ECOSYSTEM THAT CAN ALLOW THEM TO ACCESS FREE SEXUAL REPRODUCTIVE HEALTH SERVICES

Martin Okhako Jackson

BACKGROUND: Technology has been embraced by many Sub-Saharan African countries so fast. According to the Quarterly Sector Statistics Report by the Communications Authority of Kenya, mobile penetration is at 88.1% (37.8M users), large proportion being adolescents between 11-17 years. 4.2% of that proportion have access to internet via mobile phones. The increased crave among adolescents to own and access information via mobile phone has become almost like a basic need. Kenyan adolescents face a lot of challenges in accessing SRH services which include lack of information, stigma associated with access to contraceptives among 19 years old and below and judgmental/ non youth friendly providers. Mobile phones are a powerful tool that can be used to bridge the gap between information access/sharing on Sexual Reproductive Health (SRH) issues and actual service uptake. According to The Knowledge for Health (K4Health) research brief Jan 2007, nearly 20% of programs use mobile phones to link adolescents to SRH services and modern contraceptives. 82% of these programs use mobile platforms to facilitate knowledge sharing and behavior change to improve adolescent SRH.

DESCRIPTION: As the world is getting into digital media and technology advancement, Digital Media such as websites with search engine optimization and social media platforms when used in a hip, young, friendly understanding language proves to be the first referral when young people Google on abortion. The use of Telecommunication Technology, the intervention recommends the use of telecommunication technology strategies such as hotlines which are safe, confidential and all time reliable to obtain proper Sexual and Reproductive Health information. An example is the Aunty Jane Hotline which is a 24 hours available hotline that was established to bridge the gap when it comes to access of quality Sexual Reproductive Health and Rights information and referrals to an adolescent and youth friendly service providers. During office hours from 8:00 -5:00pm the callers have access to a trained tele-counsellor. The hotline serves women and girls in Kenya with a larger audience in Nairobi, Kisumu and Mombasa. Three partners, Marie Stopes Kenya (MSK), Well Told Story (WTS) and Triggerise designed a project that was based on a mobile platform to increase access to SRH services. MSK is the service delivery channel; WTS does demand generation and Triggerise developed the mobile platform for the project. Mobilizers were trained on how to enroll adolescents (15-19 years) into the platform and how to refer the clients to youth friendly centers. The girls access services and rate mobilizer on enrollments and service providers on service provision. The platform allows clients to locate nearest MSK clinics and its social franchises, AMUA clinics. Data from KDHS (2014) indicates that, 1 in every 5 teenage girl between the ages of 15-19 have begun child bearing which can be caused by lack of right information, 47% of such pregnancies being unplanned. The project uses a mobile platform to enroll clients through trained mobilizers; it allows the client to locate the nearest youth friendly center. The client rates mobilizers on enrollment and service provider on service delivery. The rating are visible to other users who can choose which health center to visit based on the ratings.

METHODOLOGY: Maries Stopes Kenya (MSK) clinics are spread across urban areas and its social franchises; AMUAs, in peri-urban and rural areas. Out of a network of 22 MSK and 131 AMUA clinics spread across the country, 3 MSK, 18 AMUA clinics and 76 pharmacies were used in the pilot region. The pilot project sites were Nakuru and Mombasa with Nairobi as a testing ground. Trained mobilizers, including community health volunteers conduct one on one sessions with adolescent girls 15-19 years old and enroll them to the program through an SMS based platform. Mobilizers generate a code, which the client input in their phones for an enrollment to be successful. This process allows the mobilizer to track how many of the enrolled clients access a service through real time SMS alert once a service provider validate the visit. The client through the platform can rate the interaction with both mobilizer and service provider as a tool of checking on quality of youth friendliness. Data is collected real time for each unique successful validation using an online-based system. The girls and service providers are rewarded with TIKO Miles, which can be redeemed at approved venders/stockiest in their localities to support budding entrepreneurs.

RESULTS: The project use of mobile phones was to increase autonomy among the adolescent girls to make informed choices and have a tool that can link them to sexual reproductive services (SRH). SRH services among 19 year old and below over the years has been stigmatized, especially use of modern contraceptives. The pilot in Mombasa and Nakuru showed that 4 out of 10 teens have phones especially those in urban centers. 3,544 girls out of 7227 did rate the service offered accounting for 57% of ratings. The ratings are visible to other users, which have shown teens will frequent some facilities, which offer high quality services and have friendly service providers. The project is learning on such best practices to improve facilities across project sites. The adolescents prefer to get short-term contraceptives from pharmacies, at 39% while long-term methods uptake in MSK centers and the AMUAs at 61% of the 6236. The mobile platform allows for effective and perfect referral tracking system among CHVs, which has improved on follow up among enrolled clients to ensure high conversion rates in terms of service uptake. The Marie Stopes toll free call center number has also created more traffic to service delivery channels and linkages to mobilizers for clients with 3 out of 10 callers inquiring on the project eligibility and services offered.

LESSONS LEARNED: The mobile platform has been hypothesized to have increased search for sexual reproductive health information among adolescents. This has greatly contributed to access of contraceptives through the mobile platform. The ratings among the service providers has led to tremendous improvement in the section criteria for facilities to register in the platform. The project has had a more targeted facility improvement plans to increase confidence among teenagers to visit some of the poor performing facilities. The facilities have reported increased income generated from SRH services among teens. There was clear evidence among service providers especially those in the rural areas to learn more on use of mobile phones and applications to get abreast with the adolescent population they attend to on a daily basis. The system has been tested and is proved to be effective in tracking enrollments, referrals, linkages and follow up visits, which have contributed, to healthy seeking behaviors among adolescents. The success of the mobile platform has necessitated introduction of smart cards; TIKO Cards, which are being issued to adolescents without phones to be able to access these services. These cards have been rolled out in the wake of government directive through the National Housing Insurance Fund (NHIF) to provide NHIF cards to school going children to allow them access SRH services. The project aims to compliment the NHIF cards with TIKO cards by providing services not included in the government cover.

USING MOBILE TECHNOLOGY AND INNOVATIVE APPROACHES TO BRING SHRH TO YOUNG PEOPLE.

Naijeria Toweett, Anthony Okoth

BACKGROUND: Getting good quality and non-judgmental information on love, sex and relationships can be challenging in any setting, more so in Kenya. Sex and sexuality are often not discussed within families, schools focus on abstinence, any sexual education is delivered in a scientific, medical language that doesn't appeal to young people, while the involvement of religious institutions mostly seems to add to the stigmatization of sensitive topics. This leaves young people vulnerable and at risk of unplanned pregnancies, STIs and even sexual violence.

METHODOLOGY: Love Matters uses new technologies to bring open, honest and pleasure-friendly SRHR information to its audience. We do this by creating persuasive content around safe and satisfying sex tailored to the 18-30 year old demographic, and designing platforms using accessible technology. Our website is mobile responsive and features resources outlining the basic concepts of sexuality education, such as first time sex, contraception, male and female anatomy as well as relationship and love information. The website is complimented by the use of social media channels. Additionally, a news article is published thrice a week. Finally, the website features a 'find a clinic' tool, which allows users to find information on medical services in their area as well as a discussion board. Local writers produce our content.

They are carefully chosen and trained to reflect the welcoming and non-judgmental tone Love Matters uses. We balance taboo topics with more general information on sex, love and relationships in order to avoid alienating our audience.

RESULTS: Love Matters Africa has grown exponentially since its launch in 2012. The website gets between 150,000 and 200,000 visitors every month and receives hundreds of questions and comments every week. Many are returning visitors, and almost all of them visit the website from their mobile phones. On Facebook, Love Matters is at 1.3 million likes, currently ranking as the 11th most popular Facebook page in Kenya. On Twitter, Love Matters Africa has 1,100 followers.

On Twitter, Love Matters Africa has 2,334 followers and 61500 followers on Instagram. The International Conference on AIDS and STDs in Africa 2013 (ICASA) ranked us second among the top 10 influencers on Twitter. Love Matters Africa is the winner of the 2015 AfriComNet Award for Excellence in Health Communication Best Digital Social Platform. From these, we deduce that our audience trusts us as a reliable source of SRHR education. We have seen a change in the way taboo topics are addressed by the audience.

LESSONS LEARNED: The program was created to bridge the gap in comprehensive sexuality education between young people, sexual health experts, educators and services, by using innovative approaches that circumnavigate the barriers. By using (mobile) technology and social media channels, larger numbers of young people can be reached effectively. Young people are able to access the information anonymously and without (perceived) judgement and are more at ease in learning about and discussing topics related to sex, love and relationships.

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