STRATEGIES INFLUENCING PROVISION OF ADOLESCENT AND YOUTH FRIENDLY SERVICES WITHIN THE PUBLIC HEALTH FACILITIES IN MIGORI COUNTY

LILLIAN NJOKI NYAGA
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DECLARATION

"I declare that this thesis is my original work and has not been presented in any other university."

Signed:

Date: 20th September 2023

Lillian Njoki Nyaga
HSM-3-2762-3/2021

Supervisors:

"This thesis has been submitted for examination with our approval as university supervisors."

Date: 20th September 2023

Dr Eunice Muthoni Mwangi

Department of Population Health

Aga Khan University-East Africa

Date: 20th September 2023

Mr. Musa Oluoch

Department of Health Systems Management

Kenya Methodist University

DEDICATION

To my family, especially my daughter Larah, who gave me all the company during those wee hours of the night during the study.

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ABSTRACT

The focus of leadership and governance in a health system is to guarantee the availability of policy guidelines along with oversight, alliance-building, control, focus to system design and accountability. Joint efforts are needed to prioritize on an all-inclusive Adolescent and Youth Friendly Services (AYFS) package that is embracive of community activities. Migori county has a population of 1,116,436 people with 37% of this being young people between 10-24 years. The Kenyan government provides guidance to ensure inclusion of Adolescents and Youth (AY) matters in the country's development agenda by developing National Guidelines for Provision of AYFS in 2016.All government sectors and stakeholders have an important role in provision of AYFS. Migori county strategic plan sates that 80% of the public facilities should be providing AYFS, however, as of 2022, only 62(39%) were providing AYFS. This study sought to determine strategies influencing the provision of AYFS within public health facilities. Specific objectives were to determine the influence of capacity building, coordination of actors and activities, networking of relevant stakeholders and community involvement, on provision of AYFS within public health facilities in Migori County. It was a cross sectional study and targeted 159 public health facilities and 455 health care providers. A sample of 114 Health facilities was selected from which a sample of 213 providers was drawn using Taro Yamane formula. Data was collected from the 213 providers using a structured questionnaire, a checklist from 114 health facilities, while qualitative data was collected from three facilities in charges using Key informant interviews (KII) guide. Statistical Package for Social Sciences (SPSS) Version 24.0 was used to analyze quantitative data while NVivo 9 software was used for transcribing and coding the qualitative data. Majority 153 (74%) of the respondents were in the profession of nursing and majority 148(71%) had worked at their current workstation between 1-5years. Bivariate analysis showed a positive and significant association between all the independent variables and the dependent variable. Capacity building (p=0.001, r=.548) Coordination (p=0.001, r=.482), Networking by stakeholders (p=0.001, r=.390), and Community Involvement (p=0.001, r=.460), positively and significantly influenced provision of AYFS. Multivariate analysis was undertaken, and the study model explained 56% of the variations in provision of AYFS. Logistic regression shows that capacity building (p=0.001), Coordination of AYFS (p=0.028), and Community involvement (p=0.002) had a significant association with provision of AYFS. The study therefore revealed that capacity building, coordination of actors and activities and community engagement all together influences provision of AYFS. This study recommends training institutions, to include a module(s) on AYFS in pre-service curriculum. Coordination of AYFS to be improved through school outreaches to share AY health matters including building the capacity of teachers on AYFS, along with communication of AYFS laws and policies. To strengthen AYFS networking, county department of health ought to map all relevant stakeholders, build partnership for advocacy, promote proprietorship and brace for execution of key AYFS policies and standards. Communities through their representatives should be engaged in the planning, implementation, and monitoring of AYFS provision with inclusion of the AY.

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ABBREVIATIONS AND ACRONYMS

AA-HA	Global Accelerated Action for the Health of Adolescents
AFHS	Adolescent Friendly Health services
AY	Adolescent and Youth
AYFS	Adolescent and Youth Friendly Services
CHEW	Community health Extension Worker
CHV	Community Health Volunteer
CSO	Civil society Organization
FHI	Family Health International
FGD	Focus Group Discussion
GAMA	Global Action for Measurement of Adolescent health
GOK	Government of Kenya
HCP	Health Care Providers
HCW	Health Care Worker
KDHS	Kenya demographic Health Survey
KHIS	Kenya Health Information System
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population and Housing Census
NACC	National AIDS Control Council
NACOSTI	National commission for Science technology and Innovation
NGO	Non-Governmental Organization

SARAM	Service Availability and Readiness Assessment Mapping
SDGS	Sustainable Development Goals
SERC	Scientific and Ethical Review Committee
SPSS	Statistical Package for the Social Sciences
SRH	Sexual Reproductive Health
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency fund
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization
YFS	Youth Friendly Services

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

The field of young people's health was borne out of research based on advances from various disciplines, alteration of mechanisms within the social structure, and technology advancement during the 20th century (Alderman et al., 2003). The field of young people's health set foot into a thrilling phase of opportunities to improve the health of adolescents globally. Further, to accelerate the momentum with an aim to enhance the existing systems influencing adolescent health among worldwide governing bodies, the adolescent health community need to continue to actualize efforts that focus on strengthening the adolescent health workforce and influencing health systems to effectively address the needs of adolescents in their communities (Lee et al., 2016)

The focus of leadership and governance in a health system is to guarantee the availability of policy guidelines along with efficacious overseeing, alliance-building, control, focus to system design and accountability**.** Development of corroborated guidelines to aid services in health, other sectors and advising governments on young peoples' health are some of World Health Organization (WHO) roles in improving the health of young people. In view of Patton et al. (2010) the Millennium Development Goals (MDGs) lay out ingress for the contemplation of adolescent health by designating targets exceptionally relevant to the young people. These include literacy, the ratio of females to males in primary, secondary, and tertiary education, unemployment rates, birth rates among adolescents, and the prevalence and knowledge of Human Immunodeficiency virus (HIV) among the young people.

The focus of the study was leadership and governance, more so, governance of Adolescent and Youth Friendly Services (AYFS) particularly the provision of AYFS in reference to the Ministry of health (MoH, 2016) guidelines.

Adolescent and Youth Friendly Services should be; available at convenient hours with available service providers; suitable and meet AY expected needs; provided in a suitable package; provided in the right way and are suitable to improve the health for all AY without discrimination and AY are able to receive the health services they need. The services should be provided in a non-judgmental way and respectful manner by the service providers. Additionally, the AY should be aware of the available services for them, and appealing service delivery points should be available while involving the community members in the AYFS provision (MoH, 2016). These services include though not limited to, counselling on Sexual Reproductive Health (SRH) information and education on SRH, post abortion Care (PAC) sexual and gender-based violence (SGBV), screening, HIV, Nutritional, personal hygiene, life skills, mental health, drug and substance use, stress management and referral, linkages, and follow-up.

Governance in health is currently seen as key on the development agenda particularly the Sustainable Development Goals (SDGs). The World Health Organization (WHO, 2017) provides justification on the need to making health services easily available to young people and provides a one step at a time guide on producing effective standards for young peoples' health service provision.

Assessment of AYFS in primary health care facilities in South Africa indicated that the facilities had all the basic elements for provision of services and the required instruments to guide execution and policy evaluation for AYFS were also available. However, due to discrepancy noted in implementation of the policies and the facility level performance, there is salient need to join efforts to develop systems that promote the implementation of policies and guidelines within the

primary health care facilities. The joint efforts need to prioritize on an all-inclusive AYFS package that is embracive of community activities as they are the renewed attention of the national primary healthcare efforts (James et al., 2018)

It is paramount to have capacity building of health care Providers (HCPs) and provide them with standardized guidelines at their service delivery points that enhance them to confer services that accommodates the wants of the AY. In addition, community outreaches and health promotion targeting the young people in and out of the schools can promote utilization and scale up of the AYFS (Ninsiima et al., 2021). Nkole et al. (2019) on assessing adherence to adolescent friendly health services (AFHS) protocols in public health facilities in Lusaka District, Zambia noted that there were no standardized principles for delivering relevant health services including age-appropriate information to adolescents. The assessment also recognized the necessity for dissemination and teaching of the AYFS standards and guidelines to the HCPs as majority of HCPs reported not to have been trained or oriented on the guidelines and the AYFS provision. Implementation of the AYFS protocols influences the delivering of the right service to the adolescents and improves the care seeking behavior of these adolescents.

Kenya has a total population of 47,564,296 out of which 34% are between the age of 10-24years, Migori county contributes to 1,116,436 people with 37% of this being young people between 10-24 years (Kenya National Bureau of Statistics [KNBS], 2019). The current Kenyan devolved governance structure and the health system provides renewed attention to address existing challenges of of AYFS provision in the health sector. The Kenya government has provided guidance to ensure the inclusion of AY matters in the country's development agenda by having;

National AYFS Training course for HCPs in Kenya (2018);Facilitator's manual and Participants Handbook and National Guidelines for Provision of AYFS (2016).The government sectors but not limited to, child protection, education, interior ,infrastructure and agriculture have an important role in provision of AYFS. Health Care Providers and facility staff are paramount in guaranteeing AY access the AYFS while noting that their beliefs and attitudes can influence how the AY access the healthcare services. Additionally inadequate skills and knowledge on provision of AYFS can also influence the uptake of AYFS among the AY. Therefore, capacity building of the HCPs on AYFS provision should aim at addressing the personal beliefs and attitudes as well as improve comprehension in AY growth and development including their unique features and counselling (National adolescent and youth friendly services training course for health care providers in Kenya facilitator's manual, 2018).

According to the Migori county strategic plan (2018-2022), the County Government intended to implement projects through the respective sectors to harness the demographic dividend such as enhancing AY to obtain health services including information, diversifying programmes to cater for vulnerable youth including those with special needs and revamp youth empowerment centers to provide AY friendly reproductive health information and services (County Government Of Migori County, 2018). Migori county being one of the counties that has made strides to improve the health and wellbeing of AY, developed a multisector action plan to improve the health and wellbeing of AY in 2018. According to the midterm evaluation report of the action plan July 2021, adolescent pregnancies was 20.8% in December 2020 while reporting of adolescent pregnancies in schools was 850 in 2020, of which 65% were from primary schools. According to United Nations Population Fund (UNFPA) Report (2017) on SDGs, focusing on early adolescence

particularly on girls is key to successful transition to secondary education since most dropouts happen at this early period. The report highlights that there exist 63 million adolescents of junior secondary school age of 12-15 years who are out of school. In cognition of the fast physical, psychological and social development the adolescents undergo, it's important to provide sexual reproductive health and gender rights education to the adolescents. In Migori county, the school drop-out cases due to pregnancy were 134 as at January 2020. Contraceptive uptake for 10-19 years was 20.1% while for ages of 20-24 years was 30.9%. HIV positivity increased from 0.9% in 2018 to 1.6% in 2020 which is attributed to targeted testing strategies. SGBV reporting increased from 91cases to 667 in 2020 and only 46 cases were successfully prosecuted. Department of gender showed defilement and child marriages as the most common reported cases in their departments. Probation department reported 104 young people successfully rehabilitated with 17 of them attached to local artisans for skills development. Department of youth affairs enrolled 4,159 on Life Skills Training and 3,956 on business skills. On coordination and governance, the County established a multi sectoral government system on AY. Key among them is rotational positions of the chairperson, a draw from different government departments. The County operationalized an online monitoring framework that allows for capturing the real time data on strategy implementation.

1.2 Statement of the Problem

Regional report 2021, on assessment of AYFS indicates that 50% of health facilities visited had the national AYFS policy documents available, however, there was inadequate knowledge of these documents among the HCPs (UNFPA, 2021). In view of the Kenya Service Availability and Readiness Assessment Mapping SARAM 2013 report (MoH, 2013), despite the existence of

AYFS policies in Kenya the national coverage of AYFS was low at 10%, while Migori county was at 21% which led to poor AY health indicators. Inadequate training of HCPs on AYFS provision, poor health infrastructure, stock outs on commodities and supplies, minimal awareness creation and week coordination of AYFS were attributed to the low AYFS coverage, (MoH, 2013). Execution of AYFS in public health facilities is still low in Migori County with only 62(39%) public facilities providing AYFS. The Migori county strategic plan states that 80% of the public facilities should be providing AYFS. Though there has been marked improvement in the AY health indicators over time in Migori County, SRH issues are the prime contributors to poor health among adolescents in Migori. Among these SRH issues are adolescent pregnancies (21%) as at 2021 KHIS and new HIV infection (15%) among 10-19 years and (36%) among 15-24 years AY (Kenya HIV estimates 2022) remain above the national level.

Despite the fact that various researches have been carried out to determine the factors of AYFS utilization and integration in Kenya, there is inadequacy on facts on strategies influencing provision of the services against the Kenya 2016 AYFS guidelines requirements in Migori County. So far there is no known research on strategies influencing provision of the AYFS in Migori. This study therefore sought to determine strategies influencing the provision of AYFS within public health facilities in Migori County.

1.3 Study Objectives

1.3.1 Broad Objective

To determine strategies influencing the provision of adolescent and youth friendly services within public health facilities in Migori County.

1.3.2 Specific Objective

i. To determine the influence of capacity building of health care providers on provision of Adolescent and Youth Friendly Services in public health facilities in Migori County.

ii. To establish the influence of coordination of actors and activities on provision of Adolescent and Youth Friendly Services in public health facilities in Migori County.

iii. To evaluate how networking of relevant stakeholders influences provision of Adolescent and Youth Friendly Services in public health facilities in Migori County.

iv. To determine how community engagement influences provision of Adolescent and Youth Friendly Services in public health facilities in Migori County.

1.4 Study Research Questions

i) How does capacity building of Health Care providers influence provision of Adolescent and Youth Friendly Services in public health facilities in Migori County?

ii) How does coordination of actors and activities influence provision of Adolescent and Youth Friendly Services in public health facilities in Migori County?

iii) How does networking of relevant stakeholders influence provision of Adolescent and Youth Friendly Services within public health facilities in Migori County?

iv) What is the influence of community engagement on provision of Adolescent and Youth Friendly Services within public health facilities in Migori County?

1.5 Study Justification

According to Kenya demographic Health Survey (KDHS, 2014), child bearing among girls between the age of 15-19years is about 20% while unmarried sexually active girls have a contraceptive prevalence rate of 49% for 15-19 years and 64% among the 20-24years. Additionally, young men have more comprehensive knowledge of HIV than young women at 64% and 57% respectively. Girls below the age of 20 years are more affected by unsafe abortion complications including maternal mortality and morbidity. The National AIDS Control Council (NACC) further estimates that the HIV incidence among AY aged between 15-24 years is significant every year while among the AIDS related deaths, the AY contribute to 17%.

Migori is amid ten Counties with high HIV burden in Kenya. In view of the Kenya HIV County profile 2016, (National AIDS Control Council [NACC], 2016). The County HIV prevalence rate was 14.3% against Kenya's average of 5.6%. This prevalence went down to 13.3% with 85,765 persons living with HIV and new infections of 2,814, out of which 788 (28%) of all new HIV infections were adolescents 10-19 years while 1463 (52%) were young women and men 15-24 years (HIV estimates of 2018). According to Migori County adolescent fact sheet, 2018, the adolescent birth rate is 136 births per 1000 girls, compared to 96 per 1000 nationally. The contraceptive unmet need among currently married adolescents aged 15-19 year is 17% compared to 37% at national level, (UNFPA, 2017). The factors contributing to poor health outcomes among AY include; low social economic status, harmful cultural practices, sexual and gender-based violence, hazardous sexual conducts like exposed sex and multiple sexual partners and lack of exhaustive and accurate facts on their sexuality. Identifying strategic ways of addressing these challenges within the health facilities is key as this will enhance and promote health and well-

being of the AY as well as utilization of the AYFS by the AY. Majority AY are unlikely to seek health services in the health facilities unless they have confidence and trust of the services provided, HCPs providing the services as well as community and parental support. Therefore, Provision of AYFS by using the stipulated strategies is key to achieving the goal of AYFS provision.

1.6 Limitations of the Study

The study was influenced by biasness since the study sample was drawn from government health facilities only, hence results were generalized to public health systems. Though various HCPs interact with AY within the health facilities, the HCPs participants of the study involved specifically clinical officers and nurses only since they are the ones who mainly interact with the AY clients.

1.7 Delimitations

This study focused on four independent variables namely capacity building of AYFS, coordination of AYFS, networking of stakeholders in provision of AYFS and community engagement in provision of AYFS while there are other strategies that could influence provision of AYFS such as social mobilization, advocacy, and dialogue and referral, linkage and follow-up. Data was collected only from GoK public health facilities in Migori County and the respondents were HCPs (clinical officers and nurses) drawn from the public health facilities. This study targeted public health facilities since it was assumed that most services are provided for free or at a low cost. The data collection tools included structured questionnaires for HCPs, key informant interview guides

for facility in charges and observation checklist for checking the standard and quality of AYFS provision within the health facilities.

1.8 Significance of the Study

The findings of this study will guide the county to provide and strengthen the implementation of guidelines used in provision of AYFS including provision of services of other issues that impact on AY health and wellbeing. It will also guide the government sectors, civil society organizations (CSOs) and AY implementing partners on areas that need reinforcement in terms of support in provision of AYFS. The researchers and academicians will use the finding of this study to generate future research questions and build more knowledge on AYFS provision. The recommendations can also be used by other counties with similar adolescent and youth challenges as Migori county.

1.9 Study Assumptions

The study assumed that the public health facilities deliver AYFS, and that HCPs were well versed with provision of AYFS and that they were willing to respond to the study questions.

1.10 Operational Definition of Terms

Acceptable	The health services provided to the adolescents and youth are suitable and meet their expected needs.
Accessible	The HCPs are available to provide health services to the AY at the convenient times of the day without any form of barrier to access.
Appropriate	The package of services delivered to adolescents and youth are suitable to them.
Effective	The health services are provided to the adolescents and youth in the right way and are suitable to improve the health and wellbeing of adolescents and youth.
Equitable	All adolescents and youth, without discrimination, can receive the health services they need.
Capacity building	The health care workers are trained on AYFS so that they can mainstream AYFS to all service delivery points.
Coordination	Organization of the elements and actors needed for provision of AYFS
Networking	Interaction of various sectors, institutions, agencies, and community at all levels to support provision of adolescent and youth friendly services.
Community engagement	Enhancing participation of parents, AY, and community members in the provision of AYFS
Referral and linkage	Ensuring that adolescents and youth access health services in a timely manner and best possible care closest to them

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

In this chapter, a review of available literature in AYFS has been documented. The first part of the chapter begins with an overview of AY definition including the challenges faced and consequences of the challenges, followed by review of literature on concepts and theories around the subject area, including frameworks on AYFS. This is followed by the discussion on characteristics of AYFS and strategies influencing provision of AYFS. At the end of the chapter, there is a summary of the problem areas identified and research gaps in the context of the provision of AYFS with particular emphasis of the situation of Migori County.

2.2 Overview of Adolescent and Youth Friendly Services

In view of the WHO, adolescents and youth are 10-19-year-olds and 15–24-year-olds respectively, while young people are defined as 10–24-year-old. As the AY transit to the adulthood, they phase various challenges including health challenges as they are in a unique phase of development. Its therefore important to respond to these challenges through providing services that are friendly to them such as health information and counselling. Nkole et al. (2019) noted that neglecting the needs of young people can lead to poor outcomes such as risky sexual behaviors that can predispose them to, early unintended pregnancies, unsafe abortion, school dropout, and sexually transmitted diseases (STDs) such as HIV, and sexual violation and abuse. The consequences of the poor outcomes affect the future of AY negatively hence the need to have comprehensive policies that establish joint actions with strategies that include promotion of AY health (Gomes, 2013). The SDGs are set of common development goals for the world after 2015. Globally there is great recognition and there is a general agreement that investing highly in adolescent health and

development will enhance the success of the post -2015 development agenda along with their survival and wellbeing (Svizzero & Tisdell, 2015).

Development of corroborated guidelines to aid services in health, other sectors and advising governments on young peoples' health and adolescent and youth (AY)responsive health systems are some of WHO's roles in improving the health of young people. The Global Accelerated Action for the Health of Adolescents (GAA-HA!) a report published by WHO in May 2017, aims to guides the governments to plan and react to the health needs of adolescents (WHO, 2017). This targets decision makers at all levels of decision making to aid in designing, execution, monitoring and evaluating initiatives of adolescent health. Further, to improve adolescent health measurement globally, WHO, in partnership with UN agencies set up the Global Action for Measurement of Adolescent health (GAMA) Advisory Group to provide technical support on matters concerning the key health indicators for adolescents including the data documentation of the indicators.

In view of (James et al., 2018) AYFS is a government prime concern and facilities need aid to achieve the standards needed which eventually drive a robust benefaction to improving adolescents' health and wellbeing, mainly in averting consequences of risky sexual behaviors in addition to ameliorate psycho-social handling. Regional report 2021, on assessment of AYFS indicates that 50% of health facilities visited had the national AYFS policy documents available, however, there was inadequate knowledge of these documents among the HCPs. However, due to discrepancy noted in implementation of the policies and the facility level performance, there is salient need to join efforts to develop systems that promote the implementation of policies and guidelines within the primary health care facilities. The joint efforts need to prioritize on an all-

inclusive AYFS package that is embracive of community activities as they are the renewed attention the national primary healthcare efforts (James et al., 2018)

In Ethiopia, (Kereta et al., 2021) found out that the success of YFS was reinforced by a combination of various strategies including financial support, national strategies, well-built capacity of the health service providers to offer friendly services, provide multiple services with availability of health products, in addition to AY involvement to make sure that the services provided to them are appropriate to meet their needs considering the community context.

The current Kenyan devolved governance structure and the Health System provides renewed attention to address existing challenges in the provision of AYFS in the health sector. The Kenya government has provided guidance to ensure the inclusion of AY matters in the county's development agenda by; National AYFS Training course for HCPs in Kenya (MoH, 2018), Facilitator's manual and Participants Handbook and National Guidelines for Provision of AYFS (MoH, 2016). The government sectors but not limited to, child protection, education, interior ,infrastructure and agriculture have an important role in provision of AYFS

2.3 Provision of Adolescent and Youth Friendly Services

There is great focus on how to ensure the AY obtain the health services they need through overcoming the barriers they face. Various countries have put in place mechanisms to enhance the service providers of AYFS provide the services without being judgmental. These mechanisms include but not limited to; capacity building of the service providers on AYFS provision, equipping the health facilities with a wide range of services needed by AY, ensuring the services are attractive

to the AY, awareness creation to ensure that the AY are aware of the services available for them, community engagement to ensure the community members support AYFS provision as well as engaging other relevant stakeholders that have a role in AY health and wellbeing. According to WHO (2006) ensuring affectionate and enticing health services influenced the adolescents to uptake the health services.

Peattie and WHO (2009) provides a guidebook designed to support health managers at all health care levels including staff of health facilities to determine the quality of the AY services they provide in line with the required characteristics of adolescent friendly services. Through following the guide, the service providers are able to identify whether the services they offer and the systems put in place are adolescent friendly and provides guidance on areas of strengthening to improve the services. Mission of the 2017 south Africa National Adolescent and Youth Health policy aims that the health status of the young people is improved by focusing on disease prevention, healthy lifestyle promotion and improving the health care delivery system with focus on ensuring that the AYFS are quality, accessible, efficient and sustainable (National eHealth strategy, South Africa 2012/13-2016/17).

Brittain et al. (2018) points out what young people value during provision of health services to them. These include privacy and confidentiality, enabling environment during interaction with the provider, competent service providers, and affordable services. Further, there is emphasis on ensuring that along with the services being friendly, they need also to be available in a wide range including adequate information. It’s also paramount to have broader interventions that include families and community along with AY specific clinics and AY support groups to enhance curb

the barriers for this very vulnerable group (Teasdale et al., 2016). Additionally, addressing provider attitudes that hinder provision of services to the AY in line with the actual situation of AY sexuality, would enhance services use among the young people since responsive provider attitudes are among what young people consider for them to uptake the health services (Ahanonu, (2014).

A study conducted in in 2018 in South Africa exhibited the facilities had all the basic elements for provision of services and the required instruments to guide execution and policy evaluation for AYFS were also available. However, due to discrepancy noted in implementation of the policies and the facility level performance, there is salient need to join efforts to develop systems that promote the implementation of policies and guidelines within the primary health care facilities. The joint efforts need to prioritize on an all-inclusive AYFS package that is embracive of community activities as they are the renewed attention the national primary healthcare efforts (James et al., 2018)

Further, there is need for more research to determine efficacy of execution of AYFS plan of actions and also documentation of procedures that go after and conversion made to adopt services to domestic needs would be important to guide in developing standardized strategies that promote implementation and sustainability of AYFS interventions. Such studies are needed for convinced decision making by policy makers for possible scale up of the services (Obiezu-Umeh et al.,2021).

The Kenya AYFS 2016 guidelines is one of the commitments of the government of Kenya towards improving the health outcomes of AY. This guideline outlines the; standards, strategies, essential

package of services, models for service delivery and service delivery approaches that are needed for provision of AYFS. All the 47 counties of Kenya are expected to implement these guidelines to improve the health outcomes of AY. The government sectors but not limited to, child protection, education, interior, infrustructure, and agriculture have an important role in provision of AYFS. Further, development partners are expected to support the provision of AYFS through but not limited to; mobilization of resources for implementation and technical assistance of the AYFS guidelines. Article 43 (1) of the Government of Kenya, (2010) states that 'every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'. Kenya's National ASRH Policy supports access to and provision of high quality and affordable adolescent friendly SRH services at all levels of health service provision.

Onyando and Njuguna, (2018) Stated that Kenya has made efforts through the government, NGOs, and private sector organizations in provision of AYFS through establishing stand-alone AYFCs in contemplation of promoting uptake of health services by AY. They however noted that the health facilities had not achieved the expected outcomes as pertaining the needs of AY. Failure to achieve the desired outcomes was attributed to inadequate facilities, health products and variety of services; poor reach to services; low standard of services; negative frame of mind of HCPs; and minimal engagement of the AY in the designing, organization and running the facilities.

2.3.1 Equitable Adolescent and Youth Friendly Services

According to Guglielmi et al. (2021) equitable access to health services as well as promotion of AY healthy lifestyle influences the health outcomes for young people. There exist international legal documents that govern the rights of children in terms of their survival growth and

development. Recommendations about entitlement of young people to the benefit of the highest feasible quality standard of health was published in 2013 while a universal committee on discerning the entitlement of children during adolescence was published in 2016. The guidelines clearly state the need to concede the unique health and development needs as well as privileges of AY. There is current attention towards the vulnerability of AY in humanitarians' settings and other vulnerable sub-populations of young people including and not limited to; young new parents, and young married partners; AY living with HIV(AYLHIV), very young adolescents and young people living with disability. In view of this, there are specific considerations in programming for these special groups of the young people WHO, (2017).

Adolescent and Youth deserve to obtain health services they need without any form of discrimination. The AYFS quality assessment guidebook (Peattie & WHO., 2009) highlights that there should be no restriction on provision of health services to adolescents irrespective of age, sex, social- cultural background, ethnicity, disability or any other form of difference. It further states that all facility service providers are expected to provide equal services to all adolescent irrespective of their age, sex, social- cultural background, ethnicity, disability, or any other reason. Groce, (2004) pointed out that young people living with disability have unique interventions and programmes depending on their culture therefore the need to put into consideration based on their social cultural needs. All AY including those of vulnerable sub-populations and those and those in humanitarian settings as pointed out earlier should obtain a variety of health services that they need without any form of discrimination (National Guidelines for Provision of Adolescent and Youth Friendly Services 2016).

2.3.2 **Accessible Adolescent and Youth Friendly Services**

The 2016 AYFS guidelines of Kenya highlights that the HCPs should be available to provide the health services to the AY considering the AY desired times of the day without any form of barrier to the access the services. To enhance the accessibility of the AYFS to the AY, the Community members, including parents should be aware of the services for them to participate in the provision of these services as well as encourage the AY to take up the services. The AYFS guidelines also recommends that efforts should be put in place to ensure there is good referral system that ensures the AY receive services they need as close to them as possible.

In a study conducted by Abuosi and Anaba, (2019) found that there are various challenges that contribute to hurdles on reach to and utilization of AYFS. Among the barriers noted during this study were a negative HCPs mind frame, deficient resources in the facilities pertaining adolescent health, minimal support from parents and community, and individual constraints. This study was similar to a study conducted in Kenya within Kisumu and Kakamega counties that identified high cost of services particularly transport, consultation fee, medication among the key individual barriers to accessing AY information and health services. The same study also implied that HCPs with negative attitudes as well as lack of confidentiality and privacy impact on uptake of AY services. This indicated that there is need for more efforts to promote AYFS such as AY friendly time and sensitizing HCPs on importance of positive attitudes towards the young people (Mutea et al., 2020).

2.3.3 Acceptable Adolescent and Youth Friendly Services

The WHO AYFS guide and the Ministry of health (MoH, 2016) guidelines explains that for AYFS to be acceptable, the health services provided to the AY should be suitable and meet their expected needs. Also, the standards and guidelines that address consistent confidentiality and privacy at all service delivery points should be available and functional at any given time.

Health care providers should allow consultations from AY within any duration of notice regardless of appointment requirements and should embrace them in a friendly manner without criticism. Convenient and timely arrangements should be done with event a referral is needed for any health problem. It is important to avail relevant information of AY health in different formants that are attractive to them and for purposes of improving the AYFS, the AY should be allowed to provide feedback on their experiences concerning the services they obtain. Involving the AY in relevant aspects of the provision such as peer education enhances the acceptability of the services by the AY. According to Onyando and Njuguna, (2018) AY who interacted with HCPs for consultations had positive remarks on their experience with most of the AY reporting that they felt the HCPs treated them in a responsive and favorable manner by taking adequate time in attending to them. A study conducted on utilization of AYFS in Ethiopia by (Motuma et al., 2016) that had both government and non-government respondent, revealed that only the non-government respondents were using the national youth guidelines despite the guidelines being available for all.

2. 3.4 Appropriate Adolescent and Youth Friendly Services

Appropriate AYFS are refers to that the health services package provided to the AY are suitable to them. These services provided at the service delivery point or through referral linkages should address the health needs of all adolescents including the marginalized groups. A study conducted

by (Deogan et al., 2012) pointed out that at country level, it's a paramount step to ensure the presence of policies and strategic plans that give attention to the health needs and suitable service delivery to the AY.

A survey conducted by Haller et al. (2007) revealed a discrepancy between the perception of illness among young people and their presentations to the HCPs. The survey identified unforeseen panic, and a disparity in linking expectations and service provided. Further, the survey highlighted that service providers should assess the fears of AY, their expectations besides their perception of their psychological and physical health so that they provide the pertinent counsel. Involving AY in each step of AYFS provision from evaluating their health needs, to designing, implementing, monitoring, and evaluating the AY programmes is best way of meeting the needs of the AY (MoH, 2016).

2 3.5 Effective Adolescent and Youth Friendly Services

A study conducted in European countries recommended that for the sake of having improved reach and standard care for AY, countries should approve strategic policies regarding AYFS within entire health care. Expectations of young people can be met by creating AY targeted clinics and enhancing public and private service delivery points (Michaud et al., 2019). To ensure effective AYFS, the HCPs have the required competencies for providing health services to AY guided by recommended standard operating procedures and policy guidelines. The HCPs provide adequate time that is convenient to the AY with the necessary supplies and commodities being availed at all service delivery points. It's worth noting that frequent stock outs of health products interfere with the provision of AYFS including SRH services (Family Health International [FHI]360 & Ministry of Health [MOH] Kenya, 2011).

These health services are provided to the AY in the right way and are suitable to improve the health and wellbeing of AY aligning them to the local environment and endorsed by the relevant gat e keepers or decision makers. Further, HCPs need to identify unique strategies that aim at engaging the young people with essential health services including SRH information that led to making informed choices. (Adokiya et al., 2022)

2.4 Capacity building of Health Workers on Adolescent and Youth Friendly Services

Capacity building is the process of increasing skills and competencies mainly at an individual level with an aim of transformation to having mind set change or attitude change. In reference to AYFS, capacity building of AYFS translates to HCPs being trained on provision of AYFS so that they can mainstream AYFS to all service delivery points. Young people have unique health needs as compared to adults therefore, the HCPs need to be trained on how to handle AY health issues (Mngadi et al., 2008). Further, according to Lee et al. (2016), it's salient to have dissemination of best practices and scaling up training opportunities through synergy networks that exist including professional organizations and institutions so as to achieve the goal of effective provision of AYFS. More so, standardizing competencies for adolescent health for trainees at all levels and recognition by health control boards of various nations is paramount to providing quality AYFS.

Provision of adequate health services to AY requires good knowledge through training and awareness of the recommended standards and guidelines. However, training alone is not adequate enough to improve the AYFs and therefore needs to be reinforced with other interventions and approaches (Denno et al., 2015). It's worth noting that from other research, improved skills

including practices and competencies among HCPs on care for adolescents can be achieved through training (AlBuhairan &Olsson, 2014). Negative mind set of HCPs to AY sexuality and minimal comprehension of AYFS were identified by stake holders as documented in the report of AY health stock taking in Kenya 2011.Studies have shown that to improve attitudes of service providers towards youth SRH embracing of preservice training and continuous education is key. Therefore, capacity building of service providers at all levels of service delivery on AYFS through training and sensitizations such as orientations should be given a priority by the national and county level decision makers of AY programs (FHI 360, & MOH 2011).

Training curriculum and standards that include adolescent responsive care are minimal in most medical training institutions. The AYFS training curriculum package incorporates competencies of HCPs on comprehensive AY health care including role of other relevant stakeholders to AY health (Montes et al., 2022). Albuhairan and Olsson, (2014) highlights that AY health targeted trainings to health care providers would make clinical skills and competencies of dealing with young people effective. There are various ways of improving knowledge among HCPs on AY health such as continuous professional education and conferences. Further, in addition to capacity building of HCPs, system strengthening need to be considered so as curb other systemic barriers such as structural barriers.

In view of Kereta et al. (2021), as a way of sustaining AYFS implementation success, progressive orientations including the new YFS providers and peer influencers, trainings and performance review meetings at all levels including facility and community are paramount. These ways provide

opportunity to strengthen and improve the knowledge and skills among all the health facility staff through sharing of ideas and concerns experienced during the YFS implementation.

2.5 Coordination of Adolescent and Youth friendly Services

Coordination in AYFS refers to organization of the elements and actors needed for provision of AYFS. Kereta et al. (2021) pointed out that to guarantee ownership of AYFS the public sector needs to be meaningfully engaged from the initial stage of design the process all through all stages up to and including the evaluation process. The success of AYFS implementation can be enhanced by having consensus building at the initial phases with all the relevant stakeholders from national health heads to all facility staff and community gate keepers as well as all relevant sectors. Supremely, ongoing capacity development and mutual experience molded the execution of AYFS customized to local circumstances and resources, enhanced sustainability of services beyond close out of AYFS support projects.

As noted by Dawson et al. (2013) to have effective dissemination of recommended information to young people in schools there need to have; training of HCPs, teachers and embracing inter-professional education; well defined roles and responsibilities and mechanisms for effective multisectoral collaboration and coordination of AYFS interventions. Even though the Ministry of health takes lead in the coordination of AY health in the country, other ministries and sectors have a role in the promotion and protection of the AY health (De et al., 2019). To enhance support and recognition of the various vulnerable subgroups of the AY, collaboration with CSOs, relevant AY organizations including movements that fight for rights of young people is of great importance. Having these kinds of networks promotes the confidence of the young people to even curb harmful

cultural practices that have negative effects on their lives such as FGM, early marriages including harmful industrial practices such as alcohol and tobacco use.

According to the Migori County Multisectoral action plan for AY 2018-2022, an integrated and coordinated planning of AY services is critical in creating synergy in investment of resources, facilitating networking, creating linkages and fast-tracking deliverables. Further implementation of the AY Action plan require a close collaboration among a wide range of partners within the Government, civil society and the development partners. Therefore, this calls for coordination and collaboration that will facilitate the best use of available resources by minimizing duplication of efforts, aligning quality assurance standards, and ensuring that the efforts of all stakeholders are harmonized towards the achievement of the common goal (Network of Adolescents and Youth Africa, Kenya. [NAYA Kenya] 2020)

2.6 Networking in Adolescent and Youth Friendly Services

Juke et al. 2008 as cited in (Nicholls et al., 2012) affirms that reaching the adolescent with SRH information is best enhanced by teachers and that this kind of information has a great impact in improving the health of the adolescents as well as minimizing challenges such as adolescent pregnancy and HIV infection. As discussed above, the ministry of health may take lead in adolescent health matters, though, to achieve the overall health and wellbeing of the AY in general, a multi-sectoral approach must be embraced especially the key sectors such as education (De et al., 2019).

In view of Kereta et al. (2021), the AYFS package comprises of comprehensive services that are age specific and oriented towards local contexts with under one roof availability approach. The design of the AYFS also provides room for linkages and referrals to ensure the AY obtain the services timely and as close to them as possible. The main important factors to consider in ensuring successful implementation of AYFS are engaging key stake holders including the AY from the beginning of the AYFs design, to the organizing, execution and its controlling and evaluation; use of evidence in making decisions; conducive aspects surrounding policy making and assisting the government to have a favorable environment for provision of AYFS.

The GAA-HA guidance supports that meaningful engagement of adolescents should be considered as one of the ways to address their issues by considering their contributions. Engagement of the adolescents meaningfully should reinforce other factors such as risk and protective factors. The guidance has renewed attention on approaches currently being used in adolescent health programming making it possible now for AY to have their own specific programs that address their health issues without riding on other programs as it was in the past years. GAA-HA guidance stipulates specific responsibilities for various sectors such as education, social protection, planning and interior to honor, safeguard and ensure the attainment of the adolescent health rights. WHO,(2017)

The Kenya 2016 AYFS National guidelines directs that to have a reliable AYFS referral mechanism, the AY need to obtain optimal care at the appropriate level; services provided are cost effective, and timely services for specialized services. The services offered by the community as well as community outreaches and the role of school in provision of AYFS service must be highly

recognized as far networking of AYFS is concerned. These AYFS guidelines further guides on the required actions to be taken to enhance effective AYFS referral system-these actions include putting in place national and county level referral directory; sensitization of HCPs on effective referral system; enhance functional referral system; avail mechanisms for monitoring and evaluating quality of the referral system.

2.7 Community Engagement in Adolescent and Youth friendly Services

Community engagement in AYFS refers to enhancing participation of parents, AY and community members in the provision of AYFS. According to (Denno et al., 2015) health services are often offered within health facilities. The health services particularly those services targeting the AY can also be delivered close to where the AY live or converge within the community. These community outreach services can be offered in strategic locations such as schools, markets, workplace, youth centers, chemists, homes, churches as well within offices of opinion leaders such as local administration. Additionally, in view of (Zulu et al., 2018), making the AYFS compatible within the local context can be enhanced by integration of the AY services within the existing community health systems such as inclusion of the AY interventions in the community unit workplans. This kind of integration of services will in turn promote the access and appropriateness of the services by the AY.

Kereta et al. (2021) highlights that as primary beneficiaries of AYFS, AY need to be involved from the inception and continue with the engagement all through entire process of the program as they are influential in identifying the existing obstacles, recognizing the wants of AY within their locality, suggesting relevant ways to tackle their barriers in addition to enhancing fellow peers to

take up the AYFS services. Demand creation for the available AYFS services is necessary at the facility level as well the community level. The organizations dealing with AY health therefore need to embrace this approach during their program design and planning with consideration of an effective AY referral system to the facilities. The AY live under the care of their parents, guardians, and the community at large its therefore important to have inclusion of parents and key community members such as guardians and community gate keepers in the AY health interventions. The inclusion of communities in AY health programming will support in the curbing of the existing challenges and break the social cultural obstacles as regards to provision of AYFS plus knowledge sharing to the young people (FHI 360, & MOH 2011).

Young people have unique health needs due to their rapid growth and development. They also have specific roles they play within their societies and communities, and they understand their specific health needs. Therefore, the national, regional, and county development policies and plans should include the views of the young people as well as involving them in the implementation process.

2.8 Theoretical Framework

This study was anchored to the systems theory framework and the Andersen Health Belief models.

2.8.1 Systems Theory

According to systems theory, to achieve improved health outcomes requires recognition and embracing the entire system that contributes to the desired outcomes. The systems theory focuses on the fact that quality of healthcare and patient safety is core in the entire healthcare system. According to Kaplan et al. (2013) there are various elements involved in patients care along with a wide range of factors influencing health and therefore, the systems approach contributes to

improving health by considering all these elements and factors. Additionally, having a clear understanding of the mutual relationships of these elements, the systems model can guide how to amalgamate; human resource, processes, policies, and organizations to improve health with minimal logistics

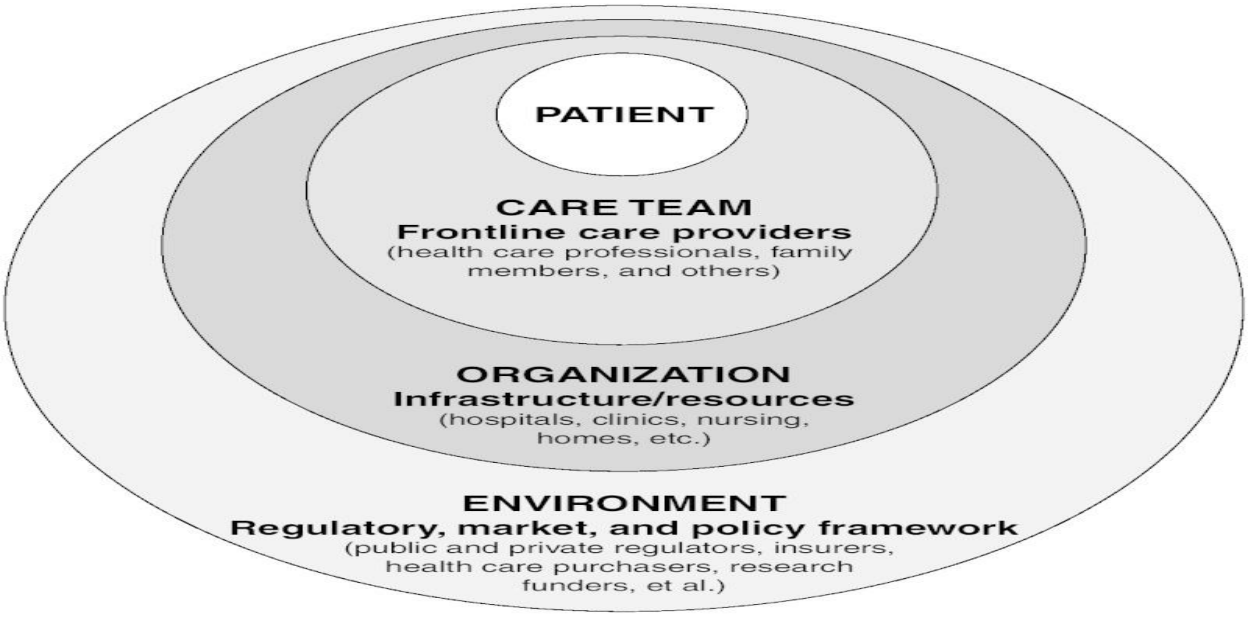
Hespanha (2018) highlighted basic principles governing the systems theory including a system's sub-parts that work together. Every sub-part supports the entire system and any malfunction in the sub-part affects the whole system. A suitable environment is crucial for a system to properly operate. This environment needs essential inputs and outputs which enhance its function. The consumer benefits by the proper working of the system. The consumer in healthcare is the patient. In designing the system, the service element is at the epicenter with the essential components surrounding it. The elements related to the system are stakeholders and the system must enhance each stakeholders' performance. The person responsible for proper working of the system is the management. The primary role is coordinating, organizing and streamlining activities in line with the systems goals. The output obtained gauges the efficiency of the system.

The systems theory was relevant to this study since according to the AYFS 2016 Kenya guidelines, there is need for organizations and agencies as well as institutions to have consensus building and strong networks across all levels to advocate and mobilize for support towards effective service delivery of AYFS. While all system elements build strong networks, the involvement of the local young people representatives as well as empowering them to reach their peers through outreaches with information sharing and the public in support of AYFS is key. Further, it's important for

collaboration of all relevant stakeholders in the sharing of best practices and reinforcing the referral systems to improve linkages and scale up of AYFS.

Figure 2. 1:

Theoretical framework systems theory



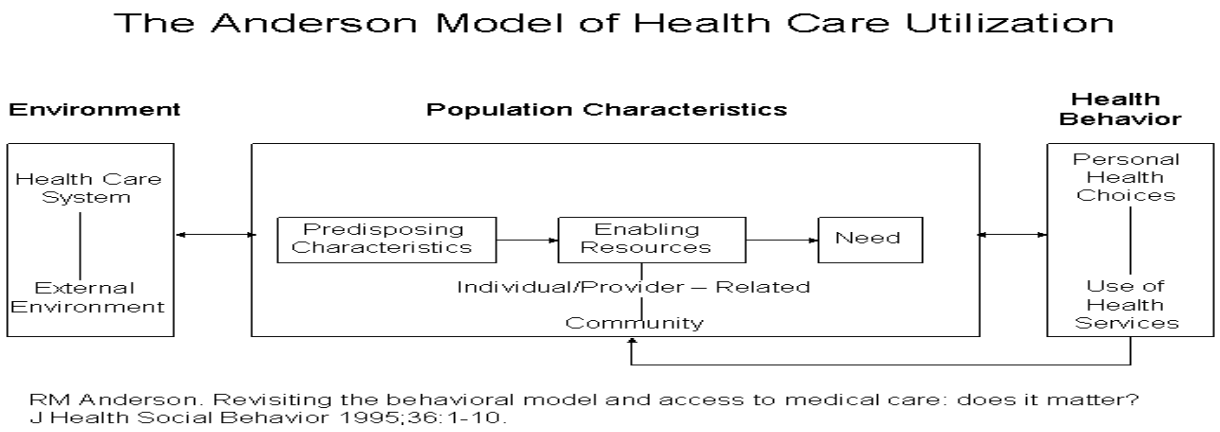
Theoretical framework systems theory (source Research Gate)

2.8.2 The Anderson Model of Health Care Utilization

This model aims at signifying elements that enhance use of health services. In its illustration, utilization of services is influenced by, inclining, warranting and requirement elements. Inclining elements include race, age, and health beliefs while warranting elements include family support, access to health insurance and one's community and requirement elements represents both perceived and actual need for health care services. The relevance of this model to this study was and not limited to; that with responsive HCPs on AYFS and support of AY by parents and community to receive AYFS would motivate the AY to seek the health services for them to meet their needs.

Figure 2. 2:

Theoretical framework-the Anderson model (Source research gate)



(Source research gate)

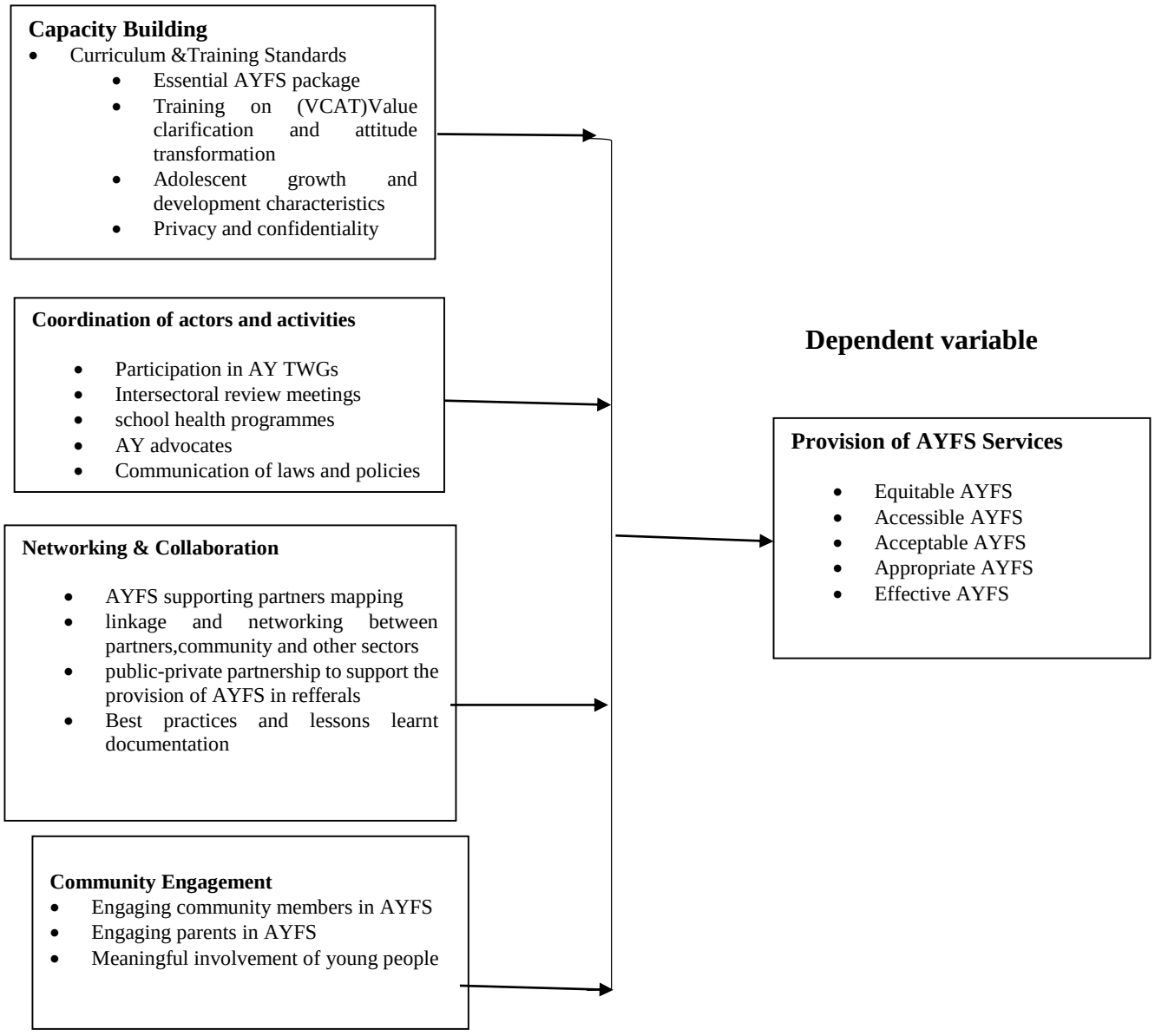
2.9 Conceptual Framework

Conceptual framework demonstrates anticipated association between variables. In the framework, independent variables were Capacity Building, Coordination, Networking & Collaboration and Community Engagement, while the Dependent Variable was Provision of Adolescent and Youth Friendly (AYF) Services.

Figure 2. 3:

Conceptual framework

Independent variables



2.10 Summary of Research Gap

From the literature reviews, there is no known research on the assessment of the implementation of the AYFS guidelines in Kenya within the health facilities. Also, other researchers have focused on utilization, access, and uptake of AYFS. No known researcher has focused on provision of AYFS which is a provider centered approach

CHAPTER THREE
METHODOLOGY

3.1 Introduction

The chapter looks at the type of design used, location of the study, target population, sampling methodologies, data collection instruments and procedures, data analysis methods and ethical considerations.

3.2 Research Design

This was a cross sectional study with mixed methods approach. Data was analyzed using both quantitative and qualitative designs. The application of the two designs enabled triangulation of study results. This enabled researcher to compare qualitative and quantitative data. It also enhanced the study findings since the participants' experiences reflected the study participants' points of view (Wisdom. &Creswell 2013).

3.3 Study Location

The study was conducted in public health facilities within the County of Migori, located in southwestern part of Kenya. Its' boundaries are Homabay county to the north, Kisii county to the Northeast, Narok to the Southeast, Tanzania to the west and south and Lake Victoria to the west. The population of the county is 1,116,436 and covers an area of 2,586.4$km^{2.}$ (KNBS, 2019).

3.4 Target Population

The study population included, 213 HCPs (clinical officers and nurses) providing AYFS in 159 public health facilities including 3 facilities in charges selected from each level (level 2, 3, and 4) of those public facilities. All the health facility levels were represented in the study.

3.5 Sampling Size and Sampling Procedure

A sample is a small representative portion of the target population selected for a study. According to the tenets of the degree of variability in the attributes being measured, the less variable (more homogeneous) a population, the smaller the sample size. According to Yamane (1967:886), where a confidence level of 95% is used, an error margin of +/-5% is acceptable with an expectation that 90% of the sampled population will answer the questions.

3.5.1 Sample Size Determination

Determination of the sample size of the facilities and the HCPs to participate was calculated using the Taro Yamane method.

$$n = \frac{N}{1+N(e)^2}$$ Whereby.

n= the sample size desired

N= size of the population

e = the level of precision

Since the county has 159 public health facilities the number of facilities used as sample size were be identified as follows.

$$n = \frac{159}{1+159(0.05)^2} = \frac{159}{1.40}$$

=114 health facilities

A total of 114 health facilities were included in the study. Respondents were drawn from these facilities.

The HCPs respondents were determined as follows.

$$n = \frac{N}{1+N(e)^2}$$ Whereby.

n= the sample size desired

N=size of the population

e = the level of precision

Since the total of HCPs were 455 from the 114 health facilities, the number of HCPs to participate as sample size were identified as follows.

$$n = \frac{455}{1+455(0.05)^2} = \frac{455}{2.14}$$

=213 HCPs

3.5.2 Sampling Procedure

After identifying the total facilities to participate, a multistage sampling was done so as to obtain sample size representation from each of the three levels of the health facilities followed by proportionate sampling to get the expected number of facilities per each level this ensured that

each level was adequately represented within the whole sample population of a research study. Every second facility in the list of each level was selected at each level till the number needed per each level was reached.

Table 3. 1: ***Health Facility Proportionate Sampling***

Health Facility Level	Target facilities	Sample facilities
Level 2	125	90
Level 3	20	14
Level 4	14	10
Total	**159**	**114**

Once the 114 specific health facilities were identified the researcher sourced for the total number of HCPs (i.e. the nurses and clinical officers (see Appendix 7,8 and 9) which gave 202 HCPs in level 4, 181 in level 3 and 72 in level 2 and an overall total of 455 HCPs. Out of the 455 HCPs, a total of 213 HCPs inclusive of facility in charges were selected across the 3 levels as participants ((see Appendix 7,8 and 9). Out of the 213, 3 facilities in charges (1 from each level) to respond to the key informant interviews while 210 HCPs to respond to the structured questionnaires (see appendix 7,8, and 9).

Table 3. 2: ***No. of Health Care Providers***

Health Facility Levels	No. of Facility Levels	Instrument	No. Participants
Facility In-Charges	Level 2-4 Facilities	KIIs Guide	3
Health Care Providers	Level 2-4 Facilities	Structured Questionnaires	210
Total			**213**

3.6 Instruments of the study

There was structured questionnaire (See Appendix two) for the HCPs which focused on capacity building on AYFS, coordination of AYFS, network and collaboration of AYFS, and community involvement in provision of AYFS. There was a key informant interview (KII) guide (See appendix four) for the facility managers/in charges focusing on their roles in the execution of the 2016 AYFS guidelines and to furnish a chance to acquire information on functionality, promotion, and knowledge of the available AYFS strategic policies and guideline. Additionally, there was an observation checklist adopted from the Kenya AYFS 2016 guidelines (see appendix three) used by the researcher focusing on the characteristics of the AYFS provision among the selected facilities.

3.7 Pre-test Study

Pre-testing entails a thorough analysis of the comprehension of each question and its meaning as understood by a respondent. Pretesting executed in similar field conditions on a group of people similar to the study population. The purpose was to identify areas of concern that the anticipated respondents might have regarding the questions. The study tools were pretested at Uriri subcounty hospital and Awendo Subcounty Hospital targeting 30 HCPs, during which focus was laid particularly on the explicitness and applicability of the questions for all types of targeted populations (providers, and managers of the health facility) included in the study.

3.7.1 Validity of Research Instruments

The researcher guaranteed validity of the instruments by ensuring justification of each question was commensurate to the study objectives and that all issues being measured were fully covered

by the questions. To ensure that the content was valid, the questionnaire was discussed with the supervisor and content experts.

3.7.2 Reliability of Research Instruments

The data collection tools were evaluated upon completion of the pretesting activity to adjust the questions to align with the study objectives. A Cronbach's Alpha of above 0.7 was deemed acceptable.

3.8 Methods of Data Collection

Data collection methods included a mixture of methodologies to gather information and combined interviews, questionnaires, and observation. The structured questionnaires self and pick while the KII was recorded through audio and documented on notebooks. The facility checklist used was as provided by the 2016 Kenya National guidelines for provision of AYFS filled by either observation, Interview or examination. The checklist focused on the standard and quality provision of AYFS among the selected facilities.

3.9 Ethical Considerations

Upon approval by the panelists after the departmental oral presentation of the proposal, the researcher incorporated the comments and submitted the proposal to the Kenya Methodist, Scientific and Ethical Review Committee (KeMU, SERC) for approval (see appendix eight) After approval from SERC, there was further approval from the National Commission of Science, Technology and Innovation (see appendix nine) which was followed by seeking further approval from Migori County Scientific Research Board/Committee (see appendix ten)before carrying out the research. After approval by the county, written informed consent (see appendix one) was

sought from all respondents prior to interview. There was unique identity to all personal numbers to anonymize the study participants and these unique identities were used all through the process of data collection and analysis.

3.10 Operational Definition of Variables

The study variables are operationalized as shown in Table 3.3

Table 3. 3:

Operational Definition of Variables

Independent Variables	**Indicators**	**Scale**	**Data collection tool**
Capacity Building	○ Essential package for AYFS ○ Value clarification and attitude transformation (VCAT) training ○ Characteristics of adolescent growth and development ○ Privacy and confidentiality	Nominal scale (Likert 1-3) Qualitative	Structured Questionnaire KII Guide
Coordination	○ Participation in AY TWGs ○ Intersectoral review meetings ○ school health programmes ○ Public Sector Engagement	Nominal scale (Likert 1-3) Qualitative	Structured Questionnaire KII guide
Networking and Collaboration	○ Mapping of AYFS partners ○ Strengthen linkage and networking ○ Documentation and sharing of best practices and lessons learnt ○ Public Private Partnership	Nominal scale (Likert 1-3) Qualitative	structured Questionnaire KII guide
Community Engagement	○ Community members and parents' ○ Involvement of adolescents and youth involvement	Nominal scale (Likert 1-3) Qualitative	structured Questionnaire KII guide,
Dependent Variable			
Provision of Adolescent and Youth Friendly Services	Equitable Accessible Acceptable Appropriate Effective	Nominal scale (Likert 1-3) Qualitative	structured Questionnaire Observational checklist KII guide,

3.11 Methods of Data Analysis

Statistical Package for Social Sciences (SPSS) data entry program was used to enter coded questionnaires before being cleaned and analyzed using SPSS Version 24.0 while NVivo 9 software was used for transcribing and coding the qualitative data and analysis followed content, thematic framework approach and comparison with standards from literature review. The results were presented on themes that make meaningful contributions to responding to the research questions and finally, a comparison based on national standards. The results were presented in tables, charts and on themes that make meaningful contributions to answering the research questions. Descriptive statistics was utilized to explain the broad features of the demographic characteristics and the study variables through frequencies and percentages. Inferential statistics of the four independent variables (capacity building, coordination, networking and collaboration and community engagement) and the dependent variable (provision of adolescent and youth friendly services), were undertaken using Chi-square, correlation coefficient and multivariate analysis.

The Pearson's Chi square was used to contrast the variables for factor analysis amid independent and the dependent variable. Adjusted odds ratio was used to determine the degree of association at 95% confidence. A p-value of <0.05 was set and correlation of the independent and dependent variables was determined through multivariate analysis using logistics regression. To enhance the bivariate and multivariate logistic regression analysis, the structured formed questions were refactored from structured questionnaires to the variable that can only take one of two values. This was aided by the dependent variable which was provision of adolescent and youth friendly services. The health care worker's responses were recorded into (1) yes (2) No and (3) Don't know

of the provision of adolescent and youth friendly services. This recoding was done for all the independent variables i.e., capacity building, coordination, networking and collaboration and community engagement and provision of AYFS. This was done with the assumption that there can be provision or no provision of AYFS. Merging was also done so as to suit binary logistic regression.

The logistic model is expressed as:

$$f(z) = 1/(1+e^{-Z})$$

Where Z is a linear combination of the covariates expressed as:

$Z= \beta_0 +\beta_1X_1+ \beta_2X_2+\beta_3X_3+\beta_4X_4+\beta_5X_5$

X_1, X_2, X_3, X_4, X_i= Independent Variables

β_0 = is the intercept

β_1, β_2, β_3, β_4, β_i=are the estimates of increase in the log odds of the dependent variable (Provision of AYFS) per unit increase in the independent variables. If the odds ratio = 1, then it is concluded that, the independent variable does not affect the dependent variable. If the odds ratios are greater than one, then the independent variable is associated with higher risk of the dependent variable and if odds ratio is less than one, then the independent variable is associated with less risk of the dependent variable or the independent variable lowers the risk of provision of AYFS.

$Z= \beta_0 +\beta_1X_1+ \beta_2X_2+\beta_3X_3+\beta_4X_4+\beta_5X_5$

X_1 = Capacity building of HCPs on AYFS

X_2= Coordination of Actors and activities of AYFS

X_3= Networking of stakeholders of AYFS

X_4= Community Engagement in AYFS

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This study sought to determine strategies influencing the provision of adolescent and youth friendly services (AYFS) within public health facilities in Migori County. The specific objectives were to determine how capacity building of health care providers, coordination of AYFS, networking of relevant stakeholders and community engagement influences provision of AYFS in public health facilities in Migori County.

This chapter presents the study response rate, reliability results, socio-demographic characteristics of the respondents and the descriptive statistics of the study variables. Further, the chapter presents the bivariate and multivariate analysis to respond to the research questions, this is by determining the relationship between the dependent variable (Provision of AYFS) and the independent variables (Capacity building, coordination, networking of stakeholders and community involvement). Bivariate analysis is presented in form of chi-square and Spearman's rank correlation coefficient tests. Multivariate analysis is presented using odds ratio.

4.2 Response Rate and Reliability Test Results

The response rate for the study was 99% with 208 out of 210 questionnaires being returned. The Cronbach's Alpha reliability test was done to ascertain internal consistency of the research instrument. A coefficient of between 0.7-1.0 was deemed acceptable for consistency. All the study variables achieved a Cronbach's Alpha of above 0.7 hence the results are highly reproducible. Validity was enhanced by improving on the data collection tools with the pretest findings to ensure

accuracy of the tool. Supervisors were also consulted and Migori AYFS coordinators were also consulted to ensure the content covered in the tools was comprehensive enough to assess provision of AYFS. The reliability test results are shown in Table 4.1.

Table 4. 1:

Reliability test

Variable	Sample Size	Cronbach Alpha	No. of questions
Capacity Building on AYFS (Xi)	208	0.915	8
Coordination of AYFS (Xii)	208	0.832	8
Networking by stakeholders (Xiii)	208	0.914	7
Community Involvement (Xiv)	208	0.929	9
Provision of AYFS (Y)	208	0.896	16
Overall reliability	208	0.966	49

4.3 Demographic Characteristics of the Respondents

The 208 respondents were health care providers (HCPs). The demographic characteristics are presented by respondents' gender, age, current profession, highest level of education and years worked in the current facility. See results in Table 4.2. Majority 121(58%) of the respondents were female with 153 (74%) being in the profession of nursing. Nearly half 93(45%) were between the age of 31-36 years and majority 166(80%) had the highest level of education as Diploma. Further, 148(71%) of the respondents had worked at their current workstation between 1-5years. These findings mirror the current Kenyan situation which shows that most of the health care workers that study nursing profession are female, and that majority of the medical training colleges offer diploma courses.

Table 4. 2: ***Study Respondents' Demographic Characteristics***

Gender	**Frequency (n)**	**Percentage** (%)
Male	87	42
Female	121	58
Age		
Below 25	01	01
25-30	45	22
31-36	93	45
37-42	42	20
43-48	22	11
49-54	04	2
Above 54	01	01
Current Profession		
Nurse	153	74
Clinical Officer	55	26
Highest level of education		
Certificate	18	9
College Diploma	166	80
Higher Diploma	11	5
Bachelor's Degree	13	6
Years worked in current facility		
Less than 1	41	20
1-5 years	148	71
6-10 years	15	7
Above 10 years	04	02

Additionally, the current Kenya national guidelines on the provision of AYFS was launched in 2016 and the majority of this respondents were in their current workstations during the

implementation of these guidelines since majority had worked in the current station between 1- 5 years and only 20% of the respondents had worked less than 1 year in their current workstation.

4.4 Descriptive Statistics on Provision of AYFS

Provision of Adolescent Youth Friendly Services (AYFS) was the dependent variable. The study sought to elicit whether provision of AYFS was in line with standards and quality AYFS. Provision of AYFS in this study was defined by equitable, accessible, acceptable appropriate and effective AYFS. Results are presented in Table 4.3 a and 4.3 b.

Table 4. 3 a: ***Descriptive Statistics on Provision of AYFS from Respondents***

Statement	**Yes** **n(%)**	**No** **n(%)**	**Don't Know** **n(%)**
Equitable provision of AYFS			
AYFS includes reaching vulnerable sub populations of young people	135(65)	18(9)	55(26)
Accessible provision of AYFS			
The AYFS training leads to setting up AYFS in the facility	145(70)	21(10)	42(20)
Whole site orientation on AYFs is done including the community gate keepers	86(41)	97(47)	25(12)
We inform the SCHMT/CHMT the facility AYFS needs	92(44)	73(35)	43(21)
There is awareness creation of AYFS to the stakeholders?	117(56)	49(24)	42(20)
Community outreaches are conducted involving the CHVs and CHEWs to reach the AY	131(63)	51(25)	26(13)
Community is regularly sensitized on AYFS including parents	107(51)	75(36)	26(13)
Acceptable provision of AYFS			
AYFS training promote value clarification and attitude transformation (VCAT) of AYFS	145(70)	21(10)	42(20)
AYFS training imparts knowledge and skills on privacy and confidentiality	155(75)	19(9)	34(16)
AY are involved in the AYFS design, planning, implementation, and evaluation	64(31)	93(45)	51(25)

Table 4. 4 b: ***Descriptive Statistics on Provision of AYFS from Respondents***

Statement	Yes	No	Don't Know
Appropriate AYFS provision			
	n(%)	**n(%)**	**n(%)**
Elaborate referral system to nearest private facility	117(56)	66(32)	25(12)
Service providers are aware of the AYFS county referral directory	83(40)	95(46)	30(14)
The AYFS plans are integrated in the facility annual work plan	106(51)	62(30)	40(19)
Effective provision of AYFS			
I'm aware of the adolescent and AYFS	199(96)	6(3)	3(01)
I have been sensitized or oriented on the provision of AYFS	112(54)	93(45)	3(01)
The training includes strategies, approaches, and service delivery models for AYFS	142(68)	17(8)	49(24)

Results on provision of equitable AYFS show that, majority 135 (65 %) agreed AYFS include reaching vulnerable sub populations of young people. The findings are in line with WHO,(2017), Groce, (2004;), National Guidelines for Provision of AYFS (2016), Peattie and WHO., (2009) that all Adolescents and Youth (AY) including those of vulnerable sub-populations and those in humanitarian settings should obtain a variety of health services that they need without any form of discrimination.

In terms of having the AYFS accessible, the study findings show that majority 145 (70%) reported that training on AYFS led to setting up of AYFS in the facility. More than half, 117 (56%) of the respondents stated that awareness is created of AYFS among stakeholders. Further, majority 131 (63%) reported that facility conducts community outreaches involving the Community Health Volunteers (CHVs) and community Health Extension Workers (CHEWs) to reach the AY at the

rural and hard to reach areas. Slightly above half of the respondents 107(51%) said they regularly sensitize the community including parents on AYFS. The findings indicate that there are efforts from the Health Care Providers (HCPs)s to make the AYFS accessible by involving the community. This is in line with AYFS guidelines and Teasdale et al., (2016) that to enhance the accessibility of the AYFS to the AY, the Community members, including parents should be aware of the services for them to participate in the provision of these services as well as encourage the AY to take up the services. In view of the acceptable AYFS, the study findings point out that a good number of respondents 145(70%) and 155(75%) reported that training of AYFS promote value clarification and attitude transformation (VCAT) and imparts knowledge and skills on AYFS privacy and confidentiality. However, the study noted that only 64(31%) of the respondents involved AY in design, planning, implementation, and evaluation of the facility AYFS programs. This is contrary to the WHO and Kenya 2016 AYFS guidelines that urges that involving the AY in relevant aspects of the provision such as peer education enhances the acceptability of the services by the AY.

On appropriate AYFS provision, about half of the respondents 117 (56%) reported that there was an elaborate referral system to ensure services not available at the facility can be obtained in the nearest private facility. This agrees with Kereta et al. (2021), that the design of the AYFS should provide room for linkages and referrals to ensure the AY obtain the services timely and as close to them as possible. However, despite having 56% of the respondents saying that there was an elaborate referral system, less than half of the respondents 83 (40%) were aware of the AYFS county referral directory. These findings are contrary to the 2016 AYFS guidelines that guides on the required actions to be taken to enhance effective AYFS referral system-these actions include

putting in place national and county level referral directory; sensitization of HCPs on effective referral system; enhance functional referral system; avail mechanisms for monitoring and evaluating quality of the referral system. About half of the respondents 106(51%) reported that the AYFS plans were integrated in the facility annual work plan. This agrees with (Deogan et al., 2012) that at country level, it's a paramount step to ensure the presence of policies and strategic plans that give attention to the health needs and suitable service delivery to the AY.

On effective provision of AYFS, it was interesting that nearly all the respondents 199(96%) were aware of AYFS, however only slight above half 112 (54%) had been oriented or sensitized on provision of AYFS. Further the findings noted that 68% of respondents were aware of the strategies, approaches and service delivery models for AYFS provision. These findings agree with Michaud et al., (2019) who found that expectations of young people can be met by creating AY targeted clinics and enhancing public and private service delivery points. Additionally, to ensure effective AYFS, the HCPs have the required competencies for providing health services to AY guided by recommended standard operating procedures and policy guidelines.

4.5 Descriptive Statistics on Provision of AYFS Observation Checklist

An observation checklist was also used to assess provision of AYFS in this study. The facility checklist used was as provided by the 2016 Kenya National guidelines for provision of AYFS filled by either observation, Interview or examination. The checklist focused on the standard and quality provision of AYFS among the selected facilities. Provision was defined by AYFS being equitable, accessible, acceptable appropriate and effective. A total of 112 health facilities were observed. Results are presented in Table 4.4 a and 4.4 b.

Table 4. 5 a:

Descriptive Statistics on Provision of AYFS (Checklist)

Statement	**Yes n(%)**	**No n(%)**
Equitable AYFS		
Policies and procedures that guarantee services are offered to all AY without discrimination available.	29(26)	83(74)
Service providers provide the equal level of care to all AY without discrimination.	110(98)	2(2)
Accessible AYFS		
AYFS services are free	87(78)	25(22)
Convenient hours for AYFS provision	66(59)	46(41)
Community enlightene on the usefulness and availability of AYFS	98(88)	14(13)
visible signages at the point of service delivery with scope of services and working hours	73(65)	39(35)
Adolescents well-informed about the range of available services and how to obtain them	94(84)	18(16)
Facilities are conveniently located for ease of access to adolescent and youth clients	104(93)	8(7)

Table 4. 4. b:

Descriptive Statistics on Provision of AYFS(Checklist)

Statement	Yes n(%)	No n(%)
Acceptable AYFS		
AY can consult with service providers at short notice, with or without a formal appointment.	103(92)	9(08)
Service providers spend adequate time with AY clients	105(94)	7(06)
Service providers are respectful and non-judgmental to AY clients	110(98)	2(02)
Referral and follow-up done in short and reasonable time frame	85(76)	27(24)
Materials provided in a familiar language and responsive to all AY types and needs	54(48)	58(52)
Policies and procedures that guarantee AY privacy and confidentiality	33(29)	79(71)
Service delivery point appealing and clean	108(96)	4(4)
AY are actively involved in designing, assessing, and providing services	47(42)	65(58)
AY are involved in decision making on AYFS	55(49)	57(51)
Service providers ensures privacy and confidentiality to AY	107(96)	5(4)
Appropriate AYFS		
Package that fulfills the needs of AY clients is available	63(56)	49(44)
Referral, linkages and follow-up systems and procedures are available	77(69)	35(31)
Effectiveness of AYFS		
Service providers have required competencies on AYFS needs	71(63)	41(37)
Service providers are trained to provide AYFS	49(44)	63(56)
Service delivery point has the relevant and appropriate equipment, supplies and technology to provide services	62(55)	50(45)
Service providers use evidence-based protocols and guidelines to provide services	26(23)	86(77)

Equitable AYFS was assessed against policies and procedures being available to guide nondiscriminatory provision of AYFS. Majority of the facilities 83(74%) did not have in place these policies. This is similar to findings of a study conducted in South Africa in 2018, which identified discrepancy in implementation of the policies at the facility level, raising the need to join efforts in order to develop systems that promote implementation of policies and guidelines within the primary health care facilities. Nearly all facilities 110(98%) were administering AYFS without discrimination. These findings agree with the AYFS quality assessment guidebook Peattie and WHO (2009) which states that there should be no restriction in provision of health services to adolescents irrespective of age, sex, social- cultural background, ethnicity, disability or any other form of difference. It further states that all facility service providers are expected to provide equal services to all adolescent irrespective of their age, sex, social- cultural background, ethnicity, disability or any other reason. Additionally, the findings are in agreement with Groce, (2004) who echoes that young people living with disability have unique interventions and programs depending on their culture therefore the need to put into consideration their social cultural needs. These findings were further corroborated with facility in-charges interview that stated;

"…provision of adolescent and youth services is for all regardless of where they come from, regardless of their political affiliation and any other background weather they are poor or rich…. we make sure that we have everything at one corner we make sure that they get it without any discrimination. Those coming from vulnerable areas and even the disabled ones, we made sure that we give them priority…" FII003

Accessible AYFS was measured against the services being free, being offered at convenient hours, the services being available, having proper signage available and being conveniently located for ease of access. Majority of facilities 87(78%) were offering free AYFS, 73(65%) had signage available and visible at the point of service delivery, and nearly all the facilities 104(93%) were conveniently located for ease of access of services. These findings are similar to a study conducted by Brittain et al. (2018) which found that young people value; privacy and confidentiality, enabling environment during interaction with service providers, competent service providers, and affordable health services.

Acceptable services were assessed against AY spending adequate time with providers, providers being respectful and non-judgmental, having referral and follow-up, IEC materials provided in a familiar language, providers having privacy and confidentiality, facilities being appealing and clean. In almost all the facilities 103(92%) AY were able to consult the service providers at a short notice and in 105 (94%) of the facilities providers spent adequate time with the AY. This is similar to a study conducted in Kisumu by Onyando and Njuguna in 2018 that showed AY who interacted with HCPs for consultations had positive remarks on their experience with most (>90%) of the AY reporting that they felt the HCPs treated them in a responsive and favorable manner by taking adequate time in attending to them. In nearly all the facilities 110(98%), service providers were respectful and non-judgmental to AY clients and further in 107 (96%) facilities service providers ensured privacy and confidentiality to AY clients. However, it's worth noting that in majority of the facilities 79(71%) policies and procedures that guarantee AY client privacy and confidentiality were not available. This contradicts the WHO AYFS guide and the Kenya national 2016 AYFS

guidelines that provides standards and guidelines to address consistent confidentiality and privacy at all service delivery points. These policies should be available and functional at any given time. About half of the facilities 58 (52%) had materials provided in a familiar language, easy to understand, eye-catching and responsive to needs of AY. This agrees with WHO (2007) that ensuring affectionate and enticing health services influenced the adolescents to uptake the health services. Majority of the facilities 65(58%) were not actively involving AY in designing, assessing and providing services and further about half 57(51%) of the facilities did not involve AY in decision making on AYFS provision. This is contrary to the (MoH, 2016) which directs that involving AY in every phase of AYFS provision from assessing their health needs, to designing, implementing, monitoring, and evaluating the AY programmes is the best way of meeting the needs of the AY.

Results on appropriate AYFS provision, show that 63(56%) of the facilities had a package that fulfills the needs of AY. Further, majority 77(69%) had referral, linkages and follow-up systems and procedures in place. This supports findings of Nkole et al. (2019) that neglecting the needs of young people can lead to poor outcomes such as risky sexual behaviors that can predispose them to, early unintended pregnancies, unsafe abortion, school dropout, and sexually transmitted diseases (STDs) such as HIV, and sexual violation and abuse. A facility in charge had this to say.

"…. we offer the services of reproductive health; we teach them about how to prevent pregnancies in those services. We also offer youth friendly services in our facility. We only have one staff trained. We do involve other people in the facility. We have the YPP, we have a youth friendly corner at our facility. The YPPs sit at the youth friendly room where they advise these youths and

then for those who cannot reach the family planning room, we offer the services at the youth friendly room…." FII002

This agrees with the Kenya AYFS guidelines (MoH, 2016) which states that involving AY in every phase of AYFS provision from assessing their health needs, to designing, implementing, monitoring and evaluating the AY programs is best way to meet the needs of the AY.

"…first, we ensure accessibility of these commodities that the youths might need and then we be friendly to these youths so that they can be free to talk to us on their needs. Then we consider the opening hours of the facility that if there is an activity, we talk through the youth lead such that if there are some youths who want to come to the facility odd hours, we can stay to the facility so that we give services to these youths. We usually liaise with the Youth Lead. There are also policies that are put in place within the facility such as the consent from parents…" FII002

Results on effectiveness of AYFS provision, show that 71(63%) of health facilities had service providers with required competencies to work with and provide AY. Slightly more than half, 63(56%) of facilities had service providers not trained to provide AYFS yet (AlBuhairan &Olsson, 2014). Recommended improved skills including practices and competencies among HCPs on care for adolescents can be achieved through training Facility in charges had this to say;

"We only have one staff trained. In total we are three; one clinical officer and two nurses." FII002
"We used to have one trained worker but was transferred." FII001

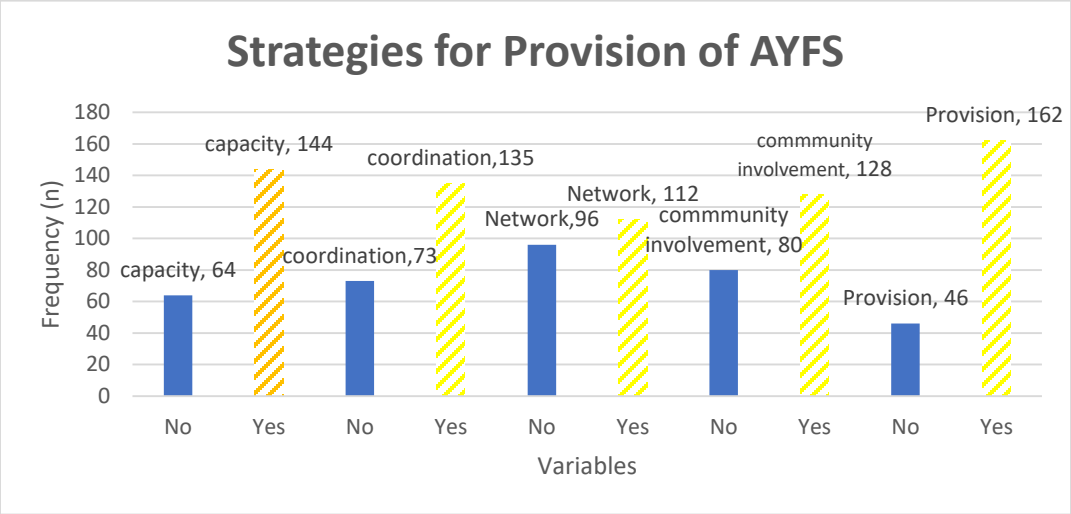
“Not all of us are trained because we have a good number of staff in the facility approximately around over 10 that is both clinical officers and nurses. But not all of them are trained but some are trained, the number who are trained we are two clinical officers and two nurses trained that is four but the other team are getting what is called orientation or mentorship.” FII003

Results show that in 86(77%) of the facilities, service providers were not using evidence-based protocols and guidelines to provide services. This is similar to a study conducted on utilization of AYFS in Ethiopia by (Motuma et al., 2016) that had both government and non-government respondents, the study revealed that only the non-government respondents were using the national youth guidelines despite the guidelines being available for all.

In conclusion results show that strategies for provision of AYFS are not being fully implemented. Results show that 144 (69%) reported that there was capacity building, 135(65%) reported coordination of AYFS was taking place in the facilities, networking of stakeholders scored the lowest with 112(54%) stating that this was taking place, community involvement in AYFS 128 (62%). This may explain the reason why AYFS provision is being provided in some facilities as reported by 162 (78%) of the respondents. See Figure 4.1

Figure 4. 1

Strategies for provision of AYFS



4.6 Descriptive Statistics of Capacity Building of Healthcare Providers on AYFS

Capacity building focused on assessing on job and pre-service training of the health care workers on the essential package of care of care, responsive health care to AY, clinical guidelines on AYFS, recommendations for reaching vulnerable sub-populations, monitoring and evaluation of AYFS, and regular updates on AYFS. Results are presented in Table 4.5. Majority of the respondents 138(66%) were aware of AYFS training including the essential package of care, 146(70%) stated that training addressed responsive care to AY. These findings agree with Mngadi et al., (2008) who highlighted that young people have unique health needs as compared to adults and therefore, the HCPs need to be trained on how to handle AY health issues.

Table 4. 5:

Descriptive statistics of capacity building of HCPs on AYFS

Statement	Yes n(%)	No n(%)	Don't Know n(%)
The AYFS orientation package captures characteristics of AY growth and development	138(66)	20(10)	50(24)
The training/orientation standards addresses adolescent and youth friendly responsive health care	146(70)	18(09)	44(21)
The AYFS training/orientation package includes clinical guidelines on AYFS provision	148(71)	17(08)	43(21)
The training/orientation includes checklist for standard and quality of provision of AYFS	124(60)	16(08)	68(33)
The training/orientation includes checklist for appropriate and relevant infrastructure and technology for provision of AYFS?	109(52)	23(11)	76(37)
The training/orientation includes monitoring, evaluation, supportive supervision, and research in AYFS	125(60)	21(10)	62(30)
During your pre-service training in college, was there a module on AYFS	83(40)	108(52)	17(08)
There are regular updates on provision of AYFS within the facility	76(37)	109(52)	23(11)

Less than half of the respondents 83(40%) and 76(37%) reported that they had preservice training on module for AYFS and regular updates on AYFS in their facilities respectively. This contradicts the recommendations on the study conducted by Kereta et al. (2021), that as a way of sustaining AYFS implementation success, include having progressive orientations of new providers and peer influencers, trainings and performance review meetings at all levels including facility and community. These ways provide opportunity to strengthen and improve the knowledge and skills among all the health facility staff through sharing of ideas and concerns experienced during the

YFS implementation. More so, the AY health stock taking report in Kenya 2011 stated service providers' attitude towards youth SRH can be improved by embracing preservice training and continuous education.

4.7 Descriptive Statistics on Coordination of AYFS

Coordination was assessed against participation of respondents in AY Technical Working Groups (TWGs), incorporating TWGs feedback into facilities decision making, holding intersectoral review meetings and school health programs. Results are presented in Table 4.6. Results show that 141 (68%) of the respondents reported that they did not participate in the AY TWGs at the facility or sub county level and only 79(38%) had feedback from the AY TWG shared to facility staff. Kereta et al. (2021), stated that to ensure ownership of AYFS the public sector needs to be meaningfully engaged from the initial stage of design AYFS through all stages up to and including the evaluation process. Additionally, majority of the respondents 123(59%) indicated that there were no stakeholder's meetings organized by the facility on matters of AYFS. This is contrary to Kereta et al 2021 who established that the success of AYFS implementation can be enhanced by having consensus building at the initial phases with all the relevant stakeholders from national health heads to all facility staff and community gate keepers as well as all relevant sectors.

Table 4. 6:

Descriptive Statistics on Coordination of AYFS

	Yes **n(%)**	**No** **n(%)**	**Don't Know** **n(%)**
I participate in the Adolescent & Youth Technical Working Groups (AY TWGs) at all levels	62(30)	141(68)	5(02)
Feedback of the AY TWG meetings is shared to the rest of the facility staff	79(38)	101(49)	28(13)
There are stakeholders (e.g education, police…) meetings organized by the facility on matters of AYFS	60(29)	123(59)	25(12)
There are planned school health programs organized by the facility	111(53)	79(38)	18(09)
The schools are visited regularly for AY health matters	78(38)	108(52)	22(11)
We are involved in building the capacity of teachers in the nearby schools on AYFS	74(36)	102(49)	32(15)
We identify the AYFS advocates (Youth Peer Providers, AY Champions) of our facility	99(48)	77(37)	32(15)
There is communication of national laws and policies, SOPs, and latest revisions on AYFS to service delivery staff	58(28)	105(50)	45(22)

Further, the findings show that about half 111(53%) of the respondents stated that there were school health programs organized by the school. However only 78 (38%) of the respondents stated they visited schools regularly to share information and only 74 (36%) were involved in capacity building of teachers in the nearby schools on AYFS and CSE. These findings contrary to Dawson et al. (2013) who recommended that to have effective dissemination of information to young people in schools there need to have; training of HCPs, teachers and embrace inter-professional education; well defined roles and responsibilities and mechanisms for effective multisectoral collaboration and coordination of AYFS interventions. Juke et al. 2008 as cited in (Nicholls et al.,

2012) states that reaching the adolescent with SRH information is best enhanced by teachers and that this kind of information has a great impact in improving the health of the adolescents as well as minimizing challenges such as adolescent pregnancy and HIV infection. Less than half 99 (48%) indicated that they identify AYFS advocates in their facility yet according to De et al., (2019), to enhance support and recognition of the various vulnerable subgroups of the AY, collaboration with CSOs, relevant AY organizations including movements that fight for rights of young people is of great importance. Only 28% of the respondents reported that there was communication of national laws and policies, SOPs, and latest revisions on AYFS to service delivery staff this agrees with regional report 2021, on assessment of AYFS which indicated that 50% of health facilities visited had the national AYFS policy documents available, however, there was inadequate knowledge of these documents among the HCPs.

4.8 Descriptive Statistics on Networking of Stakeholders in Provision of AYFS

Networking of stakeholders in AYFS focused on mapping of AYFS supporting partners, linkage and networking among partners, community and other sectors, public private partnership and documentation of best practices and lessons learnt. Results are presented in Table 4.8.

Table 4. 7:

Descriptive Statistics on Networking of Stakeholders in Provision of AYFS

Statement	Yes n(%)	No n(%)	Don't Know n(%)
Mapping of all AYFS supporting stakeholders/partners	59(28)	77(37)	72(35)
There is identification of community resources including building partnership for AYFS provision	65(31)	93(45)	50(24)
There is AYFS advocacy with service delivery point staff and relevant stakeholders	78(38)	76(37)	54(26)
The AYFS sharing of facility best practices is done	70(34)	91(44)	47(23)
Monitoring and evaluation of the implementation of quality standards in the service delivery point is done	95(46)	72(35)	41(20)
Liaise with the implementing partners to support the dissemination of the AYFS guidelines	89(43)	82(39)	37(18)
Liaise with the implementing partners to provide technical assistance on AYFS	91(44)	70(34)	47(23)

Results show that 59(28%) and 65 (31%) of the respondents reported to be mapping AYFs stakeholders and building up partnerships for AYFS advocacy in their facilities respectively. These findings don't reflect recommendations by (De et al., 2019) who stated that the ministry of health may take lead in adolescent health matters, though, to achieve the overall health and wellbeing of the adolescents and young people in general, a multi-sectoral approach must be embraced especially the key sectors such as education. Further to this, the Kenya AYFS guidelines states that services offered by the community as well as community outreaches and the role of school in provision of AYFS service must be highly recognized as far networking of AYFS is concerned.

Additionally, only 78(38%) stated that they were advocating for ownership and implementation of AYFS policies while 70(34%) were identifying, sharing and documenting best practices on AYFS with stakeholders. The findings are irreconcilable with Kareta et al 2021, who states that the main important factors to consider in ensuring successful implementation of AYFS are; engaging key stakeholders including the AY from the beginning of the AYFs design, to the organizing, execution and its controlling and evaluation; use of evidence in making decisions; conducive aspects surrounding policy making and assisting the government to have a favorable environment for provision of AYFS.

Further, 89(43%) were liaising with implementing partners for support in dissemination of AYFS guidelines and 91(44%) were receiving technical support for implementation of the AYFS guidelines respectively. These findings may suggest that majority of the HCPs may not be aware of the role of implementing partners in the provision of AYFS. The Kenya 2016 guidelines outlines some of the roles of development partners as mobilization of resources for implementation and technical assistance of the AYFS guidelines implementation.

4.9 Descriptive statistics on Community Involvement in Provision of AYFS

Community involvement focused on engaging community members including parents and AY in provision of AYFS. Results are presented in Table 4.8. Nearly half 94(45%) of the respondents reported that they conduct community dialogues on matters of AY health while 114 (56%) reported that they conduct community outreaches to provide AYFS. These findings agree with the views of (Zulu et al., 2018), that making the AYFS compatible within the local context can be enhanced by integration of the AY services within the existing community health systems such as inclusion of the AY interventions in the community unit workplans.

Table 4. 8:

Descriptive Statistics on Community involvement in AYFS

Statement	Yes n(%)	No n(%)	Don't Know n(%)
We conduct community dialogue days on matters pertaining AY health	94(45)	84(40)	30(14)
We conduct community outreaches to provide AYFS at the community	117(56)	70(34)	21(10)
We conduct parenting forums in order to promote AYFS uptake by the AY	77(37)	104(50)	27(13)
We engage the community in the planning, implementation and M&E of AYFS Provision	62(30)	102(49)	44(21)
We form networks for AY health peer educators to promote AYFS	92(44)	84(40)	32(15)
Marginalized and vulnerable AY are identified and involved in AYFS	94(45)	83(40)	31(15)
young people are engaged, as appropriate, in-service delivery, including appointing AY members of Health Facility Committees	101(49)	74(36)	33(16)
The facility Develops dialogue platforms for AY that will utilize current technological advancements	63(30)	96(46)	49(24)
We Involve AY in the facility health care worker trainings on AYFS	76(37)	94(45)	38(18)

Very few of respondents 77(37%) were conducting parents' forums on AYFS and only 62(30%) were engaging community in planning and implementation of AYFS. Recommendations from the report of AY stock staking by (FHI360 & MOH, 2011) urged inclusion of communities in AY health programming to curb existing challenges and break the social cultural obstacles regarding provision of AYFS including sharing knowledge to the young people. Further, less than half of the

respondents 92(44%) and 94(45%) formed networks for AY health and identified marginalized AY in provision of AYFS respectively. Only 30% of the respondents reported to develops dialogue platforms for AY to utilize current technological advancements and 37 % stated that they involve the AY in the AYFS trainings for HCPs. The findings on AY involvement are not in agreement with Kereta et al. (2021) who stated that as primary beneficiaries of AYFS, AY need to be involved from the inception and continue with the engagement all through the entire process of the program as they are influential in identifying the existing obstacles, recognizing the wants of AY within their locality, suggesting relevant ways to tackle their barriers in addition to enhancing fellow peers to take up the AYFS services.

4.10 Bivariate Analysis

4.10.1 Chi Square Measure of Association

Cross tabulations were done to establish whether there was a relationship between each independent variable and the dependent variable. The Chi-Square statistic was used to evaluate tests of independence of the categorical variables. The results are presented Table 4.10.

Table 4. 9:

Chi-Square Measure of Association

Variable	**Sample Size**	**X^2**	**Df**	***P-value***
Capacity Building on AYFS	208	62.535	1	0.001
Coordination of AYFS	208	48.310	1	0.001
Networking by stakeholders	208	31.583	1	0.001
Community Involvement	208	43.962	1	0.001

Results indicate that Capacity Building on AYFS, Coordination of AYFS, Networking by stakeholders and Community Involvement were significantly associated with provision of AYFS in the county of study. The results were significant at $p<0.05$.

4.10.2 Correlation Coefficient

Correlation coefficient of the categorical variables was undertaken using Spearman's Rank test. This test was undertaken to determine the level of significance of each independent variable and the dependent variable. Further a correlation coefficient was used to measure the strength of the association of the variables. Results are presented in Table 4.11.

Table 4. 10:

Correlation Coefficient

			Y	Xi	Xii	Xiii	Xiv
Spearman's rho	Y	Correlation Coefficient	1.000				
		Sig. (2-tailed)					
		N	208				
	Xi	Correlation Coefficient	.548**	1.000			
		Sig. (2-tailed)	.000				
		N	208	208			
	Xii	Correlation Coefficient	.482**	.426**	1.000		
		Sig. (2-tailed)	.000	.000			
		N	208	208	208		
	Xiii	Correlation Coefficient	.390**	.344**	.491**	1.000	
		Sig. (2-tailed)	.000	.000	.000		
		N	208	208	208	208	
	Xiv	Correlation Coefficient	.460**	.308**	.475**	.497**	1.000
		Sig. (2-tailed)	.000	.000	.000	.000	
		N	208	208	208	208	208

Capacity Building on AYFS(Xi), Coordination of AYFS(Xii), Networking by stakeholders (Xiii), Community Involvement (Xiv).

A positive and significant association was found between all the independent variables and the dependent variable. Capacity building (*p=0.001, r=.548*) Coordination (*p=0.001, r=*.482), Networking by stakeholders (*p=0.001, r=*.390), and Community Involvement (*p=0.001, r=*.460), positively and significantly influenced provision of AYFS. Results indicate that, capacity building or training was strongly correlated with provision of AYFS, followed by coordination, followed by community involvement, and finally networking by stakeholders.

Indeed, a facility in charge reported training to be key in delivery of AYFS

"…. empowering them through trainings, updates and even benchmarking. Then there is motivational speaking, they also attend some, to get the updates on youths' management…." FII001

Coordination by having, planned school health programs organized by the facility and having AYFS advocates i.e., youth peer providers or AY Champions were key in provision of AYFS. Coordination by having standards and guidelines was also found necessary in provision of AYFS.

"…yes, we have the guidelines for adolescents and youth friendly services which are in their room in fact they are in clinical rooms, and they are in MCH because we have adolescents who are pregnant and they come to the MCH…" FII003

Networking by stakeholders was found to positively influence provision of AYFS. This was through mapping of stakeholders, building partnership for advocacy, liaising with the implementing partners to support the dissemination of the AYFS guidelines and to provide technical assistance in the implementation of the AYFS. Key informants had to this to say;

"We have partners like KMET who support the youth and we also have other sectors like the Ministry of Education and even other ministries like the Social services…."FII001

"We use the Youth Leads who assist us in engaging with the other sectors. Then we have several partners like Lwala, Ciheb Kenya who assist us. We have The Ministry of Education who follow up in schools. We do work with the CHV, we do give health education when we have community dialogue. … So we work hand in hand with the community through the CHVs. FII002

Community Involvement was found to positively influence provision of AYFS. Community involvement was done by facilities conducting community dialogue days on matters pertaining AY health, conducting community outreaches to provide AYFS at the community especially during school holidays, conducting parents' forums in order to create awareness among parents, engaging the community in the planning, implementation and monitoring and evaluation of AYFS in the facilities. Community involvement is also promoted through networks of AY health peer educators and champions and by involving marginalized and vulnerable adolescents and youth in AYFS. Key informants had this to say.

"We involve parents and guardians in the provision of services since they are the ones that accompany them to the facilities, we also work closely with the CHVs since they mobilize them…" FII002

"We have youth champion, the police department because these youths also have other challenges like maybe gender-based violence cases, we work hand in hand with other stakeholders like the church leaders so that we engage all of them in matters pertaining to adolescents and youth services…. " FII003

4.11 Multivariate Analysis

Binary Logistic regression was performed to determine how capacity building on AYFS (Xi), coordination of AYFS(Xii), networking of stakeholders on AYFS(Xiii) and community involvement in AYFS(Xiv) altogether influence Provision of AYFS(Y). Hosmer and Lemeshow Goodness-of-fit test (GOF) was used to decide whether the study model was correctly specified. The results indicate that the logistic regression model was statistically significant, $\chi 2$ (5) = 7.853,

p=0.165. If a GOF result is a p-value below 0.05, you reject the prediction model, if the GOF results p-value is higher than 0.05, you do not reject the prediction model. The model explained 56.0% (Nagelkerke R^2) of the variations in provision of AYFS and correctly classified 86.1% of provision of AYFS. Further in a combined relationship, capacity building, coordination and community involvement had a significant association with provision of AYFS with p-values less than 0.05. See Table 4.11. These findings agree with the systems theory as observed by Kaplan et al. (2013) various elements involved in patients care along with a wide range of factors influencing health. Further to, having a clear understanding of the mutual relationships of these elements, the systems model guides how to amalgamate; human resource, processes, policies and organizations to improve health with minimal logistics. Additionally, Hespanha (2018) highlighted basic principles governing the systems theory including a system includes sub-parts that work together. Every sub-part supports the entire system and any malfunction in the sub-part affects the whole system.

Table 4. 11:

Multivariate Analysis

Variables in the Equation

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Capacity building	2.312	.471	24.063	1	.000	10.092	4.007	25.417
Coordination of AYFS	1.094	.499	4.815	1	.028	2.987	1.124	7.937
Networking of stakeholders	.800	.535	2.234	1	.135	2.225	.780	6.349
Community involvement	1.605	.507	10.037	1	.002	4.979	1.844	13.441
Constant	-1.517	.386	15.439	1	.000	.219		

a. Variable(s) entered on step 1: Capacity building, Coordination of AYFS, Networking of stakeholders Community involvement,

Results with a p-value of less than 0.05 were interpreted to be significant.

Capacity building (*p=0.001*) was found to have a significant association with provision of AYFS. There was a 10.092-fold increase in the odds of providing AYFS among workers who were trained on AYFS, than those who were not trained. On-job training seems to be the most prevalent form of capacity building as majority indicated that pre-service training on AYFS is not done. Majority said on job training covers characteristics of AY growth and development, responsive health care, clinical guidelines on adolescent and youth friendly services provision, checklist for standard and quality of provision of AYFS, checklist for appropriate and relevant infrastructure and technology and training also covers monitoring, evaluation, supportive supervision and research in AYFS. Interview results with the Facility in charge show that capacity building is an important aspect in provision of AYFS.

"…one of my roles is that we have what is called training log, making sure that the staff who are supposed to be trained are trained, we have what is called mentorship or OJT which is on-going…" FII003

Coordination of AYFS (*p=0.028)* was found to have a significant association with provision of AYFS. There was a 2.987-fold increase in the odds of providing AYFS when coordination of AYFS actors and activities was done than where coordination was not done. Coordination was achieved through participation in AY TWGs, intersectoral review meetings, school health programs, identification of AY advocates and communication of AYFS laws and policies

Community involvement (*p=0.002*) was found to have a significant association with provision of AYFS. There was a 4.979 -fold increase in the odds of providing AYFS when there was community involvement than where there was no community involvement. Community

involvement was done through conducting community dialogues and outreaches, conducting parenting forums to promote AYFS uptake and community engagement in all phases of AYFS provision.

"…..They prefer sharing with their peers than the parents. In most cases we have the peer educators that are of their age that may assist them. We have the outreaches and also the in-reaches organized by the youths themselves through the facility to create awareness and mobilization….."FII001

"Okay, other sectors like the community, that is the CHVs we have mentored them and some of them are even trained on adolescent issues and to make what is called referrals for these cases..."FII003

Networking of stakeholders (*p=0.135) was* found not to be significant in provision of AYFS this is most likely because the HCPs reported that they were not mapping the stakeholders relevant to AYFS within their facilities neither were they liaising with the implementing partners to support in dissemination of AYFS policies within facility.

CHAPER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of finding, the conclusion based on the research questions, study recommendation and recommendations for further research.

5.2 Summary of Findings

This study sought to determine strategies influencing the provision of adolescent and youth friendly services (AYFS) within public health facilities in Migori County. The specific objectives were to determine how capacity building of health care providers, coordination of Adolescent and Youth Friendly Services (AYFS), networking of relevant stakeholders and community engagement influences provision of AYFS in public health facilities in Migori County.

This was a cross sectional study with mixed methods approach. Data was collected using a structured questionnaire, key informant interview guide and a facility check list. Data was analyzed both quantitatively and qualitatively. The study was conducted in public health facilities within the County of Migori, located in southwestern part of Kenya. The study sample included, 213 health care providers (clinical officers and nurses) providing AYFS in 114 public health facilities including three facilities in charges selected from each level of those public facilities.

Descriptive statistics on capacity building of health workers on AYFS show that, majority of the respondents 138(66%) knew that the AYFS training include essential package of care, 146(70%) responded that the training addressed responsive care to AY. Less than half of the respondents

83(40%) and 76(37%) reported that they had preservice training on module for AYFS and regular updates on AYFS in their facilities respectively.

Descriptive statistics on coordination show that 141 (68%) of the respondents did not participate in the AY TWGs at the facility or sub county level and only 79(38%) had feedback from the AY TWG shared to facility staff. Additionally, majority of the respondents 123(59%) indicated that there were no stakeholder's meetings organized by the facility on matters of AYFS. for example, the education sector, police among other key AY stakeholders. Further, the findings show that about half 111(53%) of the respondents stated that there were school health programs organized by the school. However only 78 (38%) of the respondents stated they visited schools regularly to share information and only 74 (36%) were involved in capacity building of teachers in the nearby schools on AYFS and CSE.

Descriptive statistics on networking of stakeholders show that mapping AYFs partners and building up partnerships for AYFS advocacy was not done in facilities, as presented by 59(28%) and 65 (31%) respectively. Additionally, only 78(38%) were advocating for ownership and implementation of AYFS policies while 70 (34%) were identifying, sharing, and documenting best practices on AYFS with stakeholders. Less than half of the respondents 89(43%) were liaising with implementing partners for support in dissemination of AYFS guidelines and only 91(44%) had technical support for implementation of the AYFS guidelines.

Descriptive statistics on community involvement show that nearly half 94(45%) of the respondents were conducting community dialogues on matters of AY health while 114 (56%) conducting

community outreaches to provide AYFS. Further, results show that parents are not fully involved in AYFS provision, 131(63%) of the respondents said that parents' forums on AYFS are not held and that community is not involved in planning and implementation of AYFS, 146(70%). Further, more than half of the respondents 116 (55%) did not form networks for AY health as well as identify and involve marginalized AY in provision of AYFS,114 (54%). Only 63 (30%) of the respondents reported to develop dialogue platforms for AY to utilize current technological advancements and 76 (37%) stated that they involve the AY in the AYFS trainings for HCPs.

Inferential analysis was done using bivariate and multivariate analysis. Bivariate analysis was undertaken using chi square and spearman's rank correlation coefficient. These tests were undertaken to determine the level of significance of each independent variable and the dependent variable. Capacity Building on AYFS *(p=0.001),* Coordination of AYFS *(p=0.001),* Networking by stakeholders *(p=0.001)* and Community Involvement *(p=0.001)* were significantly associated with provision of AYFS in the County of study. The results were significant at $p<0.05$. Further a correlation coefficient was used to measure the strength of the association of the variables. A positive and significant association was found between all the independent variables and the dependent variable. Capacity building (*p=0.001, r=.548*) Coordination (*p=0.001, r=*.482), Networking by stakeholders (*p=0.001, r=*.390), and Community Involvement (*p=0.001, r=*.460), positively and significantly influenced provision of AYFS.

Multivariate analysis was undertaken to determine if the four study variables influenced provision of AYFS. The model explained 56.0% (Nagelkerke R^2) of the variations in provision of AYFS and correctly classified 86.1% of provision of AYFS. Results with a p-value of less than 0.05 were

interpreted to be significant. Capacity building *p=0.001*), Coordination of AYFS (*p=0.028),* and Community involvement (*p=0.002*) were all found to have a significant association with provision of AYFS.

5.3 Conclusion

This study sought to determine strategies influencing the provision of adolescent and youth friendly services (AYFS) within public health facilities in Migori County. The specific objectives were to determine how capacity building of health care providers, coordination of Adolescent and Youth Friendly Services (AYFS), networking of relevant stakeholders and community engagement influences provision of AYFS in public health facilities in Migori County

Capacity building or training of health care providers on AYFS had a positive and significant association with provision of AYFS in public health facilities in Migori County. In-service training seems to be the most prevalent form of capacity building as majority indicated that pre-service training on AYFS is not often done. The AYFS in service trainings cover aspects of AY growth and development, responsive health care, clinical guidelines, checklist for standard and quality, checklist for appropriate and relevant infrastructure and technology, monitoring, evaluation, supportive supervision, and research on AYFS provision.

Coordination of AYFS was found to have a positive and significant influence on provision of AYFS in public health facilities in Migori County. Coordination was assessed against participation of health care providers in the Adolescent & Youth Technical Working Groups (AY TWGs) at facility level and sub county level; having feedback of the AY TWG meetings being shared to the rest of the facility staff; having stakeholders' meetings organized by the facility on matters of AYFS; having planned school health programs organized by the facility; visiting schools regularly

to share information on AY health matters; building the capacity of teachers in the nearby schools on AYFS including Comprehensive Sexuality Education (CSE); identifying the AYFS advocates; and communicating national laws and policies, SOPs and latest revisions on AYFS to service delivery staff. Coordination seems to be taking place albeit minimally, with most of these scores being less than 40%. Coordination of AYFS seems to be supported by having planned school health programs organized by the facility and having AYFS advocates at the facilities.

Community involvement was found to have a positive and significant influence on provision of AYFS in public health facilities in Migori County. The health facilities mainly conduct community outreaches to provide AYFS at the community especially during school holidays, the facilities also ,though minimally; identify and involve marginalized and vulnerable adolescents and youth on AYFS. Further the facilities engage young people, in service delivery, including using adolescent and youth champions and appointing youth and adolescent members of health facility committees.

Networking of stakeholders in AYFS provision did not have a significant influence on AYFS provision. This may be explained by the fact that majority of the respondents felt that networking was not natured in the county and to some extent some stakeholders who were supporting AYFS are no longer active. Less than 40% of the respondents agreed that mapping of stakeholders is done, that identification of community resources and building partnership for advocacy and service provision for AY is done within the facilities. Further little is being done in advocating with service delivery point staff, other sector services and the wide community to ensure ownership and support for implementation of key AYFS Policies. Also, identification, sharing and documentation of facility best practices on AYFS with stakeholders is rarely done.

5.4 Recommendations

i. On average capacity building of health care providers on AYFS provision is taking place in Migori County, however, pre-service training curriculum seldom includes a module (s) on AYFS. Regular updates and trainings on provision of AYFS within the facility is not often done. Therefore, training institutions, ought to include a module(s) on AYFS in pre-service curriculum. Regular updates on AYFS should be communicated to the facilities. Orientation of new staff and regular in-service trainings of all staff on AYFS should be done to increase the numbers trained. Health is a right, hence AYFS should be supported to improve the lives of the young people.

ii. Coordination of AYFS can be improved if the facility through the county health and education departments organizes and facilitates school outreaches to share AY health matters with young people, including building the capacity of teachers on AYFS including Comprehensive Sexuality Education (CSE). Communication of national laws and policies, SOPs, and latest revisions on AYFS to service delivery staff is necessary in promoting coordination. This communication can be through the facility meetings such as facility AY TWGs and CMEs.

iii. Networking of stakeholders is taking place in the county albeit at a very minimal level. Therefore, the county department of health ought to map all relevant stakeholders with the health facilities, build partnership for advocacy, promote ownership and support for implementation of key AYFS policies and standards. Stakeholders should together identify, share and document facility best practices on AYFS.

iv. To improve community involvement, health care providers should hold parenting forums to promote awareness of AYFS among parents. Communities through their representatives

should be engaged in the planning, implementation, and monitoring of AYFS Provision. Total involvement of AY health peer educators and champions should be encouraged; peer educators have the capacity to draw more young people to seek services at the health facilities including the vulnerable. Facilities should develop dialogue platforms for AY that will utilize current technological advancements to promote their health and well-being. Further, the HCPs need to leverage in the existing community health services strategy within the county by use of Community health promoters to mobilize for utilization of AYFS during their routine household visits.

v. The county needs to avail and disseminate AYFS policies and reinforce the adherence of the use of all the recommended AYFS policies, guidelines, protocols and Sops during AYFS provision

5.5 Recommendations for further Research

Further research should be carried out to explore the remaining AYFS strategies not covered in this study. These are social mobilization, advocacy and policy dialogue, and referral, linkage, and follow-up to assess how these strategies influence provision of AYFS. This will inform prioritization in allocating resources, so that the strategy with the most influence on service provision can be prioritized. Further, an assessment of the implementation of the Kenya 2016 AYFS Guidelines need to be conducted within the public facilities to ascertain the level of implementation of these guidelines.

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LIST OF APPENDICES

APPENDIX ONE: INFORMED CONSENT FORM

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is **Lillian Njoki Nyaga**. I am a MSc. student from Kenya Methodist University. I am conducting a study titled: ***strategies influencing provison of adolescent and Youth friendly services among GOK facilities in Migori county*** The findings will be utilized to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This research proposal is critical to strengthening health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Procedure to be followed
Participation in this study will require that I ask you some questions and also access all the facility's department to address the six pillars of the health system. I will record the information from you in a questionnaire check list. You have the right to refuse participation in this study. You will not be penalized nor victimized for not joining the study and your decision will not be used against you nor affect you at your place of employment.
Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks.
Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits
If you participate in this study you will help us to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This field attachment is critical to strengthening the health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Rewards
There is no reward for anyone who chooses to participate in the study.

Confidentiality
The interviews will be conducted in a private setting within the facility. Your name will not be recorded on the questionnaire and the questionnaires will be kept in a safe place at the University.

Contact Information
If you have any questions you may contact the following supervisors:

1. Dr.Eunice Mwangi at muthoni.mwangi@aku.edu
2. Mr. Musa Oluoch at musadot123@gmail.com

Participant's Statement
The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.
Name of Participant ……Date…….
Signature…….

Investigator's Statement
I, the undersigned, have explained to the volunteer in a language s/he understands the procedures to be followed in the study and the risks and the benefits involved.

Name of Interviewer……Date…….
Interviewer Signature……

APPENDIX TWO: QUESTIONNAIRE FOR HEALTHCARE PROVIDER

SECTION A: DEMOGRAPHICS

1. **Your gender? (Tick Appropriately)**

Male [ ] Female [ ]

2. **Your age brackets? (Tick Appropriately)**

Below 25 years [ ] 25 - 30 years [ ]

31 - 36 years [ ] 37 – 42 years [ ]

43 – 48 years [ ] 49 – 54 years [ ]

Above 54 years [ ]

3. **What is your current profession?**

Nurse [ ]

Clinical Officer [ ]

4. **What is your highest level of education?**

Certificate Level [ ] College Diploma [ ]

Higher Diploma [ ] Bachelor's Degree [ ]

Postgraduate Degree [ ] Doctorate Degree [ ]

5. **How many years have you worked in the current position?**

Less than 1 year [ ] between 1-5 years [ ]

Between 6-10 years [ ] 10 years and above [ ]

6. Health Facility Location

Migori County Teaching & Referral Hospital (MTRH) [ ]

7.Sub CountyHealth Facility Location

Rongo Sub-County [ ] Kura East Sub-County [ ] Kura West Sub-County [ ] Nyatike Sub-County (Nyatike) [ ] Suna West Sub-County [ ] Suna East Sub-County [ ] Awendo Sub-County [ ] Uriri Sub-County [ ]

Date _____

SECTION B: CAPACITY BUILDING ON AYFS

This section seeks to elicit your opinion on the research objective one the influence of health workers training on the provision of adolescent and youth friendly services (AYFS) in Migori County. Please tick in the appropriate box that applies to your evaluation of the following statement with: Yes, No, or Don't Know

(a)	***Capacity building on AYFS***			
1	The AYFS training package captures characteristics of growth and development services?	Yes	No	Don't Know
2	The AYFS training standards addresses AY responsive health care?	Yes	No	Don't Know
3	The AYFS training include clinical guidelines on AYFS?	Yes	No	Don't Know
4	The AYFS training includes recommendations for reaching vulnerable sub populations of young?	Yes	No	Don't Know
5	The AYFS training includes checklist for standard and quality of provision of AYFS?	Yes	No	Don't Know
6	The AYFS training includes checklist for appropriate provision of AYFS?	Yes	No	Don't Know
7	The AYFS training includes monitoring, evaluation, supportive supervision, and research in AYFS?	Yes	No	Don't Know
8	During your pre-service training in college, was there a module on AYFS	Yes	No	Don't Know
9	There are regular updates on provision of AYFS within the facility?	Yes	No	Don't Know
(b)Provision of AYFS				
1	I'm aware of the adolescent and youth friendly services?	Yes	No	Don't know
2	I have been sensitized or oriented on the provision of AYFS	Yes	No	Don't know
3	The AYFS training promote value clarification and attitude transformation (VCAT) of adolescent and youth friendly services?	Yes	No	Don't Know
4	The AYFS training imparts knowledge and skills on AY privacy and confidentiality services?	Yes	No	Don't Know
6	The AYFS training standards are cognizant of favorable attitudes towards AY services?	Yes	No	Don't Know
7	The AYFS training leads to setting up AYFS in the facility?	Yes	No	Don't Know
8	The training includes strategies, approaches and service delivery models for AYFS?	Yes	No	Don't Know

SECTION C: COORDINATION OF AYFS

This section seeks to elicit your opinion on the research objective two the influence of coordination of the adolescent and youth friendly services on provision of adolescent and youth friendly services (AYFS) in Migori County. Please tick in the appropriate box that applies to your evaluation of the following statement with: Yes, No, Don't Know

(a)	***Coordination of AYFS***			
1.	I participate in the AY TWGs at facility level and subcounty level	Yes	No	Don't Know
2.	Feedback of the AYTWG meetings is shared to the rest of the facility staff	Yes	No	Don't Know
3.	There are stakeholders' meetings organized by the facility on matters of AYFS	Yes	No	Don't Know
4	There are planned school health programs organized by the facility	Yes	No	Don't Know
5	The schools are visited regularly for information sharing of AY health matters	Yes	No	Don't Know
6	We are involved in building the capacity of teachers in the nearby schools on AYFS	Yes	No	Don't Know
7	We identify the AYFS advocates of our facility	Yes	No	Don't Know
8	There is communication of national laws and policies, SOPs and latest revisions to service delivery staff	Yes	No	Don't Know
(b)Provision of AYFS				
1	The AYFS plans are integrated in the facility annual work plan	Yes	No	Don't Know
2	We inform the SCHMT/CHMT through our facility in charge the facility AYFS needs	Yes	No	Don't Know

SECTION D: NETWORKING OF AYFS

This section seeks to elicit your opinion on the research objective three on the influence of networking of relevant stakeholders in provision of Adolescent and Youth Friendly Services in public health facilities in Migori County. Please tick in the appropriate box that applies to your evaluation of the following statement with: Yes, No, Don't Know

(a)	***Networking of AYFS***			
1.	Mapping of all the supporting partners on AYFS is done	Yes	No	Don't Know
2.	Identification of community resources and building partnership for advocacy and service provision for AY within the facility is done?	Yes	No	Don't Know
3.	There is Advocating with service delivery point staff, other sector services and the wide community to ensure ownership and support for implementation of key AYFS Policies?	Yes	No	Don't Know
4	Identification, sharing and documentation of facility best practices on AYFS with stakeholders is done?	Yes	No	Don't Know
5.	The facility ensures there is monitoring and evaluation of the implementation of quality standards in the service delivery point and use data to stimulate action?	Yes	No	Don't Know
6	Liaising with the implementing partners to support the dissemination of the AYFS guidelines within the facility is done?	Yes	No	Don't Know
7	Liaising with the implementing partners to provide technical assistance in the implementation of the AYFS guideline is done?	Yes	No	Don't Know
(b)Provision of AYFS				
1	There is awareness creation of adolescent and youth friendly services among the stake holders?	Yes	No	Don't Know
2	The facility conducts community outreaches involving the CHVs and CHEWs to reach the AY at the rural and hard to reach areas?	Yes	No	Don't Know
3	There is an elaborate referral system to ensure services not available at the facility can be obtained in the nearest private facility?	Yes	No	Don't Know
4	Service providers are oriented on effective referral mechanisms?	Yes	No	Don't Know
5	Service providers are aware of the AYFS county referral directory?	Yes	No	Don't Know

SECTION E: COMMUNITY INVOLVEMENT

This section seeks to elicit your opinion on the research objective four the influence of community engagement on provision of Adolescent and Youth Friendly Services in public health facilities in Migori County.

(a)	***Involvement of community gatekeepers/parents***			
1	We conduct community dialogue days quarterly on matters pertaining AY health	Yes	No	Don't Know
2	We conduct community outreaches to provide AYFS at the community especially during school holidays	Yes	No	Don't Know

3	We conduct parenting forums to promote AYFS uptake by the Adolescent and Youth	Yes	No	Don't Know
4	We engage the community in the planning, implementation, and M&E of AYFS Provision at our facility	Yes	No	Don't Know
(b)	***Involvement of adolescents and youth***			
1	We form networks for AY health peer educators and champions to promote AYFS within the facility	Yes	No	Don't Know
2	We identify and involve marginalized and vulnerable adolescents and youth on AYFS	Yes	No	Don't Know
3	We Engage young people, as appropriate, in-service delivery, including appointing AY members of Health Facility Committees	Yes	No	Don't Know
4	The facility Develops dialogue platforms for adolescents and youth that will utilize current technological advancements	Yes	No	Don't Know
5	We Involve adolescents and youth in the facility health care worker trainings on AYFS	Yes	No	Don't Know
(c)Provision of AYFS				
1.	We regularly sensitize the community including parents on AYFS	Yes	No	Don't Know
2.	We conduct facility whole site orientation on AYFs including the community gate keepers as participants	Yes	No	Don't Know
3.	The AY are involved in the design, planning, implementation and evaluation of the facility AYFS programs	Yes	No	Don't Know

APPENDIX THREE: PROVISION OF AYFS OBSERVATION CHECKLIST

Level of facility----------

Subcounty ----------

	CHARACTERISTICS OF AYFS	YES	NO	COMMENTS
Equitable AYFS				
1	Policies and procedures that ensure services are offered to all AY without discrimination available			
2	Service providers administer the same level of care to all AY without discrimination			
Accessible AYFS				
1	AYFS services are free			
2	Convenient hours for AYFS provision			
3	Community informed on the benefits and availability of AYFS			
4	Signage available and visible at the point of service delivery with range of services and operating hours			
5	Adolescents well-informed about the range of available services and how to obtain them			
6	Facilities are conveniently located for ease of access to adolescent and youth clients			
Acceptable AYFS				
1	AY able to consult with service providers at short notice, whether or not they have a formal appointment.			
2	Service provider spend adequate time with AY clients			
3	Service providers are respectful and non-judgmental to AY clients			
4	Referral and follow-up done in short and reasonable time frame			

5	Materials provided in a familiar language and responsive to all AY types and needs			
6	Policies and procedures that guarantee AY privacy and confidentiality			
7	Service delivery point appealing and clean			
8	AY actively involved in designing, assessing and providing services			
9	AY involved in decision making on AYFS			
10	Service providers ensures privacy and confidentiality to AY			
Appropriate AYFS				
1	Package that fulfils the needs of adolescents and youth clients available			
2	Referral, linkages and follow-up systems and procedures available			
Effectiveness of AYFS				
1	Service providers have required competencies on AYFS needs			
2	Service providers are trained to provide AYFS			
3	Service delivery point has the relevant and appropriate equipment, supplies and technology to provide services			
4	Service providers use evidence-based protocols and guidelines to provide services			

APPENDIX FOUR: KEY INFORMANT GUIDE FOR FACILITY INCHARGES

1. Level of Health Facility: _____
2. Name of Sub-County: _____
3. Carder ----------
4. Date: ----------

1. **As the facility In-Charge of this facility, what is your opinion about the provision of AYFS within this facility**

_____
_____
_____
_____
_____

(Probe on – no. of HCWS trained on AYFS, involvement of non-medical staff in AYFS, identification of advocates for AYF and Communication of national laws and policies, SOPs and latest revisions to service delivery point staff)

2. **How do you engage other sectors in provision of AYFS (coordination, networking and collaboration)?**

_____
_____
_____
_____

(Probe on - Identify community resources and build partnerships for advocacy and service provision for adolescents and youth, Advocate with service delivery point staff, other sector services and the wide community to ensure their ownership and support for the implementation of key Adolescent SRH and AYFS policies)

3. **How do you ensure that the standards and quality of AYFS provision in the facility are adhered to and maintained?**

_____
_____
_____
_____

(probe on development and adaptation of appropriate local SOPS to implement key policies, Supply staff with information and training materials, AYFS practice guidelines, AYFS Guides, and other decision support tools, ensure an adolescent and youth health focus on facility reports and Monitor and evaluate the implementation of quality standards in the service delivery point and use data to stimulate action)

4. **What are your roles in terms of ensuring competency of your facility staff in the provision of AYFS?**

_____
_____
_____
_____

(note- Plan capacity building activities for facility staff and ensure staff participation and continuous professional education in adolescent & youth health care and in supportive supervision)

5. **How do you ensure continuous supply of AYFS commodities?**

_____
_____
_____
_____

(Inform CHMT about facility needs to enable funds allocation for key activities and Put in place a procurement system to ensure availability of commodities for delivery of required package of services)

6. **How do you promote Equity in provision of AYFS in your facility?**

_____
_____
_____
_____

(Mainstream interventions that address the needs of the persons with disabilities and other marginalized/ vulnerable populations.)

7. **How do you involve the community members, parents and AY in AYFS provision in your facility?**

_____
_____
_____
_____

Probe on the roles of community/parents and AYs?

8. **What other suggestions or remarks do you have in matters of AYFs provision in general?**

_____
_____
_____

APPENDIX FIVE: LEVEL 4 HEALTH FACILITIES AND HCPs SAMPLE FRAME

	Sub-County	Facility Name	Total no. of HCWs	No. of service providers for participation	Facility I/C for KII
1	Awendo	Dede Sub County Hospital	9	3	0
2	Kuria East	Ntimaru Sub-District Hospital	16	3	0
3	Kuria West	Kuria Sub County Hospital	30	3	0
4	Nyatike	Karungu Sub-District Hospital	14	3	0
5	Nyatike	Macalder Sub-County Hospital	14	3	0
6	Rongo	Rongo Sub County Hospital	41	3	0
7	Uriri	Othoro Sub County Hospital	7	3	0
8	Kuria East	Kegonga District Hospital	16	3	0
9	Suna East	Migori County Referral Hospital	27	2	1
10	Rongo	Ongo Sub County Hospital	7	3	0
			181	29	1

APPENDIX SIX: LEVEL 3 HEALTH FACILITIES AND HCPs SAMPLE FRAME

	Subcounty	Facility	Total no. of HCWs	No. of service providers for participation	Facility I/C for KII
1	Kuria East	Gwitembe Health Centre	5	3	0
2	Kuria East	Tisinye Health Centre	6	3	0
3	Kuria West	Masaba Health Centre	5	3	0
4	Kuria West	Nyamekongoroto Health Centre	5	3	0
5	Kuria West	Nyangoge Health Centre	5	3	0
6	Suna East	Ogwedhi Health Centre	8	3	0
7	Suna West	Nyamaraga Sub County Hospital	9	3	1
8	Nyatike	Wath Onger Health Centre	6	3	0
9	Rongo	Minyenya Health Centre	4	3	0
10	Uriri	Oyani Health Centre	10	3	0
11	Kuria East	Kugitimo Health Centre		3	0
12	Kuria West	Mogori-Komasimo Health Centre	5	3	0
13	Kuria West	Nyankore Health Center	2	2	0
14	Nyatike	Obware health center	2	2	0
		Total	72	40	1

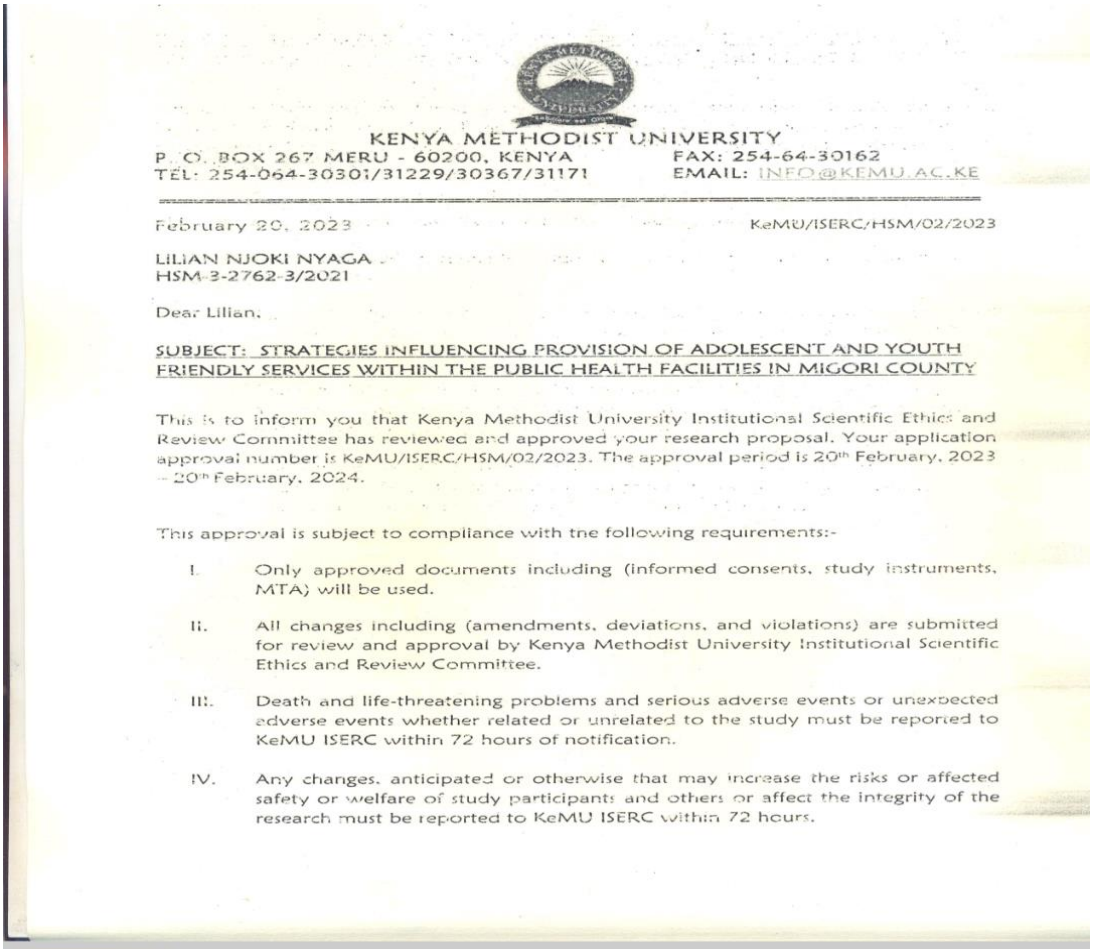
APPENDIX SEVEN: LEVEL 2 HEALTH FACILITIES AND HCPs SAMPLE FRAME

	Sub county	**Facility**	Total no. of HCWs	No. of service providers for participation	Facility I/C for KII
1	Awendo	Kuja Dispensary	3	2	0
2	Awendo	Ng'ong'a Dispensary	2	1	0
3	Awendo	Nyakuru Dispensary	4	2	0
4	Awendo	Rabondo Dispensary	4	2	0
5	Awendo	Ombo Bita Dispensary	3	2	0
6	Awendo	Obama Dispensary	1	1	0
7	Awendo	Bonde Dispensary	2	1	0
8	Kuria East	Maeta Dispensary	2	1	0
9	Kuria East	Nyaroha Dispensary	1	1	0
10	Kuria East	Gairoro Dispensary	2	1	0
11	Kuria East	Nyamagogwi Dispensary	1	1	0
12	Kuria East	Gosebe Dispensary	2	1	0
13	Kuria East	Nyamaranya Dispensary	2	1	0
14	Kuria East	Siabai Makonge Dispensary	2	2	0
15	Kuria West	Motemorabu Dispensary	2	2	0
16	Kuria West	Nyabikaye Dispensary	1	1	0
17	Kuria West	Kohanga Dispensary	1	1	0
18	Kuria West	Komomange Dispensary	2	2	0
19	Kuria West	Nyamekoma Dispensary	1	1	0
20	Kuria West	Nyasese Dispensary	1	1	0
21	Kuria West	Ngisiru Dispensary	2	2	0
22	Kuria West	Robarisia Dispensary	2	2	0
23	Suna East	Midoti Dispensary	4	2	0
24	Suna East	GK Prison Dispensary (Migori)	2	2	0
25	Suna East	Nyarongi Dispensary	3	2	0
26	Suna East	Nyamanga Nyaliende Dispensary	2	2	0
27	Suna East	God Jope Dispensary	3	2	0
28	Suna East	Suna Rabuor Dispensary	3	2	0
29	Suna West	Magacha Dispensary	2	2	0
30	Suna West	Bondo Dispensary	2	2	0
31	Suna West	Kitbul Dispensary	2	2	0
32	Suna West	Kopanga (Gok) Dispensary	2	2	0
33	Suna West	Suna Ragana Health Centre	6	2	0
34	Nyatike	Aneko Dispensary	2	2	0
35	Nyatike	Got Kachola Dispensary	3	2	0
36	Nyatike	Nyandago Koweru Dispensary	3	2	0
37	Nyatike	Yago Dispensary	1	1	0
38	Nyatike	Aego sagenya Dispensary	1	1	0
39	Nyatike	Kanga Onditi Dispensary	1	1	0

40	Nyatike	Thim Lich Dispensary	3	2	0
41	Nyatike	Agenga Dispensary	3	2	0
42	Nyatike	Kipingi Dispensary	2	1	0
43	Nyatike	Otati Dispensary	3	2	0
44	Nyatike	Kituka Dispensary	2	2	0
45	Nyatike	Mugabo Dispensary	1	1	0
46	Nyatike	Winjo Dispensary	1	1	0
47	Nyatike	Namba Kodero Dispensary	3	2	0
48	Nyatike	Kombato Dispensary	2	2	0
49	Nyatike	Got Orango Dispensary	2	2	0
50	Rongo	Ngodhe Dispensary	3	2	1
51	Rongo	Rongo University Medical Centre	8	2	0
52	Uriri	Ombo Kowiti Dispensary	2	2	0
53	Uriri	Piny Owacho Dispensary	2	2	0
54	Uriri	Kamsaki Dispensary	1	1	0
55	Uriri	Lela Dispensary	2	1	0
56	Uriri	Nyamasare Dispensary	3	2	0
57	Uriri	Ongito Dispensary	1	1	0
58	Uriri	Sibuoche Dispensary	5	2	0
59	Uriri	Midida Dispensary	2	2	0
60	Uriri	Thimjope Dispensary	2	2	0
61	Uriri	Rae Kondiala Dispensary	2	2	0
62	Awendo	Kwoyo Kodalo Dispensary	3	2	0
63	Awendo	Otacho Dispensary	3	2	0
64	Awendo	Angogo Dispensary	2	2	0
65	Kuria East	Nyaitara Dispensary	1	1	0
66	Kuria East	Kebaroti Dispensary	1	1	0
67	Kuria East	Girigiri Dispensary	2	1	0
68	Kuria East	Nyametembe Dispensary	1	1	0
69	Kuria West	Iraha Dispensary	2	2	0
70	Kuria West	Getonganya Dispensary	1	1	0
71	Kuria West	Muchebe Dispensary	1	1	0
72	Kuria West	Nyabokarange Dispensary	5	2	0
73	Kuria West	Taranganya Dispensary	2	2	0
74	Suna East	Anjego Dispensary	2	2	0
75	Suna East	Saro Dispensary	4	2	0
76	Suna West	Arombe Dispensary	5	2	0
77	Suna West	Nyamilu Dispensary	2	1	0
78	Suna West	Migori T T C Dispensary	1	1	0
79	Nyatike	Apilo Dispensary	1	1	0

80	Nyatike	Othoch Rakuom Dispensary	3	2	0
81	Nyatike	Olasi Dispensary	3	2	0
82	Nyatike	Kabuto Dispensary	1	1	0
83	Nyatike	Riat Dispensary	1	1	0
84	Nyatike	Migingo Island dispensary Dispensary	2	1	0
85	Nyatike	Lwanda Dispensary	3	2	0
86	Nyatike	Ogongo Community Dispensary	1	1	0
87	Rongo	Kangeso Dispensary	3	2	0
88	Uriri	Omulo Dispensary	2	2	0
89	Uriri	Kolwal Dispensary	2	1	0
90	uriri	Nyasoko dispensary	2	2	0
		Total	202	142	1

APPENDIX EIGHT: KEMU ETHICAL CLEARANCE



KENYA METHODIST UNIVERSITY
P. O. BOX 267 MERU - 60200, KENYA
TEL: 254-064-30301/31229/30367/31171
FAX: 254-64-30162
EMAIL: INFO@KEMU.AC.KE

February 20, 2023

KeMU/ISERC/HSM/02/2023

LILIAN NJOKI NYAGA
HSM-3-2762-3/2021

Dear Lilian,

SUBJECT: STRATEGIES INFLUENCING PROVISION OF ADOLESCENT AND YOUTH FRIENDLY SERVICES WITHIN THE PUBLIC HEALTH FACILITIES IN MIGORI COUNTY

This is to inform you that Kenya Methodist University Institutional Scientific Ethics and Review Committee has reviewed and approved your research proposal. Your application approval number is KeMU/ISERC/HSM/02/2023. The approval period is 20th February, 2023 – 20th February, 2024.

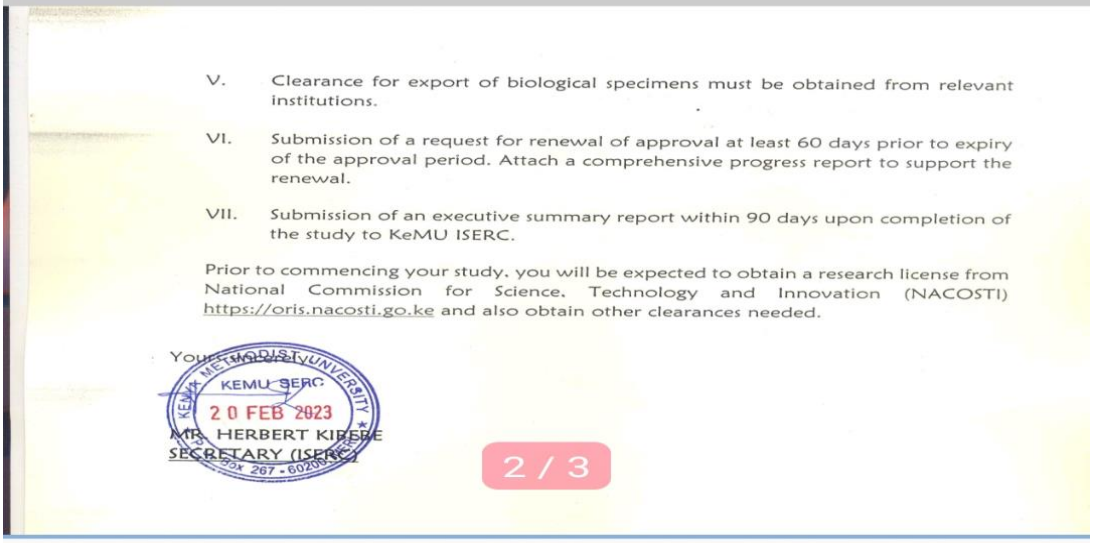
This approval is subject to compliance with the following requirements:-

I. Only approved documents including (informed consents, study instruments, MTA) will be used.

II. All changes including (amendments, deviations, and violations) are submitted for review and approval by Kenya Methodist University Institutional Scientific Ethics and Review Committee.

III. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KeMU ISERC within 72 hours of notification.

IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU ISERC within 72 hours.



V. Clearance for export of biological specimens must be obtained from relevant institutions.

VI. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.

VII. Submission of an executive summary report within 90 days upon completion of the study to KeMU ISERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

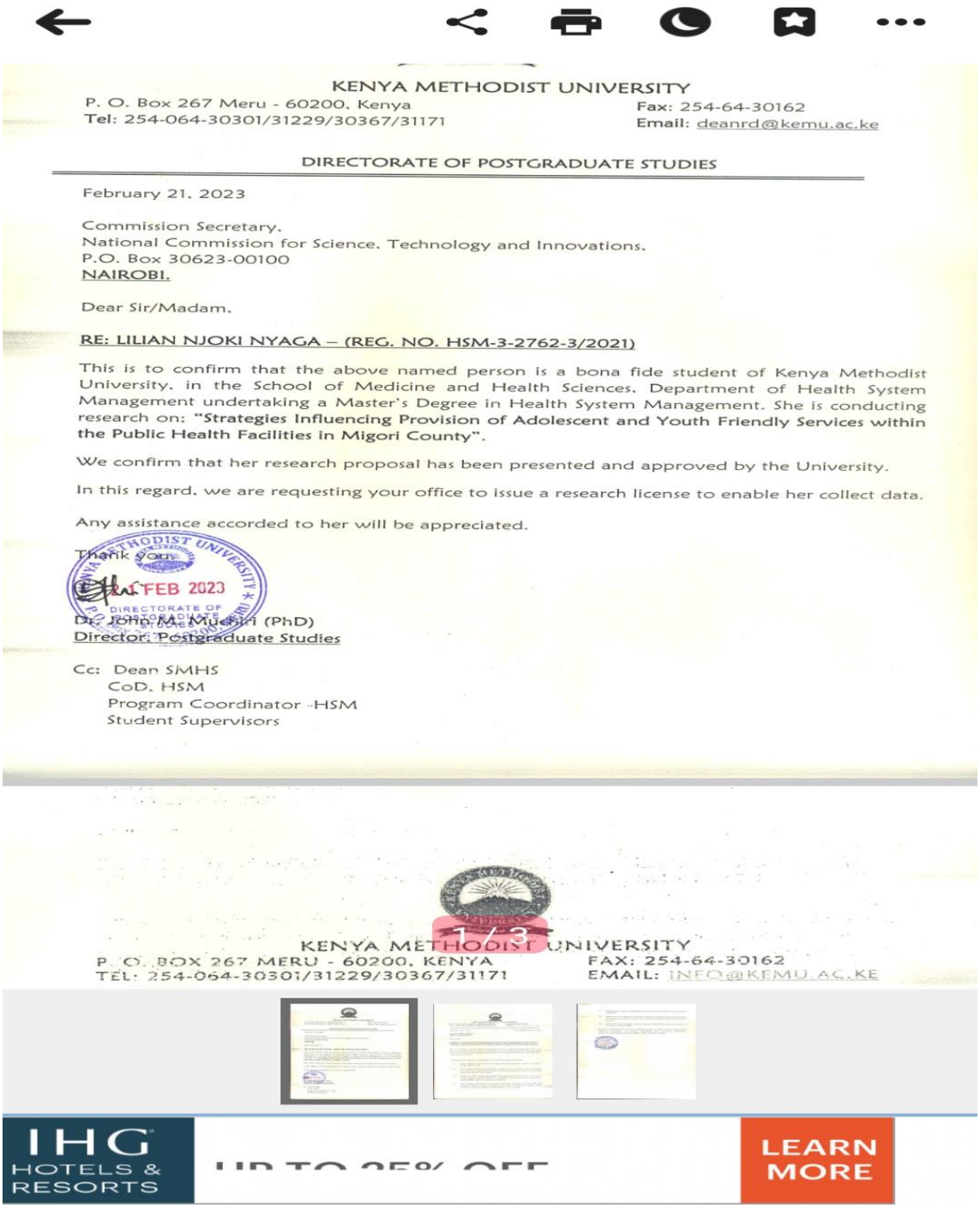
Yours faithfully

KENYA METHODIST UNIVERSITY
KEMU-SERC
20 FEB 2023
P.O. Box 267 - 60200 MERU

MR. HERBERT KIRIEBE
SECRETARY (ISERC)

2 / 3

APPENDIX NINE: NACOSTI LETTER



KENYA METHODIST UNIVERSITY
P. O. Box 267 Meru - 60200, Kenya
Tel: 254-064-30301/31229/30367/31171
Fax: 254-64-30162
Email: deanrd@kemu.ac.ke

DIRECTORATE OF POSTGRADUATE STUDIES

February 21, 2023

Commission Secretary,
National Commission for Science, Technology and Innovations,
P.O. Box 30623-00100
NAIROBI.

Dear Sir/Madam,

RE: LILIAN NJOKI NYAGA – (REG. NO. HSM-3-2762-3/2021)

This is to confirm that the above named person is a bona fide student of Kenya Methodist University, in the School of Medicine and Health Sciences, Department of Health System Management undertaking a Master's Degree in Health System Management. She is conducting research on: **"Strategies Influencing Provision of Adolescent and Youth Friendly Services within the Public Health Facilities in Migori County".**

We confirm that her research proposal has been presented and approved by the University.

In this regard, we are requesting your office to issue a research license to enable her collect data.

Any assistance accorded to her will be appreciated.

Thank you.

FEB 2023

Dr. John Mwaniki (PhD)
Director, Postgraduate Studies

Cc: Dean SMHS
CoD, HSM
Program Coordinator HSM
Student Supervisors

KENYA METHODIST UNIVERSITY
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EMAIL: INFO@KEMU.AC.KE

APPENDIX TEN: MIGORI COUNTY AUTHORIZATION LETTER

15:30 49%

Lilian Njoki Nyaga - Resear...

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF MIGORI
DEPARTMENT OF HEALTH SERVICES

Telegrams: "MOH", Migori
Telephone:0716 649 609
Email:**beffyvill@gmail.com**
When replying please quote;

COUNTY RESEARCH COORDINATOR,
MIGORI COUNTY.
P O BOX 1045-40400
SUNA - MIGORI

REF: MCG/MOH/CRLC/VOL 1/3/2023 **15th March, 2023.**

To,

Lilian Njoki Nyaga,

Student Reg No. HSM-3-2762-3/2021,

Masters of Science in Health Systems management,

Kenya Methodist University.

Attention: SCMOH, SC Research & Learning Focal Person,

RE: APPROVAL TO CONDUCT A STUDY ON STRATEGIES INFLUENCING PROVISION OF ADOLESCENT AND YOUTHFRIENDLY SERVICES WITHIN THE PUBLIC HEALTH FACILITIES IN MIGORI COUNTY.

This is to inform you that your request to conduct data collection on the above topic is officially granted having met the Migori County Research and Learning Pre-requisite, Ethical considerations and paid the required research fees.

Kindly liaise with the SCMOH's and the Sub County Research & Learning Focal Persons as you undertake the study/research. The data collection exercise will take 2 months from the date of issuance of this letter.

You will be required to prepare an outcome feedback/report and submit to the County Research & Learning Coordinator for further dissemination to relevant levels/officers.

Wishing you the very best as you partake the exercise.

COUNTY RESEARCH & LEARNING COORDINATOR * MIGORI
P.O.BOX 1045-40400
SUNA-MIGORI

Thank you.

BEFFY VILL,
COUNTY RESEARCH COORDINATOR,
MIGORI COUNTY.

CC: CEC Health, Chief Officers for Health and Directors for Health.