International Journal of Community Medicine and Public Health
Nyang'echi EN et al. Int J Community Med Public Health. 2024 Feb;11(2):725-732
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20240260

Original Research Article

Assessing accessibility of sexual reproductive health services among adolescents and young people living with HIV/AIDS in Kenya

Edna N. Nyang'echi[1]*, Justus O. S. Osero[2]

[1]Department of Public Health, School of Public Health and Community development, Maseno University, Maseno, Kenya
[2]Department of Community Health and Epidemiology, School of Health Sciences, Kenyatta University, Nairobi, Kenya

Received: 20 November 2023
Revised: 14 January 2024
Accepted: 16 January 2024

***Correspondence:**
Dr. Edna N. Nyang'echi,
E-mail: ednanyangechi@gmail.com

ABSTRACT

Background: Sexual and reproductive health rights (SRHR) are fundamental human rights enshrined in national, regional, and international laws and agreements. This study aimed to determine the accessibility of SRHR services among young people living with HIV/AIDS in Kenya.
Methods: The study was a cross-sectional study involving a sample of 224 adolescents and young people from Kenya. The study used both qualitative and quantitative methods of data collection and analysis. Before the study commenced, approvals were acquired from the Kenyatta University ethics and review committee, the National Commission for Science, Technology, and Innovation, County Governments, and selected county and sub-county health facilities in Kenya.
Results: About 68.2% of adolescents and young people (AYP) living with HIV/AIDS accessed SRH services with a significant difference in proportion between study counties (Nairobi city and Homabay counties) in Kenya (χ^2=20.553; df=2; p<0.0001). Nevertheless, 33% of them reported that there were challenges that affected access to SRHR services and the unavailability of some services. Therefore, there is a need to ensure enough and constant supply of commodities and supplies for comprehensive care services.
Conclusions: The study showed a statistically significant difference in the proportion of AYP living with HIV/AIDS who accessed SRH services in the study counties of Nairobi city and Homabay.

Keywords: Accessibility, Adolescents and young people, HIV/AIDS, Sexual and reproductive health rights, Sexual and reproductive health services

INTRODUCTION

Sexual and reproductive health rights (SRHR) are fundamental human rights, which should be enshrined in national, regional, and international laws as they are critical for gender equality and sustainable development. The number of new HIV infections among young people and adults has remained unacceptably high among young girls and women (10-24 years old). In 2015, there were approximately 4500 new HIV infections weekly among Adolescents and young people (AYP) in the eastern and southern Africa (ESA) region, double the rate for adolescent boys and young men.[1] AIDS-related illnesses are also the leading cause of death among women and girls of reproductive age.[1] For instance, in Kenya, AIDS remains the leading cause of death and morbidity among adolescents and young people. This is because approximately 51% of all new HIV infections in Kenya are among adolescents and youth. It is for this reason that the Kenya AIDS strategic framework, 2014/15-2018/19

identifies adolescents and young people as a priority population for the HIV response.

People living with HIV and AIDS, especially women, experience numerous forms of sexual and reproductive rights violations.[2] Some of the sexual and reproductive health and rights issues among young people living with HIV/AIDS include: i) sexual gender-based violence meted on women who are HIV positive; ii) indiscriminate testing of HIV among pregnant mothers without their consent and inadequate counselling offered after receiving the test results iii) sexual partners of PLWHA continue to demand to have routine sex with the HIV infected women even at times when they are not ready for sex, exposing women to higher risks of re-infection or general weakness iv) forced sterilization of HIV positive women with or without their knowledge, v) denial of the right to information and guidance to help HIV, this includes a discussion of one's status with another health provider without informed consent, vii) stigma and discrimination that leads to ostracization and abandonment, viii) abusive language used against them at the health facilities either during delivery or while attending both ante-natal and post-natal clinics, ix) denial of the opportunity to engage in safe sex and to find suitable marriage partners among others.[2]

Despite efforts to provide youth-friendly services, the uptake of services by young people is very low. What must be considered are young people's pathways to seeking services; and the specific barriers they face before getting to the services, while receiving services, and after leaving the service delivery sites. Attention to the perceptions and needs of young people is essential, along with the development of policies, services, and programs that address those needs, particularly the youth-friendly approach to service delivery.[3] Worse still with the current COVID-19 pandemic, access to SRHR services is further limited. The pandemic has made it difficult for young people living with HIV/AIDs, to get access to essential services such as drugs, medication, and treatment.[4,5]

Access to services is thus a central concern surrounding the promotion of sexual and reproductive health and rights (SRHR) of young people. A more comprehensive approach toward SRHR is needed, as is the provision of services that tackle sexual and gender-based violence, sexual diversity, discrimination, relationship issues, and fears and concerns about sex and sexuality. This study will assess the accessibility of sexual reproductive health services among this group of young people.

METHODS

The study adopted a concurrent mixed methods research approach. This approach used both qualitative and quantitative data to define the associations more accurately among the variables of interest and interpret the research findings. Quantitative data allowed for statistical analysis using simple statistics such as percentages and chi-squares. Qualitative data was gathered using structured and unstructured interviews, in-depth interviews, and case studies from the relevant target population. The study used purposive sampling to select Nairobi city and Homabay counties which have the highest HIV/AIDS prevalence rate among the youth. The research sampled young people of 15-24 years living with HIV/AIDS and who regularly attend the comprehensive care centres and ART clinics for HIV services.

Inclusion and exclusion criteria

Only those residing in the selected study locations and were willing to participate were recruited to participate in the study. The study excluded participants were those who were very sick or mentally unstable from taking part.

Purposive sampling was used to sample participants for the qualitative data collection. The qualitative sample included 11 healthcare workers, 11 civil society organizations representatives, and 11 young people living with HIV/AIDS. The field study was carried out in the month of June 2022. Statistical Package for Social Sciences (SPSS) version 23 was used for the analysis of the quantitative data collected. The chi-square test was used to test the association between the dependent and independent variables and the relationship was deemed significant when the p value was less than 0.05 at 95% confidence level. Content analysis was done for qualitative data and similar categories of data arranged into sub-themes and themes. Results were then presented as narrations or direct quotes and then triangulated with the quantitative data.

Ethical clearance was sought from the Kenyatta University ethical review committee (approval number PKU/2517/1168) and permission to conduct research from the National Commission for Science, Technology, and Innovation (NACOSTI) in Kenya (License No: NACOSTI/P/22/17701). The study also sought informed consent from the respondents before proceeding with the research.

RESULTS

Socio-demographic characteristics of the study participants

The study results revealed that; 67.4% of the participants were female; 70% were aged 20-24 years, 63.8% achieved a secondary level of education, 63.8% were not in school at the time of the study and 72.8% were single by marital status (Table 1).

Table 1: Socio-demographic characteristics of the study participants.

Variable	Category	Nairobi city (%)	Homabay (%)
Sex	Male	38 (29.5)	35 (36.8)
	Female	91 (70.5)	60 (63.2)
Age (years)	15-19	23 (17.8)	44 (46.3)
	20-24	106 (82.2)	51 (53.7)
Level of education	Pre-primary	1 (0.8)	1 (1.1)
	Primary	15 (11.6)	31 (32.6)
	Secondary	92 (71.3)	51 (53.7)
	Tertiary	16 (12.4)	10 (10.5)
	None	5 (3.9)	2 (2.1)
Currently in school	Full-time	16 (12.4)	42 (44.2)
	Part-time	12 (9.3)	11 (11.6)
	No	101 (78.3)	42 (44.2)
Marital status	Single	100 (77.5)	63 (66.3)
	Married	22 (17.1)	30 (31.6)
	Divorced	4 (3.1)	1 (1.1)
	Separated	3 (2.3)	1 (1.1)

Accessibility of SRHR services among young people living with HIV/AIDS

The study also found that 74.1% of the AYP living with HIV accessed SRHR services. Among them, 42% were from Nairobi City County while 32.1% were from Homabay County (Table 2). No significant differences were seen between the proportions of respondents in Nairobi city and Homabay counties (χ^2=0.243; df=1 p=0.647).

In a key informant interview with the health centre in-charge in one of the health facilities in Nairobi city, she mentioned that in many instances some services are not available, and young people would like to visit during odd hours when there is no one. All these make it difficult for AYP to access the services required for them.

"*Sometimes contraceptive services may not be available e.g., implants hence the youth do not access them. We do not offer abortion services- if some youth comes bleeding, we refer them to Mama Lucy or Mbagathi because we do not have gynecologists or inpatient wards. Youth demand too much privacy and can visit the hospital very early or late in the evening or suggest to come at odd hours when no one is seeing them but this is not possible since we are not in operation 24 hours a day*" (KII- medical superintendent in one of the health centres in Nairobi city).

"*We should be facilitated to provide youth-friendly services since so far we do not have youth-friendly services and of which target specific youth like for the case of those living with HIV/AIDS*" (KII- health facility in-charge in Nairobi city county).

"*Sometimes AYP aged between 14-17 years believe they should not seek some SRHR services such as FP services because they are meant for adults aged over 18 years*" (KII- health facility in-charge in Nairobi city county).

Places where respondents sought SRHR services

When the respondents were asked about the particular places where they sought SRHR services, AYP living with HIV/AIDS reported having accessed SRHR services in public health facilities (85%); private health facilities (30.7%); outreach sites (26.5%); schools (12.7%); chemists (6%); NGO/CSO (6%); online platforms (3.6%) and other places such as support groups (0.6%) (Figure 1).

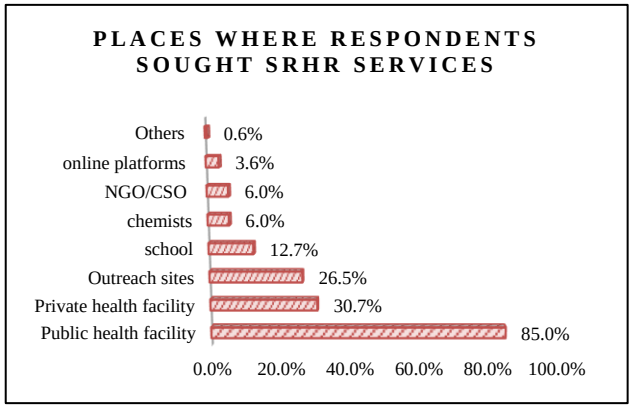

Figure 1: Places where respondents sought SRHR services.

SRHR services sought by AYP living with HIV/AIDS

AYP living with HIV sought SRHR services such as contraception (65%); STD (44.6%); HTS (27.7%) and

other services including; medicines (1.8%); ARVs (1.2%); support groups (1.2%) and stress management (0.6%) (Table 2).

When the respondents were asked about the number of times, they had sought SRHR services within the past six months, 58.4% of the respondents confirmed to have sought SRHR services 1-2 times. They further confirmed to have used various modes of transport such as; walking to their health facilities (42.8%); PSV (36.7%) among other modes of transport. Many of the respondents (78.9) reported to have taken less than thirty minutes to reach health facilities where they sought SRHR services. Most of the AYP confirmed that they were served in less than thirty minutes when they sought SRHR services (Table 2).

Table 2: Accessibility of SRHR services among AYP living with HIV/AIDS.

Accessibility of SRHR services	Homabay (%)	Nairobi City (%)	Total (%)
Yes	72 (32.1)	94 (42)	166 (74.1)
No	23 (10.3)	35 (15.6)	58 (25.9)
Significance	χ^2=0.243; df=1 p=0.647		
SRHR Services sought by AYP			
Contraception	49 (45.4)	59 (54.6)	108 (65)
HTS	31 (67.4)	15 (32.6)	46 (27.7)
MNCH	17 (56.7)	13 (43.3)	30 (18.1)
VMMC	17 (58.6)	12 (41.4)	29 (17.5)
STD	16 (21.6)	58 (78.4)	74 (44.6)
GBV/SGVB	7 (38.9)	11 (61.1)	18 (10.8)
Pregnancy termination	2 (11.8)	15 (88.2)	17 (10.2)
Gynaecological examination	2 (16.7)	10 (83.3)	12 (7.2)
Others	4 (44.4)	5 (55.6)	9(5.4)
Frequency AYP sought SRHR services			
1-2 times	54 (55.7)	43 (44.3)	97 (58.4)
3-4 times	23 (60)	16 (40)	39 (23.5)
5-6 times	1 (8.3)	11 (91.7)	12 (7.2)
More than 6 times	1 (33.3)	2 (66.7)	3 (1.8)
Mode of transport AYP use when seeking SRHR services			
PSV	8 (13.1)	53 (86.9)	61 (36.7)
Walking	33 (46.5)	38 (53.5)	71 (42.8)
Bicycle	3 (75)	1 (25)	4 (2.4)
Motorbike	23 (95.8)	1 (4.2)	24 (14.5)
Boat	2 (100)	0 (0)	2 (1.2)
Water bus	1 (100)	0 (0)	1 (0.6)
Private vehicle	2 (66.7)	1 (33.3)	3 (1.8)
Time (in minutes) taken to reach health facility when seeking SRHR services			
Less than 30 minutes	57 (43.5)	74 (56.5)	131 (78.9)
More than 30 minutes	15 (42.9)	20 (57.1)	35 (21.1)
Time (in minutes) taken to be served in a health facility when seeking SRHR services			
Less than 30 minutes	75 (50.3)	74 (49.7)	149 (89.8)
More than 30 minutes	11 (64.7)	6 (35.3)	17 (10.2)
Challenges in accessing SRHR services			
Lack of youth friendly services	21 (91.3)	16 (50)	37 (67.6)
Lack of SRHR information	18 (78.3)	10 (31.3)	28 (50.9)
Poor communication	13 (56.5)	15 (46.9)	28 (50.9)
Negative attitude of HCP	13 (56.5)	14 (43.8)	27 (49.1)
Stigma and discrimination	12 (52.2)	18 (56.3)	30 (54.5)
Lack of family/parental support	11 (47.8)	16 (50)	27 (49.1)
Unavailability of some services	11 (47.8)	14 (43.8)	25 (45.5)
Lack of private consultation rooms	11 (47.8)	13 (40.6)	24 (43.6)
Lack of fare to the health facilities	7 (30.4)	17 (53.1)	24 (43.6)

Cost of SRHR services sought by AYP living with HIV/AIDS

When the respondents were asked whether they were charged when they sought SRHR services, 87.3% of them reported that SRHR services were provided free of charge in the health facilities (Figure 2). Among those who reported that SRHR services they sought were not free of charge mentioned that SRHR services were inexpensive (57.1%); expensive (38.1%); very expensive (4.8%).

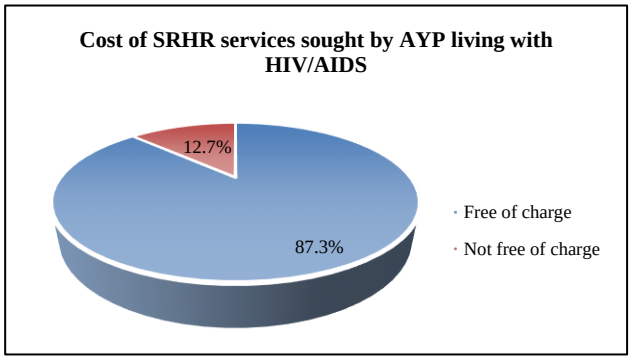

Figure 2: Cost of the SRHR services sought by respondents

Whether respondents had ever received information on SRHR

When the AYP were asked whether they had ever received information on SRHR, 93.8% confirmed to have received information on SRHR (Figure 3).

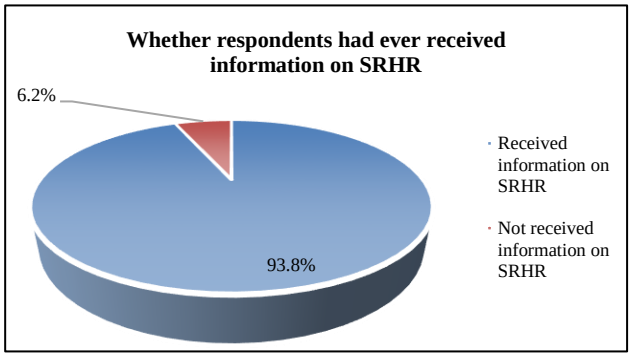

Figure 3: Whether respondents had ever received information on SRHR.

Sources of information on SRHR

Most of the AYP living with HIV reported that they received information on SRHR from different sources including; health facilities (74.8%), health care providers (65%); in schools (30%) among other sources (Table 3). Among the respondents who mentioned online platforms as their sources of information confirmed to have particularly received the information on; Facebook (61.1%), WhatsApp (16.7%); Google (11.1%), and YouTube (11.1%).

Availability of posters, brochures, and talks on SRHR in the health facilities

The majority of the respondents (84.8%) confirmed to have seen posters, 74.1% reported having attended a talk on SRHR and only 43.7% received brochures in their health facilities (Figure 4). The AYP who had attended a health talk on SRHR reported having received information on; contraception (72.9%); STD (66.3%); HTS (38%) among other information. Further, 83.1% of them reported having asked healthcare providers questions during the SRHR talk. Among them, 58% said that they were very comfortable, 28.2% were comfortable and 13.8% said that they were uncomfortable when they asked questions during SRHR talk. When the respondents were asked whether their questions were answered during the SRHR talk, all of them (100%) confirmed that the questions they asked were adequately answered. Many of the respondents (89.8%) reported that there was enough privacy when they received SRHR services/information. When the AYP were asked where they would go for treatment if they had an STD, they mentioned places not limited to government hospitals/health facilities (87.8%); private doctor/nurse/clinics (8.8%), and pharmacies (1.4%) (Table 3).

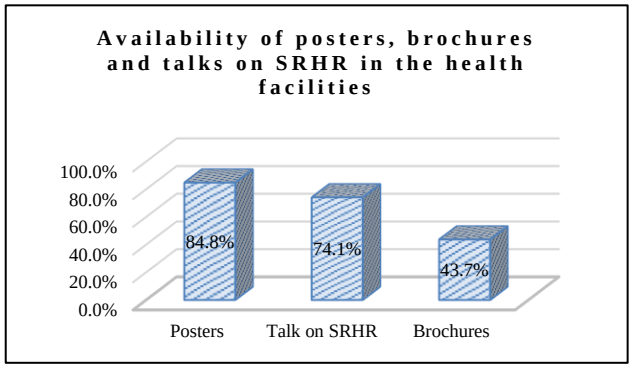

Figure 4: Availability of posters, brochures and talks on SRHR in the health facilities.

Willingness to share information on SRHR services with friends

Most of the respondents (93.4%) agreed that they would be willing to share SRHR information they received with their friends. Further analysis revealed that they will be willing to share information such as contraception (62%); HTS (41%); STDs (25.9%).

Challenges in accessing SRHR services

When the AYP were asked whether they encountered challenges when they sought SRHR services, 33% of them reported that there were challenges that affected their access to SRHR services. In particular, they mentioned challenges including; lack of youth-friendly services (67.6%); stigma and discrimination (54.5%); lack of SRHR information (50.9%); poor communication

(50.9%); negative attitude of HCP (49.1%); lack of family/parental support (49.1%); unavailability of some services (45.5%); lack of private consultation rooms (43.6%) and lack of fare to the health facilities (43.6%) (Table 2).

Table 3: Information on SRHR.

Source of information on SRHR services	Homabay (%)	Nairobi City (%)	Total (%)
At the health facilities	55 (35)	102 (65)	157 (74.8)
From health provider	61 (45.5)	73 (54.5)	134 (65)
Schools	35 (55.6)	28 (44.4)	63 (30)
Peer	7 (38.9)	11 (61.1)	18 (8.6)
Posters	18 (40.9)	26 (59.1)	44 (21)
Church	5 (55.6)	4 (44.4)	9 (4.2)
Outreaches	25 (56.8)	19 (43.2)	44 (21)
Online platforms	6 (33.3)	12 (66.7)	18 (8.6)
Media	8 (47)	9 (53)	17 (8.1)
Reading	6 (46.2)	7 (53.8)	13 (6.2)
Information provided during SRHR Health talk			
Contraception	40 (33.1)	81 (66.9)	121 (72.9)
Sexually transmitted diseases (STDs)	32 (29.1)	78 (70.9)	110 (66.3)
Gynaecological exam	6 (35.3)	11 (64.7)	17 (10.2)
GBV/SGBV	13 (30.3)	33 (76.7)	43 (25.9)
VMMC	24 (64.9)	13 (35.1)	37 (22.3)
HTS	33 (52.4)	30 (47.6)	63 (38)
MNCH	14 (40)	21 (60)	35 (21.1)
Pregnancy termination	16 (48.5)	17 (51.5)	33 (19.9)
Whether AYP were comfortable when asking SRHR questions			
Very comfortable	36 (45)	44 (55)	80 (58)
Comfortable	19 (48.7)	20 (51.3)	39 (28.2)
Uncomfortable	10 (52.6)	9 (47.4)	19 (13.8)
Where AYP would go for treatment if they had STD			
Government hospital/health centre	77 (38.5)	123 (61.5)	200 (89.3)
Private doctor/nurse/clinic	3 (33.3)	6 (66.7)	9 (0.4)
Pharmacy	10 (71.4)	4 (28.6)	14 (6.3)
Shop	1 (100)	0 (0)	1 (0.4)
Specific SRHR information AYP would share with friends			
Contraception	50 (48.5)	53 (51.5)	103 (62)
Sexually transmitted diseases (STDs)	22 (51.2)	21 (48.8)	43 (25.9)
HTS	20 (29.4)	48 (70.6)	68 (41)
VMMC	11 (35.5)	20 (64.5)	31 (18.7)
GBV/SGBV	12 (57.1)	9 (42.9)	21 (12.7)
Gynaecological exam	4 (66.7)	2 (33.3)	6 (3.6)
MNCH	15 (45.5)	18 (54.5)	33 (19.9)
Pregnancy termination	4 (40)	6 (60)	10 (15.6)

DISCUSSION

Youth-friendly healthcare delivery models are needed to address the complex healthcare needs of AYP. AYP expressed a preference for one-stop clinics with integrated services that could provide HIV services along with other services such as pregnancy testing and family planning. AYP also wanted information on staying healthy and approaches to prevent disease which could be delivered in the community setting such as youth clubs. An integrated clinic should address important attributes to AYP including short wait time, flexible opening hours, assurance of confidentiality, and positive staff attitudes. Youth-friendly, integrated care delivery models that incorporate AYP preferences may foster linkages to care and improve outcomes among vulnerable AYP.[6] AYP is denied access to child and youth-friendly, as well as sexual and reproductive health services.[6,7] Additionally, AYP lacks equal access to information concerning sexual and reproductive health and therefore they fail to make informed choices about matters of sexual and

reproductive health.[7] Furthermore, they lack equal access to information regarding SRHR and thus cannot make informed decisions regarding issues of SRHR.[8]

This study concurs with Vujovic et al, who indicate provider characteristics as barriers to accessing SRH services among AYP.[9] Recognized reasons for low confidence and inaccessibility were cultural barriers, gaps in knowledge about SRH needs of AYP, and having a limited number of healthcare providers available to offer comprehensive services.[9] Other studies show that study, AYP who didn't know where to obtain information reported discomfort in discussing sexual and reproductive health with providers and sometimes avoided seeking services due to fear of being stigmatized or judged.[10]

The study noted stigma and discrimination as part of the factors affecting accessibility to SRHR services to AYP living with HIV/AIDs. Because of their vulnerability, HIV/AIDS is heightened. Young people at high risk of HIV continue to face stigma and discrimination based on their actual or perceived health status, socioeconomic, race, sex, age, gender identity sexual orientation, or other grounds.[8] In another study conducted in Cameroon, the utilization of SRH services was influenced by socioeconomic factors, lower education levels, and restricted lifetime work.[11] Discrimination and abuse of SRHR may occur in healthcare settings, barring people from accessing quality health services. Some young people living with HIV/AIDS and other key affected populations are shunned by the wider community including families and peers, while others face poor treatment in educational and work settings, erosion of their rights, and psychological damage. This all-limit access to HIV testing, treatment, and other HIV services.[12] Access to services is thus a central concern surrounding the promotion of sexual and reproductive health and rights (SRHR) of adolescents and young people.

CONCLUSION

About 74.1% of AYP living with HIV/AIDS in Kenya accessed SRHR services with no significant difference in proportion between study Counties (Homabay and Nairobi City) (χ^2=0.243; df=1 p=0.647). The factors that affected access to SRHR services include places where SRHR services were sought, mode of transport used, time taken to be served at the health facility, the cost of SRHR services, lack of information on SRHR services, type of information during SRHR talks, healthcare provider attitudes towards and caregivers' support.

ACKNOWLEDGEMENTS

Our appreciation goes to the HIVOS and support partners Regional SRHR Fund, Ford Foundation, and Sweden Sverige for funding this study. Special thanks to all health facility in-charges and heads of various organizations who assisted in granting permission to conduct this study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. UNAIDS. The African Union. Empower young women and adolescent girls: fast-tracking the end of the AIDS epidemic in Africa. Geneva: UNAIDS; 2015.
2. Kenya National Commission on Human Rights. Realizing sexual and reproductive health rights in Kenya: a myth or reality? 2012;92-108.
3. Braeken D, Rondinelli I. Sexual and reproductive health needs of young people: matching needs with systems. International Federation of Gynecology and Obstetrics. Elsevier Ireland Ltd.; 2012.
4. Edwards PV, Roberts ST, Chelwa N, Phiri L, Nyblade L, Mulenga D, et al. Perspectives of adolescent girls and young women on optimizing youth-friendly HIV and sexual and reproductive health care in Zambia. Front Glob Women's Health. 2021;2:723620.
5. Chenneville T, Gabbidon K, Hanson P, Holyfield C. The impact of COVID-19 on HIV treatment and research: a call to action. Int J Environ Res Public Health. 2020;17(12):4548.
6. United Nations High Commissioner for Human Rights. Sexual and reproductive health and rights of girls and young women with disabilities. Seventy-second session, 2017. Available from: https://www.ohchr.org/Documents/Issues/Disability/A_72_133_EN.docx. Accessed on 12 August 2023.
7. Sexual and Reproductive Health and Rights Working Group. Awareness, analysis, action: sexual and reproductive health and rights in the Pacific. Secretariat of the Pacific Community, Fiji; 2015.
8. UNAIDS. HIV prevention among adolescents and young people: putting HIV prevention among adolescents and young people on the Fast-Track and engaging men and boys. Guidance. Geneva; 2016.
9. Vujovic M, Struthers H, Meyersfeld S, Dlamini K, Mabizela N. Addressing the sexual and reproductive health needs of young adolescents living with HIV in South Africa. Child Youth Serv Rev. 2014;45:122-8.
10. Mwalabu G, Evans C, Redsell S. Factors influencing the experience of sexual and reproductive healthcare for female adolescents with perinatally-acquired HIV: a qualitative case study. BMC Womens Health. 2017;17:125.
11. Pierre D, Moute C, Estelle P, Muriel M, Pulcherie U, Gervais B. Disability and access to sexual and reproductive health services in Cameroon: a mediation analysis of the role of socioeconomic factors. Int J Environ Res Public Health. 2019;16(3):417.

12. Stang L, Lloyd K, Brady L, Holland C, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? Int J AIDS Soc. 2013;16:18734.

Cite this article as: Nyang'echi EN, Osero JOS. Assessing accessibility of sexual reproductive health services among adolescents and young people living with HIV/AIDS in Kenya. Int J Community Med Public Health 2024;11:725-32.