

**MINISTRY OF HEALTH**

**NATIONAL GUIDELINES FOR PROVISION OF  
ADOLESCENT YOUTH-FRIENDLY  
SERVICES (YFS) IN KENYA**

**MINISTRY OF HEALTH  
DIVISION OF REPRODUCTIVE HEALTH**

P.O. BOX 43319  
NAIROBI  
KENYA

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## ABBREVIATIONS

AIDS	-	Acquired Immuno Deficiency Syndrome
ARH&D	-	Adolescent Reproductive Health and Development
ARVS	-	Anti-Retroviral drugs
CRC	-	Convention on the Rights of Children
CSA	-	Centre for the Study of Adolescence
DCT	-	Doctor
EC	-	Emergency Contraception
FGC	-	Female Genital Cutting
FGM	-	Female Genital Mutilation
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
KAPAH	-	Kenya Association for the Promotion of Adolescent Health
KDHS	-	Kenya Demographic and Health Survey
KSPA	-	Kenya Service Provision Assessment
NACADA	-	National Agency for the Campaign Against Drug Abuse
NPPSD	-	National Population Policy for Sustainable Development
OB	-	Occurrence Book
PEP	-	Post Exposure Prophylaxis
STIs	-	Sexually Transmitted Infections
VCT	-	Voluntary Counselling & Testing
W.H.O.	-	World Health Organization
YFS	-	Youth Friendly Services

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**Dr Josephine Kibaru**  
**HEAD, DIVISION OF REPRODUCTIVE HEALTH,**  
**MINISTRY OF HEALTH**

## Foreword

**Y**oung people, persons aged 10-24 years, constitute 36 percent of our total population. Today's young people have diverse experiences given the different political, economic, social and cultural realities they face in their communities. Young people today face many reproductive health challenges, which include sexually transmitted infections including HIV/AIDS, teenage pregnancy, unsafe abortion, school dropout, harmful practices like early marriages, female genital cutting, sexual violence, and drug and substance abuse among others.

The recently published Kenya Demographic and Health Survey (KDHS) report indicates that half of all new HIV infections occur among young people aged 15-24 years. Worse still, girls are twice as likely to be infected as boys the same age. The survey also revealed that by age 19, almost half of adolescents have begun childbearing and among all pregnant women, 23 percent are adolescents. In addition, teenagers from poor households are more likely to have begun childbearing and, more than half of the adolescent deliver at home. The recently launched Kenya Service Provision Assessment (KSPA) 2004 indicate that only 12 percent of our facilities are able to provide youth friendly services.

The ICPD 1994 plan of action urged governments to make reproductive health services available, accessible, acceptable and affordable to young people. These guidelines outlines the minimum essential service package which should be available to the young people and describes how the services should be made available and accessible to them. These guidelines are in line with the recently developed adolescent reproductive health and development plan of action, which identifies different strategies of how the ARH&D policy, whose aim is to improve the well-being and quality of life of Kenya's young people, will be implemented.

The national guidelines for youth friendly service provision identifies three different models through which reproductive health services can be made accessible and available to the adolescents.

Addressing reproductive health needs of adolescents requires a multi-sector approach. These guidelines outline the role of the health sector in addressing reproductive health concerns of young people.

The Ministry of Health will ensure the provision of adolescent friendly reproductive health, information, and services at all levels of health care. We hope that all stakeholders involved in adolescent reproductive health will be committed to implementing adolescent reproductive health programs in accordance with this guide.

**Dr James W. Nyikal, MBS**  
***DIRECTOR OF MEDICAL SERVICES***

# 1. INTRODUCTION

## 1.1.1 Why Focus on Youth? Why Youth Friendly Services?

**A**dolescents and youth represent a positive force in society. Adolescence is a period of physical, psychological and social transformation from childhood to adulthood. As young people pass through puberty and adolescence, new health concerns arise which impact on their sexual and reproductive health.

Adolescents and youth are neglected as a group by the health system. However, youth need specialized reproductive health services because of:

- Specific biological and psychological needs of adolescence;
- High risk of STIs, HIV/AIDS and pregnancy;

- Disproportionately high risk of sexual abuse;
- Importance of behavior-related risks that are responsive to education and counseling;
- Opportune age/stage to learn good health practices; and
- Severities of consequences from lack of RH care during adolescence.<sup>1</sup>

Effective youth friendly services need to reach adolescents and youth who are growing up in difficult circumstances, as well as those who are better off and both in and out of school.

### Why the Guidelines?

Previously, services offered to young people have been fragmented and varied from one institution to another, and have not been harmonised. These guidelines aim to rationalise the provision of youth services to the beneficiaries. In addition, the document provides for a minimum package of services to be considered youth friendly, while at the



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same time ensuring national uniformity in their provision.

### 1.1.2 Who Are Adolescents/youth?

**The World Health Organisation (WHO) defines adolescents as persons aged 10-19 years and youth as those aged 15-24 years.** There are over 10 million young people aged 10-24 years in Kenya constituting about 36 percent of the Population. Adolescents (10-19 years) constitute 25.9 percent of the population. Young people (10-24 years) will be the primary target for the youth friendly services referred to in this document. The terms “Adolescents” “Youth” and “Young People” are interchangeably used to refer to this group in different circumstances.

Adolescence is a journey from the world of the child to the world of the adult. The second decade of life (10-19 years) is a time of rapid physical and emotional change as the body matures and the mind becomes increasingly independent. Although they are no longer children, they are not yet adults. This group is faced with the challenges of growing up and experiencing new challenges from the adult world. By the age 20, young people are starting to contribute to society, acquiring rights, and making choices.

During this period, they can put themselves at risk without fully

understanding the consequences. Biologically, they can become mothers and fathers without being ready for the responsibility. They feel a growing sense of independence, but largely depend on adults for their material needs. As they change, so do their needs change with them.

- Early adolescence (10-13 years) is characterized by rapid physical growth and the beginning of sexual maturation. Young people start to think in abstract.
- In mid-adolescence (10-15 years) the main physical changes are completed, while individuals develop a stronger sense of identity and relate more strongly with peers.
- In later adolescence (16-19) the body takes adult form, while the individuals have distinct identity, more settled ideas, and opinions.
- As young adults (20 -24 years) they are increasingly expected to make decisions on career, marriage, and other adult responsibilities.

### 1.1.3 Why Pay Attention to The Health Of Adolescents

Adolescents are generally believed to be healthy because death rates for this age group are lower than for children or for elderly people. However, death rates are an extreme measure of health status and only tell

part of the story. There are many interrelated reasons why we need to pay attention to the health of adolescents.

### To Reduce Death and Disease in Adolescents Now

An estimated 1.7 million young people aged 10 to 19 years die each year mainly from accidents, violence, pregnancy related problems, or illnesses that are either preventable or treatable. Many more develop chronic illness that damages their chances of personal fulfilment. Harmful habits, e.g., smoking, alcohol and other substance/drug abuse are acquired during adolescence and have long and devastating effects.

### To Reduce the Burden of Disease in Later Life

Malnutrition in childhood and in adolescence can cause lifelong health problems, while failure to care for the health needs of young pregnant women can damage their own health and that of their babies.

Adolescence is the age when sexual habits and decisions about risk behavior and

safe practices are formed. Some of the highest infection rates for sexually transmitted infections are in adolescents. The HIV/AIDS pandemic alone is sufficient reason to look anew at health services that address the needs of adolescents.

### To Invest In Health – Today and Tomorrow

Healthy as well as unhealthy practices adopted today may last a lifetime. Today's adolescents are tomorrow's parents, teachers and community leaders. What they learn, they will teach to their own children. Adolescence is a period of curiosity when young people are receptive to information about themselves and their bodies, and when they begin to take an active part in decision making.

### To Promote Human Rights

Health is a fundamental basic right. The ICPD (1994) plan of Action acknowledges this right for Adolescents and States.

At the same time, the Convention on the Rights of the Child (CRC) gives young people the right to

"The health needs of adolescents as a group have been largely ignored by existing health services. The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions".

preventive health care and calls for specific protection for those in exceptionally difficult situations or living with disabilities. Article 24 of the CRC provides for the highest attainable standards of health and for facilities for treatment of illnesses and rehabilitation. In Kenya, these rights have been enshrined in the 2001 Children's Act (see quote).

“Every Child shall have a right to health and medical care, the provision of which is the responsibility of the parents and the Government.”

greater reproductive health risks than adults. Some key examples include the following:

- Young people take higher risks in general including unprotected sex;
- Young women are less able to resist sexual pressure and coercion;
- Young people in disadvantaged circumstances are vulnerable to sexual exploitation for favours and financial support;
- Young women are disproportionately represented among abortion-seekers, many of whom endure unsafe, clandestine procedures; and
- Young women, for biological and cultural reasons, are more susceptible to HIV infection.

## To Protect Human Capital

In some societies, two out of three adolescents are involved in productive work, while many young women below the age of 20 are already mothers. If they are no longer able to fulfil these roles because of injury, illness or psychological damage, the cost is primarily a human one, but there is also a cost to society. In Kenya, the majority of those dying of AIDS are people of reproductive age. Their death greatly affects the economy and the livelihood of their dependants.

## 1.2 What Reproductive Health Risks do Adolescents Face?

Young people continue to face

## Lack of reproductive health knowledge and information

Younger adolescents (ages 10-14 years) often lack the means to begin taking responsibility for their own health because they do not fully understand or appreciate the changes in their bodies, and may need reassurance and support. Girls may be embarrassed about growing breasts, menstruation, or nervous if they are late developers. Boys too become very anxious about the

changes to their bodies. Such concerns are generally transitory, but some young people develop low self-esteem and depression. Older adolescents (ages 15-19 years) lack decision and negotiation skills necessary to make career choices and resist pressure to engage in irresponsible sexual behaviour. Health professionals and adult workers need to be very skilled to assist young people in making the transition to adulthood in a productive and healthy manner. During the period 10-19 years, a different pattern of health concerns emerge as a result of new forms of behaviour. This behaviour relates to newly acquired skills, risk taking and experimentation, and a move toward independence. Whilst this behaviour may appear dysfunctional, it is in fact a new form of expression borne of a need to develop new interests, skills, and maturity as they approach adulthood.

## Malnutrition

When there is a shortage of food, most families know that they must make special efforts to ensure that babies are well nourished. What is less well understood is that adolescent girls and boys have a need for extra nutrition as they grow rapidly and develop. An inadequate diet can delay or impair healthy development

leading to stunting in childhood or poor performance during adolescence.

In girls, poor nutrition can delay puberty and lead to the development of a small pelvis. Malnourished adolescent girls who have babies at a young age are more likely to experience complications before, during, and after pregnancy because their bodies are immature.

Maternal mortality is higher in anaemic women. Even when they survive, poorly nourished adolescent mothers are more likely to give birth to low birth-weight babies, perpetuating a cycle of health problems which pass from one generation to the next.

## General Health Problems

Adolescents are subject to most of the same illnesses as other age groups within the population. However, they are much less likely to recognise symptoms, and much more likely to underestimate their importance. In addition, they usually do not know where to go for help. As a result, adolescents are the least likely segment of the population to go for early treatment. They may leave diseases untreated because they are afraid of the outcome, worried about the stigma or do not believe that they will be treated well at the clinic.

## Menstrual Problems

Girls need support as they begin to menstruate. Without the support of a more knowledgeable person, an adolescent girl may not know what is 'normal' or how to recognise menstrual problems. School health checks, where they exist, often fail to identify difficulties.

## Female Genital Cutting

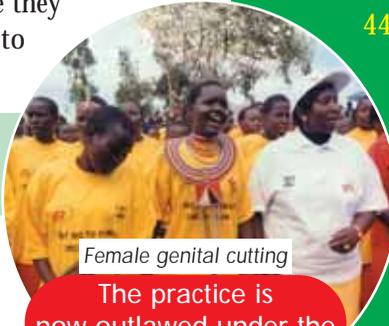
Female genital cutting (FGC) is common among several communities in Kenya. According to the KDHS (2003), 22 percent of girls aged 15 to 19, and 20 percent of young women aged 20-24 have undergone this practice. In some communities, FGC is almost universal at 90 percent. In most cases, strong social-cultural pressure is exerted on girls to undergo this procedure against their will.

## Early and Unprotected Sex

The high number of unwanted pregnancies and unsafe abortions, and the steep rise in HIV infection are all evidence that, despite taboos or

cultural disapproval, sexual activity in adolescents is more common than official surveys or sources wish to recognise.

In Kenya studies show that adolescents are sexually active by age 13-19 years. Among adolescent girls 15-19 years, 44 percent have had sex; while among young women aged (20-24 years) 60 percent have had sex by age 20. Reasons for early sexual encounters include curiosity, peer influence, expectation of gifts/money and coercion. Young people therefore need skills to deal with these pressures and expectations without putting themselves at risk.



Female genital cutting

The practice is now outlawed under the Children Act (2001) Chapter II clause 14, which states "No person shall subject a child to female circumcision."

## Early Forced Marriages

Early marriage resulting in sexual intercourse at a very young age is sometimes defended on the grounds that it is a traditional cultural custom. The same defence is sometimes made of (FGC). While it is important for health services to be sensitive to cultural customs, this cannot be at the cost of damaging the health and

well being of vulnerable young people. The Convention of the Rights of the Child, the most widely adopted in the world, is clear on this point. Article 24, gives children and adolescents a right to health care ( see quotes ).

“Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children”. In Kenya early forced marriage is outlawed under the children act-2001 article 14 which states, No person shall subject a child to early marriage”.

## Sexually Transmitted Infections

Abstaining from sex, delaying the onset of first sexual experience, reducing the number of sexual partners, and increasing levels of protection through condom use are all ways to reduce unwanted pregnancies and sexually transmitted infections. Many adolescents never have an opportunity to discuss these with a caring adult, while services, which could protect them, are not widely available.

## Abortions

The legacy of unsafe and unprotected sex is also seen in the number of adolescent girls who undergo abortions both outside and within marriage. Many pregnancies are terminated at great risk to the young women, including pelvic infection, infertility, or even death. Unsafe abortion is common in Kenya among women of all ages and socio-economic backgrounds. It is estimated that 308,000 abortions take place in Kenya annually, the majority of which occur among adolescents. It is estimated that about half of all pregnancies among girls aged 15-19 years are terminated every year.

In Kenya 50% of all new HIV infections occur among young people 15-24 years.

Globally, sexually transmitted infections (STIs) including HIV/AIDS affects one in 20 young people. Although most of the infections are curable, many are left untreated. STIs manifest most seriously among adolescent girls (15-19 years) and young women (20-24 years) who are twice as likely to be infected than males in the same age group. While knowledge on AIDS is almost universal at over 90 percent for all ages and sexes, use of condoms for protection against infection is low; only one out of every 10 young women less than 24 years uses a condom compared to 40 percent of young men the same age.

## Drug and Substance Abuse

The biggest threat to the lives, health and well being of young people are the activities they may adopt during their adolescent years when a complex wap of harmful practices and risk factors put them in peril. Addictive behaviour is often referred to as 'risk behaviour,' but it is a risk that adolescents are not good at assessing, since they do not understand the long-term consequences of adopting what they may regard as being only a temporary habit.

In Kenya, alcohol consumption and tobacco smoking are very common among young people. A recent study by NACADA indicated that one in every three youth in secondary schools takes alcohol. Another 8 percent smoke cigarettes. These habits have serious health consequences among the youth. The World Health Organization (WHO) estimates that 500 million people who are alive today will eventually die of smoking related diseases including cancers, heart and respiratory diseases. In Kenya, the cost of treating these cases is estimated at three shillings for every

"A child shall be entitled to protection from physical and psychological abuse, neglect and any other form of exploitation."

one shilling, the Government earns in revenue from tobacco tax.

## Accidents and Violence

Deaths and injuries from accidents are more likely at this age than any other. Unintentional injury is one of the leading causes of death amongst young people in many countries, with road traffic accidents a constant threat in urban areas. Boys are particularly vulnerable to injury from accidents throughout adolescence due to their adventuresome nature.

Violence within the home is not fully acknowledged and children may be at risk from violent parents well into adolescence. In Kenya, increased incidents of child and women battering have been reported in the media in recent times. Youth need to be sensitized to know that the law protects them against this form of abuse. The children's act (2001) article 13 (1) provides that protection (see quotes).

## Sexual Abuse

Across the world, a huge number of children and young people are abused sexually. In Kenya, there have been increasing numbers of such abuses, particularly on minors, adolescent girls, and young women.

According to the 2003 KDHS, about one out of every 10 adolescent girls (15-19 year) and young women (20-24 years) had ever experienced sexual violence, while the same number reported experiencing it in the year prior to the survey.

A lot of sexual abuse takes place in the home and is never reported or revealed. This situation is even worse among vulnerable groups such as homeless street children, child labourers / domestic helpers and those internally displaced or refugees where child prostitution is the main form of sexual exploitation. According to Population Communication Africa 2002, there are 10,000 to 30,000 reported child prostitutes in Kenya.

The conservation on the Rights of the Child of which Kenya is a signatory protects children from sexual exploitation. Kenya has outlawed this practice in clause 15 of the 2002 Children Act (see quote).

### Mental Health Problems

Mental health problems may first become apparent during adolescence. People experiencing depression or another mental

health problem have no frame of reference for their condition and may not recognize this as an illness or seek treatment.

Mental health problems frequently start at this age group. Depression is common, especially for young people who have low self-esteem. They may feel that they have no future or are 'useless'. Depression reduces the quality of a young person's life at a time when he or she should be full of optimism and hope. A young person who sees no future is more likely to exhibit high-risk behaviour.

### 1.3 National Commitment and Legal Framework

At the International Conference on Population and Development (ICPD) in 1994, governments including Kenya recognized the substantial and largely unmet needs of adolescents for sexual and reproductive health information and services. They set themselves the challenge of meeting those needs and recognizing adolescent's

"A child shall be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity and exposure to obscene materials."

rights. In doing this, they stated and agreed that;

“Information and services should be made available to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women’s self determination and to share responsibility with women in matters of sexuality and reproduction.”

For many years in Kenya, there were no clear policies supporting the provision of health to adolescents and youth. Service providers were unclear on how to respond to sexual and reproductive health concerns of adolescents. However, in response to ICPD Plan of Action, concerns expressed in the National Population Policy for Sustainable Development (NPPSD-2000), the National Youth Policy the Children Act (2001), and other national and international Conventions on Children and



Youth, the Government has adopted the Adolescent Reproductive Health and Development Policy (ARH & D, 2003).

The policy provides a framework to respond to the Health and related concerns of young people in the Country. It elaborates the Government’s Commitment to “Improve the well being and quality of life of Kenyan Young People” through provision of health information and services which is available, accessible, affordable and acceptable.

The policy outlines strategic actions to be taken to address young people’s concerns including Adolescent Sexual and Reproductive Health, and Rights, harmful practices; drug and substance abuse, socio-economic factors, and youth with disabilities.

## 2.1. Definition of Youth Friendly Services

There is no standard definition for youth friendly health services. They can be variably described. A simple definition could be “Broad Based Health and related services provided to young people to meet their individual health needs in

a manner and environment to attract interest and sustain their motivation to utilize such services. The World Health Organization (WHO) describes Youth Friendly Services (YFS) as;

“Services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.”

## 2.2 Strategies and Actions to Make Services Youth Friendly

As interest and activity in the area of youth-friendly services increases, program planners need to be aware of certain basic challenges of establishing such services.

### These challenges include:

#### Overcoming barriers to establishing youth-friendly services

Young people are known to be poor seekers of reproductive health. When taken along with the belief that the youth enjoy robust health, this fact can easily be used as an excuse not to establish youth friendly

services. Program planners therefore need to recognize such barriers and find ways of overcoming them.

#### Providing RH services to young people is a sensitive public issue

In Kenya, discussions on providing reproductive health services to young people has always been sensitive. This is borne out of cultural and traditional orientation on matters related to sexuality. Some sections of the community are concerned that providing such services may encourage sexual activity among young people. Though research has shown that this is not true, program planners need to be aware of this as they seek to mobilize the widest community support for youth services.

#### Staff / Providers can be negative or ambivalent about providing RH services to young people

Negative attitudes of service providers have been cited as the single most important barrier to youth access to reproductive health services. These attitudes are greatly influenced by religious and cultural backgrounds, professional training and orientation. Assessing the feelings of service providers helps determine training needs and other staff, operational, and structural

changes necessary before the introduction of youth friendly services in a health facility.

### **Making RH services youth friendly requires additional training, staff time, and costs**

Introducing youth friendly services in a health facility may require structural and operational time adjustments. This may involve renovations, such as the partitioning of rooms to create additional space for confidential counseling, examinations and conducting health talks. In addition, staff may be required to re-schedule their working hours to make it possible for young people to receive services on weekends, late evenings, or other times convenient for the youth. This will require the management of these institutions to commit resources, including financial allocations, for youth friendly services.

## **2.3 Approaches for delivery of youth friendly services**

Before deciding on the essentials service package, or in other words the minimum expected range of services for youth friendly services, it is important to be clear about the approach through which those packages would be delivered. Two broad categories of approaches have been identified. The targeted and integrated approaches.

The targeted approach refers to a situation where services are designed and planned for youth alone and are offered in settings that meet only the needs of the youth and do not include other groups. Such services may be clinical, non-clinical, or a combination of both.

The integrated approach refers to a situation where young people receive services as part of the general public, but special arrangements are made to make the services more acceptable to them. These two approaches have been applied by different organizations in Kenya with varying levels of success. A recent review of youth activities in Kenya (CSA, 2003) showed that irrespective of which approach is adopted, certain minimum conditions must be met if the needs of young people are to be adequately addressed.

### **Minimum Conditions for YFS**

- \* Affordability and accessibility
- \* Safe and basic range of services
- \* Privacy and confidentiality
- \* Provider competence/attitude
- \* Quality and consistency
- \* Reliability and sustainability
- \* Inbuilt monitoring and evaluation system

Services that target young people will not work if the attitude of

providers is hostile, judgmental or insensitive. Providers must be sensitized to understand the needs of young people and be able to offer a comprehensive range of services.

“Services for young people must be of high quality, affordable, safe and comprehensive, provided by people who have the skills to respond to young people’s needs, and be in an environment that protects their dignity and confidentiality “(CSA, 2003)

## 2.4. Models for Youth Friendly Services with Recommended Essential Service Package

The most common models in Kenya include the clinic-based model, youth centre model, and school-based peer youth programs. Each of the models can adapt either of the above-mentioned approaches. However, in all cases each model MUST put in place a strong and effective referral system for services not available at the facility.



Peer Education outreach activities in the Community

YOUTH-CENTRE BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE)	CLINIC BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE)	SCHOOL BASED MODEL (RECOMMENDED ESSENTIAL SERVICE PACKAGE)
<ol style="list-style-type: none"> <li>1. Counseling Services on <ul style="list-style-type: none"> <li>* Sexuality</li> <li>* Growing up</li> <li>* Relationships</li> <li>* Pregnancy, Abstinence</li> <li>* Unsafe abortion and abortion Prevention</li> <li>* STIs and HIV/AIDS</li> <li>* Substance and Drug abuse</li> <li>* Contraception</li> <li>* Careers</li> <li>* Rape prevention</li> <li>* Nutrition</li> <li>* Male involvement in RH</li> <li>* Parenting</li> <li>* Ante and post natal care</li> <li>* Skilled attendance</li> </ul> </li> <li>2. Screening and treatment of sexually transmitted infections</li> <li>3. Voluntary Counseling and Testing (VCT)</li> <li>4. Provision of information and Education on Reproductive Health.</li> <li>5. Availability of IEC, audio/visual Materials.</li> <li>6. Ante and post natal care</li> <li>7. Comprehensive post rape care (see Annex)</li> <li>8. Provision of contraceptives</li> <li>9. Promoting community based and school based outreach activities</li> <li>10. Recreational facilities (In and Outdoor) where possible. Linkage to school based and Clinic based model</li> </ol> <p>Refer where necessary</p>	<ol style="list-style-type: none"> <li>1. Counseling services on <ul style="list-style-type: none"> <li>* Sexuality</li> <li>* Growing up</li> <li>* Relationships</li> <li>* Prevention of pregnancy, Abstinence, consequence of unsafe abortion</li> <li>* STIs and HIV/AIDS</li> <li>* Substance and Drug abuse</li> <li>* Contraception</li> <li>* Careers</li> <li>* Rape Prevention</li> <li>* Unsafe abortion and abortion Prevention</li> <li>* Nutrition</li> <li>* Male involvement in RH</li> <li>* Parenting</li> <li>* Ante and post natal care</li> <li>* Skilled attendance</li> </ul> </li> <li>2. Provision of information and Education on Reproductive health</li> <li>3. Training in livelihood and life skills</li> <li>4. Availability of IEC, audio/visual Materials</li> <li>5. Promoting community Based/School Based outreach IEC activities Working with peer youth educators</li> <li>6. Provision of contraceptives</li> <li>7. Recreation facilities (In and Out door games)</li> <li>8. Screening and treatment of STDs, HIV/AIDS (Where possible)</li> <li>9. Voluntary counseling and testing VCT</li> <li>10. Curative services for minor illnesses including ante and postnatal care</li> <li>11. Comprehensive post rape care (see Annex) Linkage to school based and Youth center based model</li> </ol> <p>Refer where necessary</p>	<ol style="list-style-type: none"> <li>1. Life skill training on <ul style="list-style-type: none"> <li>* Goal setting</li> <li>* Decision making</li> <li>* Negotiation</li> <li>* Moral values</li> <li>* Assertiveness</li> <li>* Communication skills</li> </ul> </li> <li>2. Counseling Services on <ul style="list-style-type: none"> <li>* Sexuality</li> <li>* Growing up</li> <li>* Relationships</li> <li>* Abstinence</li> <li>* Pregnancy, Abortion and their Prevention</li> <li>* STIs and HIV/AIDS</li> <li>* VCT</li> <li>* Substance and Drug abuse</li> <li>* Contraception</li> <li>* Careers</li> <li>* Self esteem Nutrition</li> <li>* Male involvement in RH</li> <li>* Parenting</li> <li>* Ante and post natal care</li> <li>* Skilled attendance</li> </ul> </li> <li>3. School health talks <ul style="list-style-type: none"> <li>* Personal hygiene</li> <li>* Sexuality and growing up</li> <li>* Reproductive Health</li> <li>* STD-Prevention</li> <li>* HIV-AIDS Prevention</li> <li>* Rape Prevention</li> <li>* Communication skills</li> </ul> </li> <li>4. Post rape care (see Annex) Linkage to clinic based and Youth center based model Refer for management.</li> <li>5. Refer for treatment and management</li> </ol>

### 3. Youth Friendly Services Characteristics<sup>6</sup>

For the services to be truly youth friendly, certain basic factors should be considered and put in place. These include:



*Providers being trained on YF services*

#### 3.1 Service Facility Characteristics

##### **Convenient Hours / Special times set aside**

Having youth friendly sites open when youth can attend is critical to motivating them to seek services. Many youth are either in school or are engaged in other things most of the day. They may therefore find it difficult to miss school sessions or opportunities for employment to attend clinics unless it is an absolute emergency. Facilities offering services to the youth should therefore fix special sessions during late afternoons, after schools/ work, during weekends, or holidays in order to make it possible for them to attend.

##### **Acceptable Costs**

Young people are generally nervous and fearful of being seen by family, friends, adults or neighbours

seeking health services. At the same time, they are also known to be poor seekers of health and the distance to a health facility may be a perfect excuse not to go. The location of the facility should be such that young people find it

easily, feel free to go there, and receive services at pocket friendly/minimal cost.

##### **Adequate / separate space and sufficient privacy**

A youth friendly site should provide for ample space for provision of information, education and communication on health; counseling and examinations. Rooms where counseling and examination are conducted should ensure there is audio and visual privacy. Young people are overly sensitive and suspicious of others finding out about their health concerns. In a situation where there is no special place for young people in a health facility, special arrangements can be made to establish youth friendly corners, where they can be attended to in privacy.

## Comfortable secure surroundings

Young people are attracted to a facility, which provides comfort. A place where there are adequate seating arrangements. A highly formalised facility may discourage youth from seeking services. Informality and youthful environment with posters and literature touching on their concerns displayed conveniently in the facility would encourage them to open up and seek help.



*Laikipia Youth Centre.  
Comfortable Surrounding*

## 3.2 Provider and Staff Characteristics

### Specially Trained Staff<sup>7</sup>

Staff selected to work in a youth friendly site must be understanding and sensitive to the health concerns of the youth. Those expected to counsel or examine youth must have appropriate skills. They must be able to listen and take note of body language in order to understand unexpressed feelings and experiences of the youthful clients. The staff should have good interpersonal communication skills and be able to

interact freely with young people, put them at ease, and encourage them to share their needs and concerns freely.

## Respect for Young People

One of the impediments to the provision of youth friendly health services has been the attitude of service providers. Some service providers have pre-judged the youth seeking sexual and reproductive health services. Negative providers attitudes have made young people reluctant to seek those services. Service providers assigned to youth health services must foster positive attitudes towards youth seeking services. Those with deeply entrenched biases against adolescent sexual activities and those who cannot relate respectfully should not be assigned to work in such facilities.

Age is an important factor in dealing with attitudes. Younger staff or adults who are young at heart are ideal for youth friendly sites. However, older staff assigned to work in these sites must demonstrate positive attitudes in working with youth. The attitudes and

performance of security personnel, receptionists, or persons manning the registration desks in those facilities is of great importance as they give the first impression of the institution to the youth.

### **Privacy and Confidentiality Honored**

Young people are greatly disturbed and affected by a feeling or suspicion that their sensitive and intimate health concerns are being shared with other persons. Youth friendly health facilities must assure young people that their right to privacy and confidentiality will be respected at all costs. Service providers in these facilities must cultivate confidentiality with youth including ensuring that no information is leaked to any other person including the parents.

### **Adequate Time for Client and Provider Interaction**

Young people value attention and understanding on their health and related concerns. Those concerns may seem insignificant to a service provider, but they are extremely important to a youth. When young people come to seek advice on various health concerns, counselors and those

conducting examination should allocate adequate time on them to discuss, clarify or dispel any lingering myth related to these concerns.

### **Peer Counsellors Available**

Many times, young people feel more comfortable talking to their peers about certain sensitive matters. Youth friendly sites need to incorporate trained peer youth counselors to deal with the aspects of youth concerns that do not require technical or clinical skills. In addition, linking and working with local trained peer youth educators can help to mobilize youth and community support for the facility. This will also increase youth involvement and promote youth ownership of the services.

### **3.3 Supportive Elements of Youth Friendly Services<sup>3</sup>**

#### **Youth Involvement**

One facilitating feature in running youth friendly health services is cultivating a sense of youth



*Youth at the Isiolo Market*

owning the service. Young people know better how to identify their health and related needs. They are in a better position to prescribe solutions in meeting those needs. Their involvement in designing, planning, and running the services can greatly assist in mobilising support and sustaining motivation to utilise the services by their peers.

The facilities should link and work with a core group of peer youth educators to assist in conducting IEC activities within and outside the facility, and monitor and provide feedback on service provision. Youth should be given opportunities and skills to develop materials suitable for their needs, but sensitive to local culture and social values.

### **Young Men and Women Welcome and Served**

It is uncommon in Kenya to see young people accompanied by partners or significant others and friends when they seek health services. It is, however, a valuable consideration particularly now that an enabling policy and program environment exists in Kenya to determine one's HIV status. Secondly, it is important in a situation where you need to cultivate shared responsibilities in decision

making, managing relationships, seeking services, and taking precautionary measures against the risks and consequences of sexual activities.

### **Group Discussion Available**

In a youth friendly site, group discussions and talks on various aspects of health particularly those related to sexual and reproductive health should occur routinely. A schedule of topics and times these are held each day should be widely publicized to allow, as may young people as possible to attend. The discussions or talks should be accompanied with relevant audio-visual materials where possible. These sessions build peer social support mechanisms. Young people who might ordinarily fear seeking assistance can be encouraged to do so once they realize that they are not alone in their personal experiences.

### **Necessary Referral Mechanisms Available**

In all cases, any facility offering youth friendly services must have an effective system of referring youth who need more specialized services. Clinical services operating within health facilities must develop an internal system where young people

can be attended to in other departments of the institution without undue delay. Youth centers with limited or no clinical services should link up with the nearest health facility where young people can receive services not available at the centre.

School based programs should work closely with the nearby health facilities, and allow staff from such institutions to visit the school regularly to offer necessary support to students. Where this is not possible, students needing specialized attention should be referred to these health facilities.

### **Delay of Pelvic Examination and Blood Test Possible**

Generally, people are uneasy with certain medical examinations and tests, particularly those which involve exposing the intimate parts of their bodies. This is especially true for young people who may not have been aware of such requirements. Youth-friendly health facilities should create opportunities to prepare young clients for such experiences. Options for delaying examinations and tests until the youth are psychologically and emotionally prepared should be created. Meanwhile, an alternative mode of meeting the immediate health need for such adolescents should be considered.

### **Affordable Fees**

Studies in Kenya have indicated that the cost of health services hinders a significant number of young people from seeking healthcare. The majority of the youth are in school, unemployed and poor. They depend on their parents, guardians or relatives to meet health care and other costs, a situation which contributes to their reluctance to seek services.

Youth Friendly Service delivery sites should work out systems whereby costs are waived/subsidized for young people who are too poor to pay.

### **Wide Range of Services Available (One Stop Shop)**

Health services offered in youth friendly health sites should meet the widest possible available range of individual youth health needs. Young people are very reluctant to seek health services when referred to other facilities. As much as possible, youth friendly health sites or programs should make available services particularly those related to sexual and reproductive health such as counseling on various aspects of sexual and reproductive health, STD diagnosis and treatment, counseling on STD prevention, and Voluntary Counseling and Testing (VCT) among others.

## **Drop-in/Phone in Clients Welcomed and Appointments Arranged Quickly**

Young people dislike rigid, formalized systems of making appointments to receive health services. They prefer being attended to quickly if they drop by a facility. Youth friendly health sites should therefore make flexible arrangements whereby youth can receive services when they call in to seek them.

## **Education Material Available on Site and to Take Away**

Information, Education and Communication (IEC) materials, particularly those on critical issues in sexual and reproductive health, should be available at a Youth Friendly Health Site. The materials should be available to read and take away for youth who would like to read more on their own. Information can include issues covered during group discussions and talks conducted in the facilities. This helps youth comprehend and clarify issues, especially those which may be complicated.

## **Publicity/Recruitment that Informs and Reassures Youth**

Making the youth-friendly services known to youth is crucial for

effective utilization. Providers should publicize the location of services, the times they are available, and assure that privacy and confidentiality are maintained. In addition, young people need to know that the services they need are available and that they can afford them. Physical features of a youth friendly site are important. Labelling of doors, walls, or entrances to the facility should avoid using names which can stigmatize the place.

## **Community Mobilization**

Any youth friendly services established without the support of the community is likely to fail. The community, which includes parents, teachers, local opinion leaders, civic and religious leaders are key gatekeepers. They are all interested in knowing what services are being provided to their young people. Their involvement in planning and establishing such services will help in mobilizing support and ensuring the long-term sustainability of such services. The role of the family MUST be acknowledged in the provision of services.

## **Perception of Privacy At A Facility**

Youth-friendly services have to be provided in places where youth can easily reach them. These services should be available at times when

youth are available. Facilities offering such services should develop work schedules, which allow services to be given late in the evenings, during holidays and on weekends. Where possible, outreach services at schools or worksites can be planned so that they are taken to the places where young people congregate.

At all times youth friendly sites should be managed in a manner to reassure young people that confidentiality and privacy is strictly being observed. The

handling of medical records should adhere to this principle. Those waiting outside should not be able to hear or see service providers in sessions with individual youths.

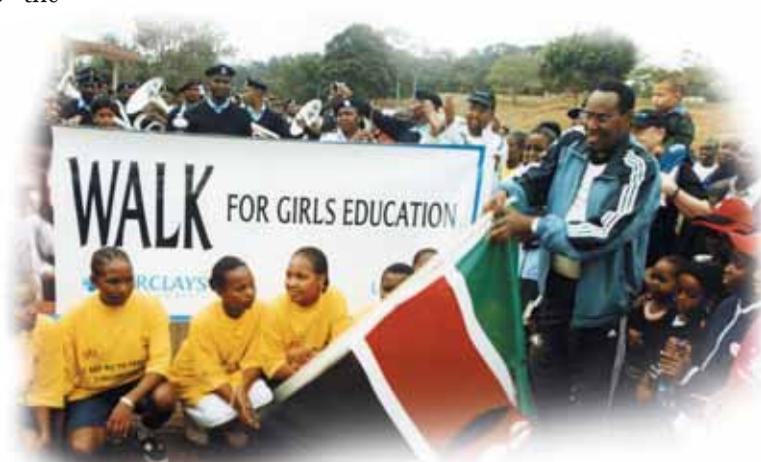
In cases where legal requirements exist such as seeking parental consent in treating certain conditions, these provisions must be explained clearly to the youth and other parties concerned.

Youth-friendly services should cultivate and sustain the TRUST of youth so that they can access health and related services in a conducive environment free of prejudice,

betrayal and fear of being heard or seen by others.

#### 4. Networking And Collaboration

Given the diverse nature of youth friendly services, it may not be



*Networking and Collaboration*

possible for institutions or health facilities to meet the basic demand for such services. In order to compliment each other for effective service delivery, institutions and agencies needs to build strong networks at all levels to mobilize support for youth friendly services. Organizations need to recruit and train local youth groups to provide outreach IEC support services and mobilize youth and the public in support of youth friendly services. Organizations should collaborate in sharing best practices and building effective referral systems for YFS.

#### 4.1 Initiating Youth Friendly Services – A Checklist

EXPECTATIONS	ACTIONS	EXPECTATIONS	ACTIONS
<ul style="list-style-type: none"> <li>Establish demand for Youth Friendly Services</li> </ul>	<ul style="list-style-type: none"> <li>Needs assessment study</li> </ul>	<ul style="list-style-type: none"> <li>Range of services offered</li> </ul>	<ul style="list-style-type: none"> <li>Type of preventive health service offered</li> <li>Type of counseling offered</li> <li>VCT service offered</li> <li>Referral system in place</li> <li>Screening and treatment of STI offered</li> <li>IEC materials available for reading and take away</li> <li>Types of Health talks and schedule</li> <li>Audio/Visual aids available</li> </ul>
<ul style="list-style-type: none"> <li>Establishing Community Support for YFS</li> </ul>	<ul style="list-style-type: none"> <li>Share assessment study results with community</li> <li>Recruit and train youth as peer educators</li> </ul>	<ul style="list-style-type: none"> <li>Operational times and cost of services</li> </ul>	
<ul style="list-style-type: none"> <li>Involving Beneficiaries in planning for YFS</li> </ul>	<ul style="list-style-type: none"> <li>Involve youth in needs assessment</li> <li>Share results with them</li> <li>Sensitize staff and management on YFS</li> </ul>		<ul style="list-style-type: none"> <li>What times does the facility open for services</li> <li>Do they operate in the evenings and on weekends?</li> </ul>
<ul style="list-style-type: none"> <li>Institutional Preparedness</li> </ul>	<ul style="list-style-type: none"> <li>Train and orientate staff in YFS</li> <li>Select staff with positive attitudes to work in YFS</li> <li>Is the facility located in a discrete place to ensure privacy</li> </ul>	<ul style="list-style-type: none"> <li>Outreach Activities</li> </ul>	<ul style="list-style-type: none"> <li>Is the cost of various services displayed</li> <li>Are there trained peer youth educators working with the YFS facility.</li> <li>Are there waiver systems for youth who cannot afford to pay for services</li> </ul>
<ul style="list-style-type: none"> <li>Physical Facilities Preparedness</li> </ul>	<ul style="list-style-type: none"> <li>Are there enough rooms to ensure facial and physical privacy and confidentiality in providing service</li> </ul>		

## 4.2 Monitoring and Evaluation

Monitoring and evaluation should form an integral part of Youth Friendly Service provision. A well-designed monitoring system has the potential to assist the management to improve the quality of services to young people and sustain the quality.

It also helps to keep the program on course. A monitoring and evaluation plan should be put in place at the beginning of the program.

The checklist provided on page 30 can be used by health care providers to monitor and assess the delivery of services to youth.

### Checklist For Training Course For Youth Friendly Staff

<b>METHODOLOGICAL APPROACH</b>	
<b>Monitoring Criteria</b>	
<ul style="list-style-type: none"> <li>• Training guidelines has specific learners objectives</li> <li>• Methodology is participatory and competency based</li> <li>• Pre and Post Test Conducted</li> </ul>	
<b>COURSE CONTENT</b>	
<ol style="list-style-type: none"> <li>1. Introduction to ASRH and related Issues               <ul style="list-style-type: none"> <li>• Definitions</li> <li>• Target Population</li> <li>• ASRH Problems faced by young people</li> <li>• Why focus on young people</li> </ul> </li> <li>2. ASRH and Related Policy and Guidelines</li> <li>3. Values and Principles</li> <li>4. Human sexuality</li> <li>5. Adolescent sexual and psychosocial development               <ul style="list-style-type: none"> <li>• Anatomy and physiology</li> <li>• Psychosocial characteristics of adolescents</li> <li>• Understanding the youth</li> </ul> </li> <li>6. Communicating with young people</li> <li>7. Counseling young people</li> <li>8. Relationships</li> <li>9. Life skills               <ul style="list-style-type: none"> <li>• Goal setting</li> <li>• Decision making</li> <li>• Negotiation skills</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Career choices</li> <li>• Self esteem, self awareness</li> </ul> <ol style="list-style-type: none"> <li>10. Contraceptive Update</li> <li>11. Management of critical ARH related problems               <ul style="list-style-type: none"> <li>• Sexual violence/Assault (Comprehensive Post Rape Care)</li> <li>• Post Abortion Care</li> <li>• Pregnancy in adolescent/youth</li> <li>• STIs/HIV/AIDs</li> </ul> </li> <li>12. Drug and substance abuse</li> <li>13. Providing youth friendly services               <ul style="list-style-type: none"> <li>• Definition of YFS</li> <li>• Why youth friendly services</li> <li>• Models of YFS</li> <li>• Characteristics of YFS</li> <li>• Gender Issues in YFS service provision</li> <li>• Barriers to provision of YFS</li> <li>• Visit to YFS Centre</li> </ul> </li> <li>14. ARH Needs Assessment</li> <li>15. Monitoring and Evaluation</li> </ol>

## Checklist for “Youth-Friendly” Service Characteristics

<b>PROVIDERS AND STAFF</b>			
<b>Characteristics</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Staff is friendly and responsive to youth clients			
Staff is respectful to and ensures privacy of youth clients			
Staff is understanding of and knowledgeable about youth concerns and needs.			
Staff is specially trained to work with youth			
Counselors spend adequate time with youth clients			
Medical providers spend adequate time with youth clients			
Information on need for and timing of follow up visits(s) is provided and clear			
Peer counselors available			
<b>POLICIES AND PROCEDURES</b>			
<b>Characteristics</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Youth drop-in's are welcome and accommodated (for drop-ins only)			
Service are offered to both male and female clients			
Facility provides informational and/or audiovisual materials on RH services and concerns of youth clients.			
Group talks/discussions available			
Service are linked to other youth services			
Program network and necessary referrals available			
Cost of RH services is affordable			
<b>ENVIRONMENT AND FACILITIES</b>			
<b>Characteristics</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
ARH services are provided at convenient (and separate) hours for youth clients			
Décor and surroundings are inviting to youth clients (i.e., non-medical)			
Counseling and examination rooms ensure privacy for youth clients			
Facilities are conveniently located for youth easy access			
Education materials are displayed and available to youth clients to take away.			
Peer youth education outreach programme available			
Youth involved in decision making on youth friendly services provision			
Community informed on the benefits and availability of youth friendly services			

### Comprehensive Post Rape Care

Due to the profound impact sexual violence has on victims and increasing incidents among the youth, excerpts from the National Guidelines on the Medical Management of Rape/Sexual Violence have been reproduced below:

Rape/sexual violence can result in serious physical injuries, profound psychological trauma, unwanted pregnancy and infection with HIV and STIs. Care of rape survivors needs to address all of these as well as legal and forensic issues.

Compassion, respect, and confidentiality should be offered to all patients, but particularly important for rape survivors – it is vital that questioning, examination and sample taking cause the absolute minimum of additional distress to these already highly traumatized patients.

Informed consent should be obtained before examination and the purpose of any examination should be made clear to the survivor. Also, the individual should be told that some of the questions are personal and may seem intrusive, but are important in documentation and as part of legal evidence.

The guidelines on medical management of rape/sexual violence by the Ministry of Health are designed to cover the management of vaginal rape and also forced anal penetration of men, women and children, although at present, Kenyan law does not recognize the existence of male rape.

### Sexual Violence

There is one generic definition of sexual abuse in law: Sexual violence is the use of physical sexual contact or erotic non-contact sexual exposure by one person to another against his or her will and may include acts such as rape (sex against a person's will), touching the private parts of a persons (such as the penis or vagina), oral sex (placing the mouth or tongue on a person's vagina or penis), anal intercourse (placing the penis inside the buttocks opening), dry intercourse (the rubbing of a penis against another person's body) and performing such acts with an animal. However, the law defines each of these activities differently.

### Rape

This is having sex with a woman or girl without her consent or with

her consent if obtained under threat, force or intimidation of any kind, fear of bodily harm or misrepresentation as to the nature of the act or by a person impersonating her husband.

If the girl is less than 16 years of age then she is deemed incapable of consenting to sex in law and therefore sex with her is considered rape even with her consent. Technically in law, the rape of a girl below 16 years of age is termed defilement. For the act to be considered as rape or defilement, there must be penetration of the vagina with the penis.

### Attempted Rape

If someone tried to rape a girl or woman but fails then this is still an offence called “attempted rape” and it is punishable by life imprisonment. In attempted rape, there is no penetration.

### Penetration

This is the partial or complete insertion of the penis into the vagina. No ejaculation is necessary for penetration to be considered to have occurred.

### Medical Management

The management of any life threatening injuries should naturally take precedence over all other aspects

of post rape care, but the management of, for example, minor cuts and abrasions should not delay the delivery of other more timely dependent treatments.

The efficacy of both **Pregnancy Prevention** and **HIV Prevention** decrease rapidly with the length of time from exposure, **so these should be seen as a priority.**

**History taking and examination** of the patient must be undertaken immediately. It is vital that the examination causes the absolute minimum of added trauma that is possible. **Careful and precise documentation** of the examination procedure is critical to providing evidence of violence and corroborative evidence in cases of litigation (**Refer to section 4 for guidelines on examination**).

The first point of contact at the hospital should provide basic counseling and attend to the patient with sensitivity.

### Pregnancy Prevention

In view of the psychological consequences of conceiving after being raped, every non pregnant woman/girl of childbearing age (including all girls who have started menstruation), or shows secondary sexual characteristics and is at risk of precarious puberty, not covered by a reliable form of contraception, should

be offered emergency contraception (EC).

This can be given up to 72 hours (i.e. in casualty) and free of charge in all Government Health Institutions where women are likely to present themselves after being raped.

## HIV Prevention

For many survivors of rape/sexual assault, the thought of becoming HIV infected can greatly add to their psychological distress.

The actual risk of HIV infection without intervention is difficult to quantify, but it is thought to be considerably higher than from unprotected consensual sex, as a result of violent penetration and lack of lubrication, resulting in both microscopic and often also visible mucosal tears.

Children who have been raped are especially at risk due to the immaturity of their mucosal linings and size disproportions resulting in increased trauma. Likewise, forced anal penetration of both adults and children carries a higher risk of transmission.

The HIV prevalence among men who rape is generally considered to be higher than that of the general population, although actual figures are not known in Kenya as the numbers of arrests are minimal.

Post exposure prophylaxis (PEP) is the administration of one or a combination of Anti-Retroviral drugs (ARVs) for 28 days after the exposure of HIV.

Studies have shown that if ARVs are given to health care workers who have been exposed to HIV infected blood from a needle injury, the risk of becoming infected is reduced by about 80%. There is little direct evidence that it works after rape/sexual violence, but it has been shown to be effective after consensual sex in high-risk groups, so most experts agree that it should be beneficial.

## Counseling

Counseling should be offered to all rape survivors, and should cover three basic areas: Trauma counseling/crisis prevention, HIV pre- and post-test counseling and PEP adherence counseling on an on-going basis of up to a minimum of five sessions. Ideally, referral for long-term on-going trauma counseling should be undertaken.

Counseling should be done by an experienced VCT/DCT counselor who has been trained in rape trauma counseling in the context of HIV. Counseling can be undertaken in the VCT or DCT room, or any other room within the hospital that provides privacy for the survivor.

The client should be referred to the counselor after an initial dose of Post-exposure Prophylaxis and emergency contraceptive. This will enable the client to make an informed choice about HIV testing in order to continue PEP.

### Trauma Counseling/Crisis Prevention

Counseling is of priority for the survivor and should be offered to reduce posttraumatic stress disorder. The counselor needs to spend time exploring the survivors' fears and feelings without undue curiosity or cross-examination. Ideally, counseling should also be offered to partners and families of survivors of sexual violence, who are often also highly traumatized.

Clients who present after 72 hours and are therefore not eligible for PEP, should be provided support with initial counseling and, ideally, referred for long-term on-going support for themselves and their family.

### HIV Pre- and Post-test Counseling

HIV Counseling should follow the established National Guidelines. While examination officers may provide information to the client (often the client is high traumatized), it is essential for the counselor to

clarify the survivors understanding of the information already provided. For example:

- **PEP.** Many patients cannot understand why they are given HIV drugs if they are HIV **negative**, whereas if they test positive these drugs are stopped).
- The **Window Period** (During the time between exposure to and testing positive for HIV, which is **approximately 6-weeks**, a person will show HIV negative results if tested but have and can transmit HIV. It is therefore important to discuss previous risks and the possibilities of HIV infection prior to the rape.
- **Emergency Contraception.** Termination of pregnancy as an option in case conception occurs as a result of the rape should be discussed. This is allowed in Kenya under these circumstance. It does, however, require psychiatric evaluation and recommendation.
- **STI prophylaxis.** Safe sex should also be advised (and condoms provided) until follow up testing has been completed given the potential risk of sero-conversion, even in patients taking PEP.

## IMPORTANT

*Note: If the client is not psychologically ready, the baseline HIV test can be delayed by up to 3 days after commencement of PEP*

The counselor should obtain informed consent (the client should sign at the back of the laboratory request form). The client should be referred to the laboratory for HIV testing. Written results are necessary in this case. For this and legal reasons, testing should be done in a laboratory although counseling can be done in the VCT site. The counselor should collect HIV results from the laboratory. Post-test counseling should be provided as per national guidelines.

### PEP Adherence Counseling

Subsequent counseling sessions (particularly for clients on PEP) should be booked to coincide with PEP clinic follow ups. Efficacy of PEP is directly linked to the level of adherence, which unfortunately is often poor in this situation. Effective counseling has been shown to increase adherence. Therefore, while trauma counselling and on-going support for survivors and their families are provided, drug adherence support counseling is vital for people taking PEP.

### Examination, Documentation and Laboratory (Legal Forensics)

There are two types of evidence that need to be collected: Evidence to confirm that sexual assault occurred and evidence to link the alleged assailant to the assault.

### History, Examination and Documentation

This is often done poorly. The lack of proper documentation means that even the minority of cases that get to court are often thrown out because of lack of evidence. It is vital that the examination causes the absolute minimum of added trauma that is possible.

All bruises, abrasion, teeth marks, etc., to the head, mouth, neck, breasts, perineum, anus and vagina should be documented carefully in the clinical notes in the PRC9 available in health facilities. This allows the P3 form to be filled effectively, preferably by the person performing the examination (this is not always possible). The PRC1 form should be filled in duplicate, the original given

to the client while the copy is left for facility records.

### Specimen collection, the laboratory & preservation of evidence

**Torn or soiled clothing** should be collected and passed to the police and signed for in a specific rape register 10 located at casualty or outpatient department by the police officer who takes away the specimen. Replacement clothing needs to be arranged in these instances.

### Reporting Procedures

Rape survivors should be encouraged to report to the police immediately after medical attention. It is, however, an individual choice and should not be forced.

Police should encourage and assist anyone presenting to the police station following rape/sexual assault, to attend the nearest health facility as soon as possible, preferably before legal processes commence as both PER and EC become less effective if delayed.

### What the client should expect at the police station:

- At the police station a report is entered into the Occurrence Book and the survivor is issued with a

P3 form. The P3 form should be provided **free of charge**. An OB number should be available to the survivor.

If the client has not been to the hospital, it is important that they go there immediately after reporting. Other procedures such as writing a statement can be undertaken after initial treatment has been received.

- The police should record the statement of the survivor and any witnesses, and the survivor should sign it only when they are satisfied with what the police have written.
- The P3 form should be completed by an authorized health worker based on the clinical notes found in PRC1.

**Note:** The P3 form does not have to be completed immediately. This can be done at a later date after medical evaluation is complete.

- While taking the P3 form to be completed, it is important for the survivor to have original copies of PRC 1 form.

**N.B:** Ensure you have a copy of post rape guideline from MDH for reference

## Annex 1

### RECOMMENDED CHARACTERISTICS OF YOUTH FRIENDLY HEALTH SERVICES

#### **Adolescent Friendly Policies that**

Fulfill the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations.

- Take into account the special needs of different sectors of the population, including vulnerable and under-served needs of different sectors of the population, including vulnerable and under-served groups.
- Do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age.
- Pay special attention to gender factors.
- Guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care.
- Ensure that services are either free or affordable by adolescents.

#### **Adolescent friendly procedures to facilitate**

- Easy and confidential registration of patients and

retrieval and storage of records.

- Short waiting time and (where necessary swift referral).
- Consultation with or without an appointment.

#### **Adolescent Friendly Health Care Providers who**

- Are technically competent in adolescent specific areas and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances.
- Have interpersonal and communication skills.
- Are motivated and supported.
- Are non-judgmental and considerate, easy to relate to and trustworthy.
- Devote adequate time to clients or patients.
- Act in the best interests of their clients.
- Treat all clients with equal care and respect.
- Provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

### **Adolescent Friendly support staff who are**

- Understanding and considerate, treating each adolescent client with equal care and respect.
- Competent, motivated and well supported.

### **Adolescent Friendly health facilities that**

- Provide a safe environment at a convenient location with an appealing ambience.
- Have convenient working hours\Offer privacy and avoid stigma.
- Provide information and education material.

### **Adolescent Involvement, so that they are**

- Well informed about services and their rights.
- Encourage to respect the rights of others.
- Involved in service assessment and provision.

### **Community Involvement and Dialogue to**

- Promote the value of health services and
- Encourage parental and community support.

### **Community based, outreach and peer-to-peer**

- Services to increase coverage and accessibility.

### **Appropriate and comprehensive services that**

- Address each adolescent's physical, social and psychological health and development needs.
- Provide a comprehensive package of health care and referral to other relevant services.
- Do not carry out unnecessary procedures.

### **Effective health services for adolescents**

- Those are guided by evidence-based protocols and guidelines.
- Having equipment, supplies and basic services necessary to deliver the essential service package.
- Having a process of quality improvement to create and maintain a culture of staff support.

### **Efficient service, which have**

- A management information system including information on the cost of resources, A system to make use of this information.

*Adopted from WHO*

## Members of the ARH taskforce.

NAME	ORGANISATION
Dr Josephine Kibaru	Head, Division of Reproductive Health
Dr Solomon Marsden	Deputy Head, Division of Reproductive health
Dr Godia Pamela	Program Manager DRH
Anne Njeru	Program Officer DRH
Meshack Ndolo	IEC Manager NASCOP
Patrick Mose	Provincial ARH co-coordinator. Nakuru
Dorcas Kiptui	Provincial General Hospital Program Officer, Division of Non-Communicable Disease Control
Dr Kennedy Ongwae	Program officer UNICEF- KCO
Dr Robina Bituyi	Amref
Joseph Karueru	KAPAH Provided Technical assistance
Juma Mwatsefu	Program officer FPAK
David Kinyua	Population officer NCPAD
Dr. Anne Khasakhala	PSRI. UoN
Jane Abunga	Kenya Girl Guides Association
Dr Anna Karani	University of Nairobi, Division of Nursing
Judy Karongo	Program officer UNPA
Malinda Wheeler	Director, Hope Wolrd Wide
Job Akuno	Program officer, Hope World Wide
Rosemarie Muganda	Centre for adolescent health and Development Provided Technical assistance
Dr Elizabeth Wambua	Medical officer of health, Nairobi City Council
Joyce Kinaro	Planned Parenthood Federation Of America
Dr Wasike CSG	Dept Obs/Gyn- KenyattaNational Hospital Kenya MedicalAssociation
Dr Joyce Lavussa	Program officer WHO
Mary Gathitu	Program Officer DRH
Megan Wysong	PATH
Irene Atieno	PATH
Celina Agutu	PATH
Josepheller Mogor	Division of Child Health
Lenet M Bundi	NASCOP

## Footnotes Reference

- 1 *“Ä Rapid Assessment of Youth Friendly Reproductive Health Services”. Pathfinder International Technical Guidance Series Number 4, September 2003 (page 2). Judith Senderowitz, Gwyn Hainsworth and Cathy Solter.*
- 2 *“Ä Rapid Assessment of Youth Friendly Reproductive Health Services”. Pathfinder International Technical Guidance Series Number 4, September 2003 (page 2). Judith Senderowitz, Gwyn Hainsworth and Cathy Solter*
- 3 *Clinical based*
  - *service offered to youth within/based on health facility setting.*
- 4 *Youth center based*
  - *Services offered to youth within community/non-medical setting*
- 5 *School based*
  - *Services offered to youth within school setting*
- 6 *“Clinic Assessment of Youth Friendly Services. A Tool for Assessing and Improving Reproductive Health Services for Youth”. Pathfinder International. 2002. Judith Senderowitz, Cathy Solter and Gwyn Hainsworth*
- 7 *Provider refers to any person working and providing any form of service at a youth friendly site*
- 8 *“Partnering with African Youth: Pathfinder International and The African Youth Alliance Experience.” Pathfinder International and AYA. Page 9. Judith Senderowitz. May 2004.*
- 9 *This is a form developed from the P3 form that has been developed to aid documentation by examining officers. The term PRC is derived from Post Rape Care Form 1.*
- 10 *This has been developed to ensure that data is captured and management of clients can be tracked, and a chain of custody of evidence is maintained from the facility level.*