State of access to SRH by young women and men in Kenya

Perceived stigma and judgement impede access to Sexual and Reproductive Health(SRH)

Why youth-friendliness of healthcare delivery systems could enhance fight against chronic diseases in Kenya

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Contents

Summary

Over the past few years, Kenyans have engaged in an emotional debate over whether cancer should be pronounced a national disaster. Rarely this debate is structured enough to deliberate on the root causes of cancer and explore innovative ways to save Kenyans and the World from losses of loved ones and leaders at prime age of leadership. Cancer and other chronic diseases are normally diagnosed at middle age, yet, the debate rarely consider young people as a stakeholder in efforts to trace the menace to its root causes.

70% of non-communicable diseases (NCDs) are linked to habits, or risk behaviors that start at adolescence and go on throughout adult life. Perceived stigma, judgement and lack of privacy in healthcare delivery systems prevent access to healthcare, thus, young people find alternatives in the practice risk behaviors e.g. drug abuse, unsafe sex etc.

Youth-friendliness of healthcare delivery systems has been discussed and recognized globally as one way to address unique needs of young people, yet, policies, economic planning and budgetary programs do not reflect efforts to unpack what friendly healthcare system constitute in Kenya. Even with budgetary programs on SRH and efforts such as Universal Health Care (UHC), access is not guaranteed without addressing negative perceptions and lack of trust in the delivery systems.

In this paper, we discuss current state of access to Sexual and Reproductive Health (SRH) by young people in Kenya – reflections on findings from a survey we conducted in July 2019 to collect ideas and experiences of young in regards to access to SRH. Young people rated public health facilities as the least friendly for the access of SRH.

Finally, in effort to win the trust of young people in healthcare delivery systems and broadly, make efforts to free the middle age population in the near future, from the agony of cancer and chronic diseases, we discuss and recommend participatory co-design of an ideal youth friendly healthcare delivery system. On this, we call upon health policy practitioners, advocates of young people's issues as well as young people in their organizations and individuals to take action.

In summary, we argue that Kenya's healthcare delivery system is in violation of young people's social and economic rights – whether by design or otherwise. Even though social and economic rights are guaranteed and anchored in Kenya's supreme laws and policies, intended and unintended actions of government and facility management have perpetuated inequalities and discrimination against young people.

Socio-cultural beliefs and barriers that are motivated by deficiencies in healthcare delivery systems exacerbate inequality and discrimination of young women and men – consciously and unconsciously

– Anonymous

Introduction

Kenya, like all or many countries of the World understand and appreciate the overwhelming burden of Non-Communicable Diseases (NCDs) on countries' resources – financial and human capital. However, in contrast, the efforts to counter the threat has never been commensurate despite existence of robust knowledge.

Policy and medical practitioners alike have adequately argued the causes of NCDs, including habits, or risk behaviors, lifestyles – most of which have been cited to begin at adolescence and go on throughout adult life as reflected in journals, papers and documentaries.

Most of these habits, risk factors and behaviors at young age are largely preventable. Yet, success of preventive and mitigative measures rely on the effectiveness and efficiency of healthcare – accessible, reliable, acceptable, appropriate and equitable, especially for young women and men. Inadequate access to healthcare, particularly for Sexual and Reproductive Health (SRH) and mental health counseling for young people has been cited to perpetuate emergence of Non-Communicable Diseases (NCDs).

NCDs accounts for more than 50 percent of total hospital admissions and over 55 percent of hospital deaths in Kenya, according to National Council of Population and Development Policy Brief No. 57 of 2017[1]. Globally, World Health Organization (WHO) states that Cardiovascular diseases account for most NCD deaths, or 18 million people annually, followed by cancers (9 million), respiratory diseases (4million), and diabetes (1.6 million)[2] causing an approximately 15 million deaths among people of the ages of 30 and 69 years – with 85% of these occurring in low and middle-income countries.

While setting health outcome targets for its "Step Up!" The AstraZeneca Young Health program, AstraZeneca links 70% of NCDs to habits, or risk behaviors that start at adolescence and go on throughout adult life. Lack of physical activity, unhealthy eating, alcohol abuse and tobacco use are among the most common contributing factors. Poor mental health underpins these risk behaviors of which half of it [all mental illnesses] begin by the age of 14 and three-quarters by the mid-20s[3].

[1] http://www.ncpd.go.ke/wp-content/uploads/2016/11/Brief-57-ADDRESSING-THE-RAISING-BURDEN-OF-NON-COMMUNICABLE-DISEASES-IN-KENYA.pdf
[2] https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases
[3] https://www.younghealthprogrammeyhp.com/content/dam/young-health/Resources/Publications/Step%20Up!%20Guidance%20to%20Appplicants%202018.pdf

The challenge

Young people have unique needs and face unique challenges as well that require targeted and deliberate efforts. Unemployment and socio-economic opportunities and related frustrations of teenage life, put pressure on young people. In the absence of proper mental support system and enabling environment, young people resolve their frustrations through abuse of illicit drugs and related substances and, engage in behaviors such as unprotected sex whose consequences include unsafe abortions, unplanned marriages and contracting of STIs – these are unproudly consequences that unless environment is enabling, young people find it difficult to openly discuss, share and seek medical advice.

Unfriendliness of healthcare systems prevent young women and men from seeking medical advice and counselling and; getting tested or treatment for sexually transmitted infections (STIs), sexual and maternal health related complications while limits access to and use of contraceptives. We discuss current state of access later in the paper.

Young people have identified: perceived judgement, stigma and negative attitude of health personnel; lack of guaranteed confidentiality and privacy and; cost of care to impede access to healthcare, particularly SRH. Socio-cultural barriers and deficiencies in healthcare delivery systems exacerbate inequality and discrimination – consciously and unconsciously. So that without targeted and deliberate measures to make healthcare delivery system e.g. facilities, people and environment more friendly and facilitative, even government efforts to promote universal health coverage (UHC) will not meet young people's healthcare needs. Experience from Sri Lanka's gives a classic example of inequalities and marginalization perpetuated inaccessibility.

"Even in countries with relatively promising maternal, newborn and child health indicators, Sarah Soyosa, Women Deliver Young Leader and Sexual and Reproductive Health Coordinator for Asia Doctors of the World says "inequities in health coverage can exacerbate the impact of NCDs." She argues that in Srilanka's isolated tea plantation communities experience high rates of cervical cancer, mental health problems and substance abuse" and that, "young people lack access to mental health counseling as well as sexual and reproductive health services. And young women often feel uncomfortable getting tested or treatment for sexually transmitted infections (STIs) or human papillomavirus (HPV), which can lead to cervical cancer."

"If I can just promote one thing, it would be universal screening for gestational diabetes for all women," Dr. Sood said [Country Director of Jhpiego in India]. "Then we can prevent needless deaths of many women and babies."

Unfriendliness of healthcare systems contribute to failure to diagnose and prevent treatable disease incidences from evolving to chronic stages or contributing to heath complications. “Gestational diabetes is easily treatable” Dr. Sood argued in a panel discussion hosted by Management Sciences for Health. She goes on to state that “almost 90% of all women diagnosed with gestational diabetes [in India, according to a survey] can manage their conditions with lifestyle modifications and nutrition, and only 1% of women need insulin. Yet, if gestational diabetes remains undiagnosed, women might have pregnancy or childbirth complications or develop Type 2 diabetes, and babies might experience health challenges as well”.

Legal and policy background

Article 260 of Kenya’s constitution 2010 recognize and define youth as individuals who have attained the age of eighteen (18) years and, under the age of thirty-five (35) years. Kenya is also a signatory to international conventions and treaties that guarantee protection of various social and economic rights as well as Social Development Goals (SDGs) – set of global targets to be achieved by all states by 2030.

Kenya’s constitution 2010 has been considered one of the most progressive in advancing social and economic rights. More specifically, Article 43 of the constitution provides for the right to healthcare, including reproductive healthcare. Furthermore, formulation of Kenya’s National Policy on Reproductive Health 2015 is expected to enhance realization of these constitutional provisions.

Kenya has a youthful population, with 35 years old and below constituting 70% split in equal parts of young women and men. This segment experience unique challenges ranging from access to economic and political opportunities to barriers such as socio-cultural related impediments.

With a youthful population and about 2.5% annual population growth rate, this segment presents both an opportunity and challenge – opportunity to align health and economic policy measures towards achievement of national and internationally set targets including Social Development Goals (SGDs) 3.7 and 3.4. and others that directly address issues affecting young people. This way, the country strengthens its efforts manage burdens of non-communicable diseases in the future.

Status of access to SRH and related healthcare by young people in Kenya: a mini-survey report

Both the constitution and the national SRH policy categorize youth as vulnerable segment, thus, deserve attention. Whereas constitutional provisions and formulation of relevant policies is an indicative effort towards advancement of the realization of young people's social and economic rights, it is imperative to continuously assess the extent to which efforts towards advancement are reflected in policies, economic plans and budgets. We conducted a survey in July 2019 with aim of assessing efforts to advance access to healthcare by young women and men. We received 137 responses from young women and men (54% and 45%). 1% preferred to say their gender.

Knowledge and Accessibility

Most young women and men have knowledge of SRH, but few have used the services due to unfriendliness of healthcare delivery systems. 96% of the respondents have heard about SRH, of which 53% are male and 43% female. Of this, 73% – 42% male and 30% female have used contraceptives while 58% have sought advice on contraceptives respectively.

Of the respondents that have sought advice of contraception, 42% of the respondents have used primary and recommended sources of advice i.e. trained medical practitioners (public and private hospital personnel) as preferred source. A combined 58% are not accessing SRH advisory services at all or are using alternative sources - 35% of the respondents gave no response while 14% and 9% preferred friends (and relatives, pastor and teachers) and chemist personnel respectively.

Barrier methods e.g. condoms and emergency contraception pills (P2) are the most preferably used SRH commodities with 48% and 39% of the respondents reporting to have used the commodities. A combined 10% have used long-term plans i.e. long-acting reversible pregnancy protection methods e.g. implants or intra uterine device and permanent pregnancy protection methods e.g. vasectomy or tubal ligation. Asked about preferred access points for the above commodities and services in terms of friendless, 78% preferred chemists and private health facilities at 39% each. Only 19% of the respondents found public health facilities friendly for access while 4% had no responses.

The sensitivity of the matter of SRH owing to fear of perceived stigma and judgement may have affected responses on contracting and medication of Sexual Transmitted Infection (STIs). We asked respondents whether they have contracted any STI before and if they sought medication for the same and or why they did not seek medication, if so.

- Only five percent (5%) responded to have contracted an STI, with two percent (2%) of this having contracted skin disease (scabies) and 1% each for HIV/AIDS, Gonorrhea and Hepatitis B. While the response are desirably positive that of 137 respondents, 95% have never contracted any form STI before, there is also a chance that fear of stigma, judgement and perceived inadequate guarantee of confidentiality of the data collected from the survey influenced the responses, thus, indirectly expressing low trust levels young people have over friendliness of healthcare delivery systems or efforts to promote access.
- Only 10 percent (10%) responded to have sought medication with private health facility leading as preferred source with seven percent (7%) while public health facility and chemists having two percent (2) each. 56% gave no response while 34% found the question not applicable implying that they may not have contracted an STI before or preferred to share experience for the same reasons discussed in this paper. The responses on access to medication are slightly higher in proportion to responses on contracting STI before by 6%. This implies that the extra 6% respondents may have contracted an STI but did not respond as such for confidentiality reasons or fear of stigma and judgement.
- Six percent (6%) of the respondents that reported to have contracted an STI but did not seek medication responded not have found good reasons to seek medication for the infection contracted while five percent (5%) reported to have been ashamed to seek medication. 75% did not respond to the question while 14% found the question not applicable. The 11% of the respondents that responded to have found no good reasons and were ashamed to seek medication is insignificant, however, it reinforces the concerns of unfriendliness of health facilities in seeking SRH services.

Acceptability and appropriateness

We measure acceptability and appropriateness of healthcare delivery system using friendliness ratings given by young people on various health facility types. We also look at factors that young people considered barriers to access of healthcare in this survey.

As preferred source for access to SRH on the basis of friendliness, public health facilities received the lowest friendliness rating of 15% compared to 53% and 46% ratings for private health facilities and chemists respectively. Similarly, public health facility received the highest unfriendly responses at 23% compared to 0% and 2% for private health facilities and chemist respectively. In all aspects, public health facilities are least trusted to be friendly for the access of SRH by young people.

Friendly rating	Public health facilities	Private health facilities	Chemist (private)
Not friendly	23%	0%	2%
Somewhat friendly	32%	11%	17%
Friendly	30%	35%	35%
Most friendly	15%	53%	46%

Young people identified various factors that are perceived to make healthcare delivery systems unfriendly. We grouped these factors into conceptual categories of barriers that affect acceptability and appropriateness of the current structure and design healthcare delivery systems for the access of SRH as shown below:

a. 36% of the respondents identified communication, consultation, knowledge and information;
b. 33% of the respondents identified composition & personalities (age, gender, attitude) of health personnel, perceived stigma, judgement, confidentiality and privacy;
c. 28% of the respondents identified inadequate contraceptives and SRH service in facilities, high cost of healthcare and absents of segmented special units (youth clinics) to serve needs of young women and men;

To improve acceptability and appropriateness of healthcare delivery systems, young people proposed the following measures.

a. improve communication, consultation, knowledge and information by introducing e-consultations and e-self-diagnosis (pre and actual, whenever possible) to compliment in-person diagnosis; creating awareness among young people to enhance knowledge and information on access, usage and options for contraceptive commodity and services;
b. make healthcare delivery systems more attractive to young people by assigning youthful and gender-sensitive health personnel to attend to young people's healthcare needs;
c. eliminate any chances of perceived stigmatization, judgement and enhance confidentiality in health facilities by retraining health personnel on and reinforcing work ethics through greater public disclosure of work ethics and policies;
d. restructure health facilities' infrastructure to offer more privacy & confidentiality at consultation and medication stages by introducing youth clinic segmented units within health facilities that are reserved to serve young women and men in order to physically demonstrate guarantee of no judgement and stigmatization. Such special units should have sufficient enablers such as internet and related comfort facilities;
e. enhance access to SRH services and commodities by addressing inadequacies and reducing cost of access as well as waiting time.

Summary and conclusions

Kenya's health service delivery system is in violation of young people's social and economic rights – whether by design or otherwise. Even though guaranteed and anchored in Kenya's supreme laws and policies, the findings from this survey has identified impediments and difficulties experienced by young women and men while accessing Sexual and Reproductive Health (SRH). These difficulties are fueled by various factors including intended and unintended actions of government and facility management that perpetuate inequalities and discrimination against young people.

In light of cultural beliefs and perceived judgement by communities, young people in Kenya prefer the practice of habits and risk behaviors that later evolve to chronic health complications than to endure the perceived shame that accompany courage to seek and use of contraceptives to mitigate against STIs and effects of irresponsive sexual practices such as unsafe abortions and mental health cases emerging from responsibilities of unplanned and forced child upbringing.

Even when fully equipped and have sufficient personnel, availability of health facilities alone does not guarantee access to SRH services and commodities. And, from our survey, young people have demonstrated that they are better off not using medication and healthcare services from qualified and recommended sources as long the friendliness of healthcare delivery systems is not guaranteed. This creates a problem for the government because failure to seek medication implies that young people develop chronic health complications from which NCDs in later stages of life.

Young people identified condoms among others as the commonly used contraceptive among young people and cost of the commodity as greatest impediment. This confirms the wanting state of publicly accessible condom dispensers installed in public health facilities as shown in the inset image photo of condom dispenser located at the entry to a health center in Elgeyo Marakwet County. This dispenser is empty and not in use. Even if it was in use, its positioning is unfriendly for access. In such cases, the alternative access to such healthcare commodity are expensive purchases from chemists and in some cases where cost is a barrier, the practice of unprotected sex.

Recommendations and opportunities

Move from policy and legal provisions to actions – there is an opportunity for stakeholders and advocates of young people's issues and needs to advance realization of social and economic rights. Young people desire friendly environment for the access to healthcare while the resource that is young people's population with sufficient voices and ability, if mobilized, and utilized well, provides a strong basis for influencing and aligning budgetary and policy priorities to unique needs of people. The principle of fairness that 'whoever needs more should get more', should be observed while planning and budgeting to ensure needs of majority of the population that is young women and men receive commensurate budget and policy priority attention.

Enhance access and cost-effectiveness – availability of contraceptives and related commodities such as condoms should be guaranteed at affordable costs with sufficient privacy, as a starting point. Simple and accessible platforms include public condom dispensers, but must be repositioned to guarantee privacy, refilled to ensure full time access and rebranded to make them appealing to young people. Access may also be enhanced through regulation of the prices of commercial condoms as well through tax exemptive measures. Awareness, information and access to advice on SRH options, usage and side effects of various contraceptives should complement enhanced availability and access to SRH commodities.

Cultivate and leverage on youth leadership for ownership and sustainability – young people should be supported to lead efforts towards making healthcare delivery systems youth friendly in efforts to inspire confidence. Efforts should be put to advance youth-led awareness creation among fellow young women and men and, to educate communities to begin to appreciate the unique needs that young people have in order to aid reduction of stigma and judgement.

Other youth-led initiatives include participatory co-design of what constitutes a youth friendly healthcare delivery system, participatory monitoring of the implementation of budgetary programs, national and county policies, constitutional provision as well as social auditing of health service delivery.

Enhance capacity of health personnel to understand and serve young people better – retrain, redistribute and tighten work ethics of health personnel to cultivate culture of trust and confidence of young people in healthcare delivery systems. Disclosure of rights of patients and personnel work ethics should be encouraged through enhance service charters and other disclosure efforts.