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ADHERENCE OF HEALTHCARE PRACTITIONERS TO THE ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY AT THE GARISSA PROVINCIAL GENERAL HOSPITAL, KENYA
C. M. Musee, BScN, MScN, Nurse, Kenyatta National Hospital, P.O. Box 20723-00202, Nairobi, L. K. Bitok, BScN, MHSM, PhD, Senior Lecturer, S. Wakasiaka, KRN, MPH, PhD, Senior Lecturer, School of Nursing Sciences, University of Nairobi, P.O. Box 19676-00202, Nairobi and J.M. Mweu, BSN, MScN, Senior Nursing Officer, Kenyatta National Hospital, P.O. Box 20723-00202, Nairobi, Kenya.

Request for reprints to: C.M. Musee, Kenyatta National Hospital, P.O. Box 20723-00202, Nairobi, Kenya

ADHERENCE OF HEALTHCARE PRACTITIONERS TO THE ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY AT THE GARISSA PROVINCIAL GENERAL HOSPITAL, KENYA

C. M. MUSEE, L. K. BITOK, S. WAKASIAKA and J.M. MWEU

ABSTRACT

***Background*: Kenya's policies relating to population, family planning (FP) and reproductive health (RH) receive weak/fluctuating levels of adherence. The Adolescent Reproductive Health and Development (ARH&D) policy gives directives and actions to follow in meeting identified ends and goals in the reproductive and developmental needs of the youth- majority of Kenya's population (Ministry of Health-Youth Friendly Services (MOH-YFS), National Coordination Agency for Population and Development (NCAPD), 2011).**

***Objective*: To evaluate adherence of healthcare practitioners (HCPs) to the Adolescent Reproductive Health and Development (ARH&D) policy at the Garissa Provincial General Hospital, Kenya (GPGH).**

***Design*: A cross sectional study.**

***Setting*: Garissa Provincial General Hospital, Kenya.**

***Subjects*: Comprised of 172 Healthcare practitioners (HCPs), including 88 nurses, 14 doctors and 17 clinical officers (COs) and 53 adolescent clients.**

***Results*: The HCP policy utilisation rate of the ARH&D which was 62.2% was influenced by religious affiliation, age, frequency of supervision. Adolescent client satisfaction level was about 34%. Severity of infibulations has reduced in severity among the Somali people. Consanguineous marriages of under-age girls, drug addiction, poverty, HIV and AIDS and FP stigmatisation are still high in North Eastern Province.**

***Conclusion*: Adherence to the ARH&D policy was about 62% at the GPGH. There was no ideal set up for YFS. The adolescent satisfaction low was at about 34%. Infibulation has reduced. There were shortcomings with the HCP characteristics, facility deficits, and service management hurdles.**

INTRODUCTION

The World Health Organisation (1) defines health policy as the decisions, plans and actions that are undertaken to achieve healthcare goals. Mere articulation of policy is not adequate to accomplish the policy goals (2). United States Agency (3) for International Development indicates that Kenya's national health policies help set the stage for provision of quality health care.

The Kenya's National Coordinating Agency for Population and Development (4) indicates that more than a quarter of Kenya's population are adolescents, who face unprotected sex, sexual pressure/ coercion/sexual exploitation, unsafe abortions, and susceptibility to HIV (5).

The Kenyan ARH&D policy dated 2003 responds to concerns raised in the National Population Policy for Sustainable Development (NPPSD), National Reproductive Health Strategy (NRHS), Children's Act and other national and international declarations and conventions on the health and development of adolescents 6. This policy was used to set up youth friendly service (YFS) and stipulates the HCP and programme characteristics (7).

In North Eastern Province (NEP) infant mortality rate is 57/1000 live births and the under five mortality 80/1000 live births, both worse than the national

average of 52 and 74 respectively (8). The maternal mortality rate is the highest in the country at 1000 to 1300 per 100,000 live births, the national average being 484 per 100,000 live births (8).

NCPD, 2003 (6) indicated that Somali community which is predominant in NEP culturally perceives Female Genital Mutilation / Cut (FGM / C) as a tool for fostering family honour (9) and thus the prevalence rate of FGM was 97%. They practice infibulation (severe genital mutilation) associated with obstetric / gynaecological complications (9). WHO (1) indicates that the Somalis favour high fertility and that poverty / social conflicts, hinder family planning (FP), uptake being less than one per cent (10,11). Evidence indicates rampant early marriage, female genital cutting (9) and gender-based violence / disparity, forced marriages / domestic violence, high school dropout rates, high divorce rate (10) in NEP. HIV prevalence was 4.2 in 2007 up from one per cent in 2002, low HIV testing rate, substantial HIV / AIDS stigmatisation (10, 9). In recognition of these challenges in NEP and elsewhere, the Kenya government targets adolescent RH needs through its ARH&D policy by increasing YFS from baseline to 80% by 2015 (7).

MATERIALS AND METHODS

Study design: A cross sectional study.

Study area: GPGH in NEP. NEP is one of the eight (8) provinces in Kenya. It borders Ethiopia to the North, Somalia to the East, Coast province to the south and Eastern province to the west. It has a population of 2,345,000-(70% are nomads) that is dispersed in a vast region within an area of 126,000km^2 (20% of Kenyan land).

Study population: A total of 119 HCPs and 53 adolescents were interviewed.

Sample size determination: Determined using the Fishers formula formula for determination of sample size (Fisher *et al* 1999 as cited by Mugenda and Mugenda 2003).
= 119 qualified healthcare workers
In addition a total of 53 adolescents and 7 key informants purposively sampled.

Table 1
Proportionate Sample Sizes of the HCPs

Cadre	Number	Proportions	Proportionate Sample size
Nurses	127	127/172x100=73.837%	73.837%x119=87.866=88 nurses
Doctors	20	20/172x100=11.628%	11.628%x119=13.8373=14 doctors
Clinical officers (COs)	25	25/172x100=14.535%	14.535%x119=17.29665=17 clinical officers
Total	172	100%	119

Sampling method: A hospital list of the target population was obtained. Every second eligible HCP participated for simple random sampling purposes. Key informants and the youth were purposively chosen.

Data collection procedures: After ethical clearance eligible consenting participants filled a questionnaire. Additional information was obtained from key informants. A check list was used to assess YFS characteristics.

Pretesting of the questionnaire: Ten HCP' questionnaires were pretested among equivalent HCPs (nurses, RCOs, doctors) at Kitui District General Hospital (Eastern Province) for reliability and validity.

Ethical consideration: Permission to undertake this study was obtained from University of Nairobi, Kenyatta National Hospital, Ethics Research Committee (UON, KNH, ERC), GPGH, Ministry of higher education, Kitui District General Hospital (pretesting area). Participation was voluntary. Eligible participants signed a written informed consent. Confidentiality, privacy, anonymity, justice were adhered to during the study.

RESULTS

Characteristics of HCPs: A total of 119 HCPs providing adolescent RH at GPGH, seven key informants (KIs) and 53 youths were recruited for the study. There was 100% response rate.

Gender: About 72(60.5%) HCPs were female. Males were older (mean = 34.9 years [SD = 8.6]) than the females (mean = 31.9 years [SD = 6.7]) (t-statistic = 2.13; p value = 0.035).

Profession: Nurses constituted the majority (n=88, 73.95%), doctors were 14(11.76%) and COs were 17(14.29%).

Religion: Christians were 88(73.95%) while 28(23.53%) were Muslims.

Table 2
Characteristics of the HCPs Recruited in the Study

	n = 119	Percent
Gender		
Male	47	39.5
Female	72	60.5
Profession		
Doctor	14	11.76
Nurse	88	73.95
Clinical officer	17	14.29
Religion		
Christian	88	73.95
Muslim	28	23.53
Other	3	2.52
Academic qualification		
Certificate	24	20.17
Diploma	76	63.87
Bachelors degree	16	13.45
Masters degree	3	2.52
Total	119	100

Duration of service
The HCPs had served for a median duration 6 years (Interquantile range (IRQ) 2 to 13) (The IQR represents the boundary between 25% (1st quartile) and 75% (3rd quartile) of a variable). There was statistically significant differences in the length of service among HCPs in the different professions (Kruskal Wallis (chi squared = 9.75; p = 0.0077). Nurses had served for the longest median duration (seven years), clinical officers (median = three years) and doctors two years.

Reading of the ARH&D Policy by the HCPs
Most (n = 90, 75.6%) HCPs had not read the ARH&D policy.

Training of HCPs on ARH&D
Only 16(13.45%) HCPs were trained in ARH&D. There was no significant association between receiving ARH&D training and the profession of a HCP (p = 0.363) but those who had training had a significantly shorter median duration of service (median = two years) compared to those who did not have ARH&D training (median = 6.5 years; Mann-Whitney p = 0.0172).

HCP Adherence to the ARH&D Policy
Implementation of the 12 components presented in Table 3 below, were used to define HCP adherence to ARH&D policy. Those who implemented at least 80% (9 out of the 12 components) were considered to be adhering to the ARH&D policy. About 74 (62.2%) were utilising ARH&D policy.

Table 3
HCPS' Responses used to define ARH&D Utilisation

ARH&D component	No. of HCPs	Percentage
Discuss sexuality	106	89.08
Discuss HIV and AIDS	114	95.80
Discuss family planning	110	92.44
Provide FP methods to married clients	108	90.76
Provide FP methods to unmarried clients	81	68.07
Provide artificial FP methods to unmarried youth and school age adolescents	36	30.25
Support masturbation	7	5.88
Support female circumcision ban	108	90.76
Support traditional male circumcision ban	62	52.10
Fight gender violence	112	94.12
Professional post abortion care for unmarried clients	87	73.11
Separate place for adolescent reproductive health services	99	83.19

Figure 1
Adherence of the HCPs to the ARH&D policy at GPGH

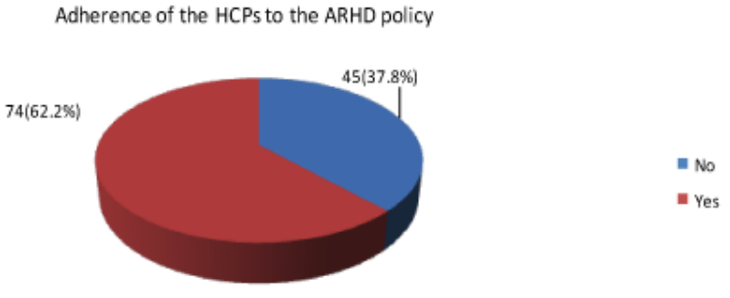


Table 4
Provider Factors Influencing Adherence to the ARH&D Policy

	ARH&D utilisation			
	Yes	Number	Chi square	P value
Gender				
Male	31(66.0)	16(34.0)	0.47	0.49
Female	43(59.7)	29(40.3)		
Adequate staffing				
Yes	8(53.3)	7(46.7)	3.64	0.16
No	55(67.9)	26(32.1)		
Don't know	11(47.8)	12(52.2)		
Provider has read ARH&D policy				
Yes	20(74.1)	7(25.9)	-	0.29*
No	53(58.9)	37(41.1)		
Academic qualification				
Certificate	15(62.5)	9(37.5)	-	0.086
Diploma	44(57.9)	32(42.1)		
Bachelors	14(87.5)	2(12.5)		
Masters	1(33.3)	2(66.7)		
Age in years	Adhered to ARH&D policy	Did not adhere to ARH&D policy		
20-29 years	37(75.5)	12(24.5)		0.005*
30-39 years	15(40.5)	22(59.5)		
40-49 years	21(65.6)	11(34.4)		
50 years+	1(100)	0		
Religion	Adhered to ARH&D policy	Did not adhere to ARH&D policy		
Christian	61(69.3)	27(30.7)		0.006*
Muslim	13(46.4)	15(53.6)		
Other	0(0.0)	3(100.0)		
Frequent of HCP support supervision	Adhered to ARH&D policy	Did not adhere to ARH&D policy	Chi	P value
Yes	35(72.9)	13(27.1)	3.94	0.047
No	39(54.9)	32(45.1)		

HCP Age and Adherence to the ARH&D Policy
The age of HCPs was significantly associated with adherence to ARH&D policy (p=0.005). Rates of adherence to ARHD policy was lowest among HCPs aged 30-39 years, 15(40.5%) followed by 40-49 years, 21(65.6%). Highest adherence was among the youngest age group, 37(75.5%).

HCP Religion and ARH&D Policy Adherence
Religious affiliation showed a statistically significant association with ARH&D adherence (Fishers exact p = 0.006). Adherence to ARH&D policy was higher among Christians, 61 (69.3%) compared to Muslims, 13 (46.4%).

Supervision of HCPs and Adherence to the ARH&D Policy
Frequent support supervision was significantly associated with ARH&D policy adherence (p = 0.047).

Team Work among the HCPs
Most (n = 102, 85.71%) HCPs reported working with cooperative teams and 81 (680.7%) experienced staffing shortages.

Record Keeping on ARH Services
About 71(59.66%) HCPs kept records on ARH while 35(29.41%) did not.

Research on ARH
Two (1.68%) HCPs had done and published research on ARH.

Concerns facing youth in Garissa

Generally, KIs expressed concerns on ARH rights/ harmful ARH practices, drugs/substance abuse, low socio-economic status and FGM.
"*…drugs of addiction like miraa/early marriages, high school dropout,… the climate is harsh to allow children from poor families to walk long distances to school. ... Malakote people-infibulation is grade 4. FGM causes difficult labour, infections, perineal and cervical tears, recto-vaginal fistula, very painful sex, poor delivery outcomes. .....*"

Implementation of ARH&D policy

"*…need for stakeholder meetings…, engage the youth, social forums, youth groups, ministry of youth affairs, local actors..hatch work plan for implementation..involve Key community and government administrators...*"

Challenges Faced In Adolescent Reproductive Health

Stigmatization of FP:
"*…A wife who does not have at least ten children is not respected as being woman enough among Somalis*."

FGM:
" *infibulation has gone down. The community has been enlightened that FGM is not sunna (a religious obligation) but traditional practice. Sheikhs have been used to talk to the community.*"

Early marriages and maternal complications:
"*…we have young girls of ages ,12, 13, 14, 15 coming to deliver, married to polygamous elderly men who do not care for them…the men mainly get married to have children…expectant mothers fear antenatal clinic, … decline caesarean sections because it limits the number of children a woman can get…*"

Illiteracy:
"*…illiteracy persists… children do not work hard in school…*"

Lack of YFS:
"*The youth avoid the hospital clinics. Youth are impatient and want first priority which may not be forth coming in the integrated services…..*"

Age and Gender
A total 53 adolescents participated. About 50(94.33%) were female. The mean age was 19.5 years (SD = 3.7), range 11 to 24 years. The male clients were younger (mean ages 18.7 years versus 19.6 years; difference -0.93 (95% CI -5.8 to 3.96.

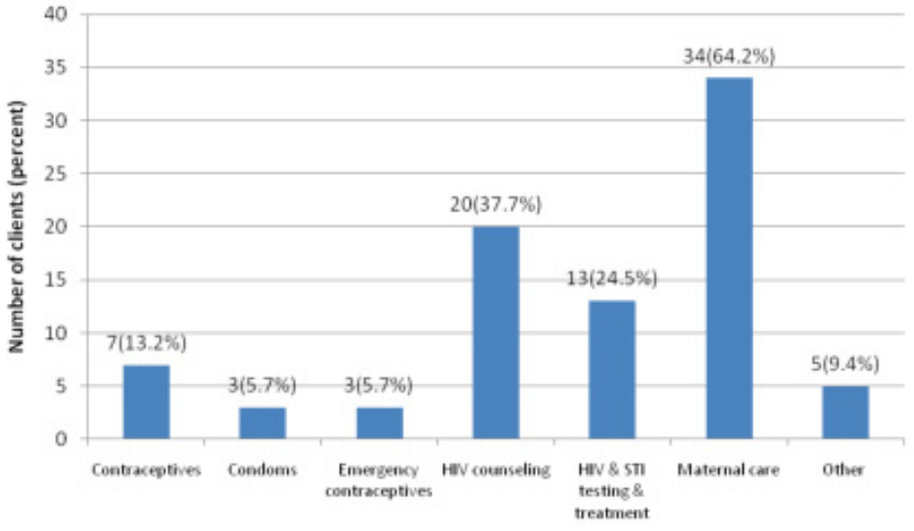
Marital Status
Three-quarters (n = 41(77.36%) were married. All male clients were single. Eighteen (33.96%) were visiting GPGH for the first time.

Table 5
Basic Characteristics of Adolescent Clients at GPGH

	Number (n)	Percentage
Gender		
Male	3	5.66
Female	50	94.34
Marital status		
Single	11	20.75
Married	41	77.36
Divorced/Separated	1	1.89
First visit to clinic		
Yes	18	33.96
No	35	66.04

Services Required by the Clients
The most demanded services were maternal care (64.2%), HIV counseling (37.7%) and HIV and STI testing and treatment (24.5%).

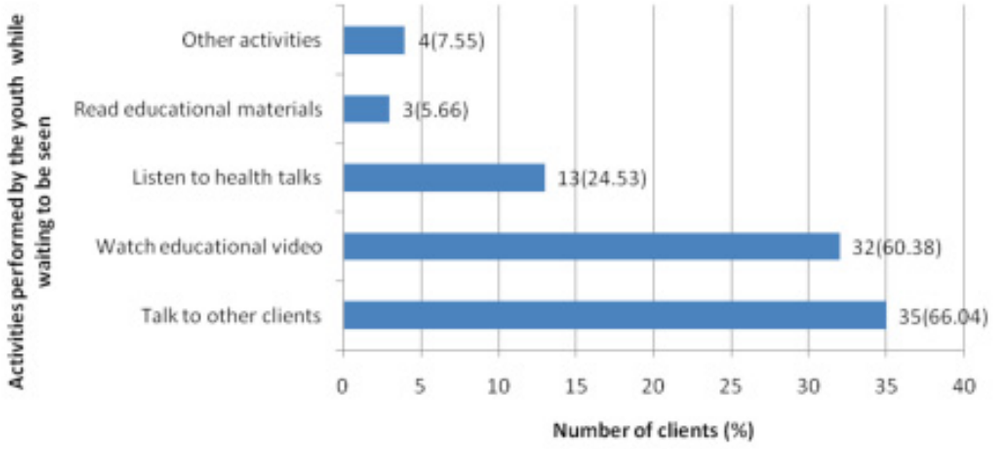
Figure 2
Services sought by clients in the healthcare facility



Client Privacy and confidentiality
Thirty seven (69.8%) youths reported lack of privacy and 39(73.6%) lack of assurance of confidentiality. Two female clients were disappointed because of being examined by a male HCP.

Client Waiting Time
While waiting, activities that the adolescents engaged in were: 35(66.04%) talking to other clients, 32 (60.38%) watching videos and 13(24.53%) listening to health talks. Many engaged in more than one activity.

Figure 3
Activities performed by the youth while waiting to be seen



Three (5.7%) clients found time spent at the clinic was too short, 15 (28.3%) too long, while the rest said it was just right. All the respondents, 53 (100%) reported that the clinic opening hours were convenient.

HCP Dissemination of Information on ARH&D
Thirty-three (62.26%) clients were educated on prevention of HIV/STI and unwanted pregnancies, 31 (58.49%) on safer sex, and 16 (30.19%) on FP. Only 8 (15.09%) were informed about available ARH&D service delivery points. Most clients, 51 (96.2%) were informed about follow on appointment and 48 (90.6%) about "walk in" follow up.

ARH Care Aspects either Liked or Disliked by Clients
These are aspects used to determine overall client satisfaction rate. About 18(33.96%) adolescents indicated they liked caring, friendly/welcoming HCP attitude, and short waiting time. Thirty four (64.15%) youths disliked dirty toilets, long waiting hours, male

HCP attending to female clientele, delivering alone, and expensive cost of ARH services. Thus the client satisfaction level was about 34%. Despite this, all the clients indicated that they would recommend the clinic to a friend or relative.

DISCUSSION

This study established that HCP adherence rate to ARH&D policy was about 62%. This contrasts a US based study where HCP RH policy adherence rate was 82% (12).

Majority HCPs had not read ARH&D policy and copies of the policy were not in the GPGH. Similar findings were reported in another Kenyan based (13) study where adherence to RH policy was adversely affected by poor policy dissemination.

In GPGH younger (20-29) HCPs were adhering to ARH&D policy more than the older ones. Previously, findings (14) in Kenya indicated that adolescents preferred to be attended to by young HCPs.

In Garissa, adherence to ARH&D policy was higher among Christians (Fishers exact p = 0.006). Previous APHIA 11 research (15) indicated that the Somali cohesion and cultural/religious influence upheld FGM/early marriages to girls/illiteracy, religion/poverty/gender inequality, stigmatization of FP/HIV and AIDS, language barrier and fear of attending antenatal clinics.

It was established that some see FGM as "sunna", a religious obligation in Islam while others indicated that FGM was a culture. Similarly, studies (16,14, 17, 18) in America, Kenya and Tanzania, asserted that interaction of culture, knowledge and religion , is essential for effective RH policy adherence among HCPs.

Barriers to adherence of the HCPs to ARH&D policy in Garissa include, haphazard support supervision compared to what is reported in the implementation of other health policies19. For example, in Tanzania (16), on site supervision increased adherence to health policy and in Botswana, Ghana, Tanzania and Uganda. Contrastingly, support supervision of a new YFS policy was inadequate due to lack of supervisor training (5).

In GPGH, HCPs were motivated by cooperative work teams. Comparatively in China (13), Indonesia and Vietnam RH policy implementers' motivation was high due to personal, organisational, or institutional motivation and commitment.

In GPGH, policy implementation planning seemed poor. Training of HCPs on ARH was low at 13.45%, there was staff shortage, ARH services' supplies were inadequate. Contrastingly in Jamaica (19), ARH policy implementation plan including training, strong community/social structure scaled up policy utilisation. Similarly, in Tanzania (16), infrastructure was renovated, careful staffs/ managers selection/training, done before implementing the YFS policy resulting in quality/high YFS policy adherence.

In GPGH record keeping and research on ARH was minimal. Similarly, in another Kenyan (14) research based on evaluation of RH, HIV and AIDS policy implementation and adherence, monitoring and evaluation of these policies was reported to be poor due to poor data collection. Comparatively, in Tanzania (16) record keeping in public sector was poor/recording systems were outdated, reports/ data gaps/data analysis existed on ARH. Similarly, in Uttarakhand, India (15) systematic linkages/ monitoring/ planning processes were lacking resulting in decisions that were not evidence based.

Location of GPGH was accessible but the CCC/ VCT clinic is near the morgue/red roofed-seen as indication that clients being seen/treated here were on transit to the mortuary-thus many youth avoid it. This contrasts Shaw (20) states that youth patients preferred health services offered at a convenient location, during convenient hours, with sufficient privacy, and comfortable surroundings.

At GPGH, ARH health services operate between 8 am-5 pm week days. These findings (20) contrast a previous research which reported that youth clinics that opened between 8 am and 5 pm were problematic for youth who were in school. On the contrary, 100% of the GPGH clients said the GPGH hours (8 am to 5 pm) were convenient.

The GPGH study established that there were no take away study materials for the adolescents. However, in Tanzania (16), study materials for youth to read/carry home were availed because some adolescents are too nervous to retain information on a face to face session and often prefer to learn on their own.

Most of the GPGH clients received the services they had come for. Only one client (1.87%) did not receive the ARH service sought. Shaw (20) states that good HCP adherence to ARH&D policy indicators included wide range availability services for both boys/girls, affordability, youth involvement, referral system, acceptable waiting time, policy support/ publicity. Studies (21) indicate that >= 90% of customers who are dissatisfied with the health service they receive will not return to the facility.

In GPGH adolescents were dissatisfied with level of privacy/confidentiality. Similar findings indicated that clients preferred to be seen behind closed doors/ non labeled rooms with no interruptions and records stored confidentially (22,5, 14). Further concurring reports inTanzania (16) reported the fear of HCP sharing information with a relative. About 62.7% of adolescents preferred a separate place especially for first clinic attendants, the non-sexually active and the marginalised.

At GPGH, ARH services were affordable for the majority (84.91%) and for those who could not afford

a waiver and credit facility were offered. Similarly, Pathfinder (16), indicated that ARH services were affordable for the majority in public hospitals.

At GPGH, a minority of clients indicated short waiting period, about a third found it too long, while the majority (about two thirds) found it just right. Contrastingly, Pathfinder (16) indicated that youth clients waited for a half an hour to two hours and they were willing to wait even longer if their services were in a separate place from the adults.

In GPGH, 18 (33.96%) youth liked the caring/friendly/welcoming staff attitude, and short waiting times. Thirty four (64.15%) youths disliked dirty toilets/long waiting hours, male staff attending to women, delivering alone, and expensive cost of ARH services.

Consequently, the client satisfaction level was about 34%. On the contrary about two thirds did not like the dirty toilets, long waiting hours, male staff attending to female clients, delivering alone and high cost of services received. This concurs with findings (5, 16) in Tanzania. Facilities were poorly maintained/limited waiting area/low cleanliness levels, and high HCP burn out which resulted in low motivation. Here 80% of adolescents were unhappy, while NGOs facilities were more attractive.

In GPGH, FGM has now reduced in terms of the grade of infibulation, among the Somali people. In contrast, The EDC study (10) findings indicated that female circumcision had been rampant in Garissa in numbers and severity. It further indicated that the proportion of Muslim women who were circumcised was about double that of Christian women, with FGM being most prevalent among the Somali at 98% (23).

CONCLUSION

The HCP adherence to the ARH&D policy was (62.18%). Adherence was higher among Christians. Adherence was also lowest among HCPs aged 30-39 years, followed by 40-49 years. The highest adherence to the policy was reported in the youngest age group 20-29 years. Support supervision of HCP was associated with increased adherence. There was no ideal YFS clinic. Most of the ARH services sought were provided. The majority of HCPs at GPGH were however untrained on the ARH&D policy. The staffing levels low. Family Planning and HIV and AIDS are highly stigmatized. FGM has now reduced in terms of the grade of infibulation, among the Somali. Among the Malakote community, infibulation is at grade 4. Early girl marriages, gender inequality, poverty, drug addiction especially miraa is rampant in Garissa.

The adolescent client service satisfaction level was about 34%. They found some HCPs unfriendly, confidentiality and privacy was compromised and the facility unclean. Male adolescent clients were few and complained that FP services were not tailor made for males.

RECOMMENDATIONS

There is urgent need to train and give support supervision to the HCPs on implementation of the ARH&D policy. Copies of the policy are required urgently in the facility. Ideal YFS are required in order to foster increased ARH&D policy.

Record keeping on ARH services needs to be adhered. Research on ARH&D policy needs to be scaled up.

There is a high rate of HCP turnover, nevertheless, staffing should be scaled up. Partnerships should be build with parents/guardians, community leaders and their followers, politicians, religious leaders to benefit from their influence to be effective in providing ARH in Garissa.

The economic status and sexual education should be strengthened. Networks and support systems need to be scaled up to fight drug addiction, early marriages, gender inequality and female genital cutting in NEP.

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