

**POSITIVE
ACTION**

KELIN
Reclaiming Rights, Rebuilding Lives



**FACILITATING ACCESS TO SEXUAL AND REPRODUCTIVE
JUSTICE FOR ORPHANED AND VULNERABLE
ADOLESCENT GIRLS IN KISUMU AND HOMA BAY
COUNTIES**

BASELINE SURVEY REPORT

JUNE 2017

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CONTENTS

List of Figures	4
List of Tables	5
Abbreviations	6
Acknowledgement.....	9
Executive Summary	10
1.0 Introduction and Background	13
2.0 Study Design and Methodology	21
3.0 Study Findings	27
4.0 Conclusions and Recommendations	86

List of Figures

Figure 1: Map of Kisumu County.....	16
Figure 2: Map of Homa Bay County.....	19
Figure 3: Highest level of schooling attained.....	49
Figure 4: Person controlling access to mobile phone.....	57
Figure 5: Knowledge on safe days.....	58
Figure 6: Friends and peers who have had sex.....	61
Figure 7: Current job status of young people	61
Figure 8: Knowledge of where to obtain method of contraception.....	68
Figure 9: Discussion about contraception	67
Figure 10: Source of contraceptive method frequently used.....	66
Figure 11: Signs and symptoms of STDs in men	67
Figure 12: perceived risk of contracting HIV and STD from partner	68
Figure 13: Ever seen a condom	71
Figure 14: Ever used a condom.....	71
Figure 15: Ever visited facility for SRH services	72
Figure 16: Reason for choice of facility for last services sought	72
Figure 17: SRH topics that medical health care provider talked about to respondent.....	73
Figure 18: Places/spaces where SGBV occurs	74
Figure 19: Forums from where young people learnt about laws on SGBV.....	80

List of Tables

Table 1: Socio-demographic profile of boys and girls interviewed.....	49
Table 2: Media sources of information on sexual and reproductive health issues	54
Table 3: Most Important source of information on SRH topics.....	55
Table 4: Participation in lessons on puberty, pregnancy and relationship in school.....	58
Table 5: Description of current relationship with partner.....	60
Table 6: Young peoples' physical intimacy experiences.....	61
Table 7: Spontaneous and prompted knowledge of method of contraception.....	63
Table 8: Contraceptive method frequently used by young people.....	66
Table 9: Perceptions of young people regarding HIV and AIDs.....	69
Table 10: Perceptions regarding condom use among young people.....	70
Table 11: Awareness of Pre-Exposure Prophylaxis (PrEP).....	71
Table 12: Sources of treatment for STIs.....	73
Table 13: Forms of violence known by young people.....	74
Table 14: Availability of SGBV services in the community.....	76
Table 15: Negative consequences of SGBV according to the young people.....	77
Table 16: Awareness of laws against SGBV.....	78
Table 17: Proportion reporting own or family ownership of property.....	80
Table 18: Avenues for seeking justice reported by respondents.....	81
Table 19: Proportion reporting avenues for resolving injustices experienced.....	81
Table 20: Proportion reporting land and property rights violations	82

Abbreviations

AACSE	Age Appropriate Comprehensive Sexuality Education
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ARH & D	Adolescent Reproductive Health and Development
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
CACC	County Aids Control Coordinator
CIC	Commission on Implementation of the Constitution
CRC	Convention of the Rights of the Child
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
CBO	Community Based Organizations
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe
ESA	East and Southern Africa
FAO	Food and Agriculture Organization
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FIDA – K	Federation of Women Lawyers - Kenya
GBV	Gender Based Violence
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
IDI	In-depth Interviews
IUCDs	Intrauterine Contraceptive Device

KAIS	Kenya Aids Indicator Survey
KDHS	Kenya Demographic Health Survey
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
KEMRI	Kenya Medical Research Institute
KIIs	Key Informant Interviews
KNBS	Kenya National Bureau of Statistics
KNCHR	Kenya National Commission on Human Rights
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoE	Ministry of Education
MYP	Meaningful Youth Participation
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGOs	Non-Governmental Organizations
OVC	Orphaned and Vulnerable Children
PBO	Public Benefit Organization
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person living with HIV
PLWHA	Persons living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-exposure prophylaxis
PSA	Priority Service Area
RAs	Research Assistants
RH	Reproductive Health
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender Based Violence

SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services

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We are enthusiastic that the results of this baseline will inform current and future programs seeking to address sexual and reproductive health and rights and justice for orphaned and vulnerable adolescents and young people.

A handwritten signature in black ink, appearing to read 'Allan Maleche'. The signature is stylized with a large initial 'A' and a long horizontal stroke.

Allan Maleche,

Executive Director KELIN

Executive Summary

Supported by ViiV Healthcare through Positive Action for Girls and Women and PEPFAR, KELIN is implementing the DREAMs Innovative Challenge in Homa Bay and Kisumu Counties.

To facilitate intervention development and provide benchmark data for the project, this study was conducted to: 1) Assess the current levels of knowledge, awareness and appreciation of sexual health and reproductive health laws, policies and practices among orphaned and vulnerable girls in Kisumu and Homa Bay Counties; and 2) Assess the current levels of access to sexual health and reproductive justice for orphaned and vulnerable adolescent girls in Kisumu and Homa Bay Counties.

The study used a cross sectional descriptive survey research design involving mixed methods approach involving both quantitative and qualitative techniques to collect primary data supplemented by desk review.

Conducted between March and April 2017, the study targeted orphaned and vulnerable adolescent girls and boys and young men and women aged 15 to 24 years, project stakeholders and partners.

Results from qualitative assessments shows that AGYW are confronted by a number of challenges: early and unprotected sexual activities with multiple sex partners; limited access to health services; high risk of STIs including HIV infections; low knowledge on the range of contraceptives;

unplanned pregnancies; unsafe abortion; early and forced marriages; exchange of sex for favors and money; drug and alcohol abuse; limited knowledge on how to handle menstruation; lack of sanitary towels; lack of guidance and counseling on growing up and sexuality; child labour; poverty; and, peer pressure.

Adolescent and young people's knowledge, attitude and practice SRH

Survey findings show most of the respondents had ever attended classes on puberty, pregnancy and relationships (males – 98%, females – 97%) and equally considered the lessons as very important. Among the male respondents, contraceptive methods cited spontaneously were; condoms (40%), pills (34.7%), injection (25.5%), and, emergency contraceptive pills (10.2%). Among women were injections (41%), pills (40%) and condoms (39%). Most of the study respondents (males – 91%, females – 91%) know at least one STI. Most commonly known STIs are: syphilis (males – 86%, females – 83%), gonorrhoea (males – 76%, females – 76%) and HIV and AIDS (males – 48%, females – 52%) among many other STIs. Half of the respondents reported to consider HIV and AIDS as STIs. A Significant proportion of respondents (26% of females and 15% of males) reported not knowing any signs of STI infection in men while 15% of females and 29% of males did not know of any in women.

About 79% of males and 85% of females confirmed discussing contraception with their sexual partners. A significant proportion (45% of the males and 39% of females) did not know what safe days were in a woman's menstrual cycle.

Disaggregation of young people in sexual relationships by age revealed that about 43% (66), 67% (76) and 77% (72) of the young men aged 15-17 years, 18-20 years and 21-24 years were at the time of the study in a sexual relationship.

On the other hand, about 42% (66), 73% (85) and 82% (87) of the AGYW in the same age categories were at the time of the study in a sexual relationship. Bivariate analysis showed a significant association between age and current relationship status. A higher number of older young people aged 18-24 years than the younger ones were in a sexual relationship at the time of the study.

About 30% (46) of those aged 15-17 years, 59% (67) aged 18-20 years and 77% (72) aged 21-24 years old of male respondents reported to have ever had sex compared to 30% (47), 67% (78) and 83% (88) of the AGYW in the same age categories. The most commonly used contraceptive method was reported as condoms (males – 63%, females – 51%).

About 44% of the young men and 46% of the women interviewed confirmed having used a condom with a third (31%) of the males and 26% of the females reporting experiencing condom split or breakage during sexual intercourse. This suggests the need for awareness creation on correct condom use. Among the young people who have ever had sexual intercourse, just about 6% and 13% of males and females respectively have ever had a sexually transmitted disease. Nearly all males who had ever suffered from an STI sought treatment from a government facility.

Qualitative study findings show the range of SRHR services sought by adolescents and young people: contraception mostly e-pill and condoms; STI screening, treatment and counseling; HIV testing, counseling and treatment; pregnancy testing, antenatal services, SRH counseling; breast and cervical cancer screening; post abortion care services; Ante-natal care services; menstrual counseling, and Voluntary medical male circumcision.

Access and utilization is however hampered by low knowledge levels of the availability of these services, poor health seeking behavior, negative service provider attitudes and perceptions of unfriendly services including lack of confidentiality and privacy and fear of meeting parents and guardians at the health facilities.

About 81% (104), 87% (95) and 91% (81) of the young men aged 15-17 years, 18-20 years and 21-24 years respectively, had ever been tested for HIV before the survey compared to 84% (113), 88% (97) and 95% (99) of the AGYW in the same age categories. About 18% of young men and 21% of young women reported awareness of laws on SGBV.

Better linkage to Pre-Exposure Prophylaxis (PrEP) for AGYW

About 18% of males and 22% of females have ever heard about PrEP. Among the young people who confirmed having heard about PrEP, only 31% knew how PrEP is used with the remaining 69% reported not knowing how can used.

Under HIV prevention, 59% of males and 57% of females reported that HIV infection could be prevented 2% of males and females reported knowing Pre-exposure prophylaxis (PrEP). Post-exposure Prophylaxis (PEP) was only mentioned by about 1% of males and females. A low knowledge level suggests the need to create more awareness about PrEP among AGYW and linkages to the services.

Focused persuasive action to meet the SRH needs of the AGYW

Results from qualitative assessment confirm the high cases of SGBV in the communities. Incidences of early marriage, rape, defilement and other sexual and gender based violence cases were cited as common occurrences in the communities with AGYW more vulnerable than their male counterparts.

Causes of rights violations affecting adolescents and young people stem from their vulnerability due to primarily, poverty, cultural practices, age, gender, societal expectations and exploitations. Cultural practices like widow inheritance expose the orphaned and vulnerable children to maltreatment.

Indeed, it was reported that many of orphans were stigmatized and discriminated against due to the HIV and AIDS associated with the death of their parents. Concerted efforts are required to increase SRH community awareness.

Community involvement in SRHR programme

Study results identify the different stakeholders at the community and county levels for engagement in addressing SRH justice for AGYW in the two counties. For instance on SGBV, study respondents indicate that chiefs (males – 97%, females – 90%), the police (males – 76%, females – 63%) and community elders (males - 79%, females - 50%), social workers (males - 27%, females - 29%) and women leaders (males – 4%, females – 17%) were responsible for resolving SGBV issues involving orphaned and vulnerable adolescent girls and young in the community.

Findings show that most young people (males; 78%, females; 71%) are not be involved in events or activities aimed at addressing SGBV issues in the community. They however observed that they knew where most of these activities took place hence the need for multisectoral engagements at the community level in addressing AGYW SRHR needs.

Male involvement in addressing and championing for SRH justice

Study findings show that male adolescent boys and young men perceptions do not differ drastically from those of AGYW. Qualitative findings have alluded to patriarchal nature of the societies in the two Counties that negatively affects the SRH rights and access to justice for AGYW. Findings show filing of male children only in succession cases, boy preference in education, early marriage for girls, widow inherence and disinheritance. These challenges adversely affect AGYW and would benefit from concerted efforts in creating awareness and attitude change by engaging boys and men in programing.

Linkages between SRH and land and property rights amongst adolescent girls

The survey further investigated incidences of abandonment and disinheritance. Of all those interviewed, about 13% of the young men and 17% of the women reported ever being abandoned. Almost similar proportions (12%-males; 14%-females) of young people interviewed had themselves, or their family members been disinherited at some point in their lives. On access to justice for those who had ever been disinherited or abandoned, 43% of the young men and 51% of the young women reported that their issues were eventually addressed. Over two thirds of the respondents 37% of males and 40% of females perceive the incidences of land and property violations in their communities as either *high or very high*.

Legal and structural issues affecting access to justice among the AGYW

Over two thirds of AGYW who had ever reported an incidence of SGBV indicated that they would report to the same structure in future because they felt: the services provided them were very good (50%); they were provided with protection against the perpetrator (13.6%); and, their issues were settled in secret something they were happy or okay with (13.6%) among other reasons. Among male respondents, the reasons why they would report to the same structure was because: the previous cases had been given proper care; they received justice; and were compensated. Significant proportion, 57% of the young men and 38% of females indicated they would not report to the same structure due to lack of privacy, unfriendly services, and lack of protection from the perpetrators.

1.0 Introduction and Background

All young people should have the opportunity to grow up with adequate access to sexual and reproductive health services of their choice. International instruments touching on health such as the WHO recognise that access to sexual and reproductive health is a universal right for all including orphaned and vulnerable adolescent girls.¹ Universal access to health is affected by many aspects of life. It involves individual's most intimate relationships, including negotiations and decision making within these relationships and interactions with health information and providers.² Designing and implementing evidence based interventions for orphaned and vulnerable adolescent girls is therefore critical in ensuring beneficiary meaningful participation and effectiveness of the interventions.

1.1 About KELIN

Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) was formed in 1994 and registered as a Non-Governmental Organisation (NGO) in 2001. KELIN is a human rights NGO originally created to protect and promote HIV-related human rights in Kenya but whose scope has expanded to include three other thematic areas namely: - sexual and reproductive health and rights; key populations; and women, land and property rights. KELIN's goal is to advocate for a holistic and rights-based system of service delivery in health and for the full enjoyment of the right to health by all, including the vulnerable, marginalized, and excluded populations in these four thematic areas. KELIN provides legal services and support, training professionals on human rights, advocacy campaigns that promote awareness of human rights issues, research and evidence-based policy change.

KELIN has broadened its scope to tackle issues pertaining to access, knowledge, and capacity to fully exercise these rights. The SRHR thematic area seeks to contribute to four key objectives including:- (a) ensuring that SRHR laws, policies and operational frameworks are compliant with a rights based approach; (b) ensuring access to justice for victims of sexual violations; (c) building the capacity of CSOs and PBOs to take up SRHR interventions; and (d) fostering partnerships and both national in regional platforms to further the uptake of SRHR interventions.

In the DREAMS Innovation Challenge, KELIN is seeking to work with orphaned and vulnerable adolescent girls and young women aged 15-24 years in Homa Bay and Kisumu Counties.

1.2 DREAMS Innovation Challenge project

ViiV Healthcare through Positive Action for Girls and Women and PEPFAR, KELIN is implementing DREAMS Innovative Challenge in Homa Bay and Kisumu Counties. Primarily, the Project seeks to:

- 1 Raise awareness and facilitate access to sexual health and reproductive health justice for orphaned and vulnerable adolescent girls and young women in Kisumu and Homabay Counties;
- 2 Utilize safe spaces within which the adolescent girls can learn more about their sexual and reproductive health, and how to access justice when their rights are or have been violated;

¹ <http://www.unfpa.org/publication/universal-access-reproductive-health-progress-and-challenges>

² *ibid*

- 3 Partner with existing community structures, such as youth groups and activity clubs in increasing dialogue, visibility about sexual and reproductive health and access to legal aid.

Under this initiative, the project seeks to undertake two broad activities to bridge the lack of access to sexual and reproductive health and land and property rights and justice among orphaned and vulnerable adolescent girls. These are: raising awareness amongst the orphaned and vulnerable girls on their sexual and reproductive health and rights, land and property rights and how they can access justice when these rights have been or are likely to be violated; and, building the capacity of stakeholders to offer support to and create an enabling environment for access to information and justice by the orphaned and vulnerable girls.

Implementation is guided by the Theory of Change (see annex 1). KELIN has identified ten thematic areas under which the results of the innovation challenge will be measured. These include:

1. Improved knowledge and attitude change among the 15,000 girls on sexual and reproductive health and rights components, such as condom use, access to HIV testing and counseling, contraceptive method mix, and sexual and reproductive health laws;
2. Better linkage of Pre-Exposure Prophylaxis (PrEP), among the Adolescent Girls and Young Women (AGYW) at highest risk of infection;
3. Focused persuasive action to meet the reproductive health rights needs of the AGYW who are a vulnerable group, with steadily expanding coverage;
4. Enhanced community involvement in SRHR

- programme and intervention development, and building upon the will of AGYW to contribute to national HIV prevention efforts;
5. Increased male involvement in championing for the sexual and reproductive health rights issues;
6. Meaningful engagement of the elders in addressing the sexual and reproductive health issues at the community level;
7. Increased understanding of the linkages between sexual and reproductive health and land and property rights amongst adolescent girls, widows and elders;
8. Engaging the community through existing organizations, groups, and structures for education and support;
9. Enhance meaningful engagement and inclusion of AGYW in the formulation and implementation of PrEP guidelines;
10. Greater awareness of the legal and structural issues affecting access to sexual and reproductive justice among the AGYW.

1.3 Overall study goal

To collect baseline data to inform development of DREAMS Innovation Challenge project interventions and implementation strategies.

Specific objectives:

The specific aims of the study are to:

- 1) Assess the current levels of knowledge, awareness and appreciation of sexual and reproductive health laws policies and practices among orphaned and vulnerable girls in Kisumu and Homa Bay Counties.
- 2) Assess the current levels of access to sexual health and reproductive justice for orphaned and vulnerable girls in Kisumu and Homa Bay Counties.

1.4 County Profiles

Kisumu and Homa Bay Counties are two of the six Counties in the Nyanza region which is in the South-West part of Kenya. The Counties in the region are Siaya, Nyamira, Migori and Kisii. Nyanza is largely inhabited by members of the Luo community speaking Dholuo although other languages spoken include: Ekegusii, Luhya, Kuria and Suba, English and Swahili.

1.4.1 Profile of Kisumu County

Location and administrative units

Kisumu County is among the six counties that constitute the former Nyanza Province. The County borders Vihiga County to the North, Nandi County to the North East, Nyamira to the South, Homa Bay County to the South West and Siaya County to the West. Kisumu County occupies a geographical area of 2,086 Km² and has seven sub-counties namely: Kisumu East, Kisumu West, Kisumu Central, Nyando, Seme, Nyakach and Muhoroni. The county has a total of 35 electoral Wards.

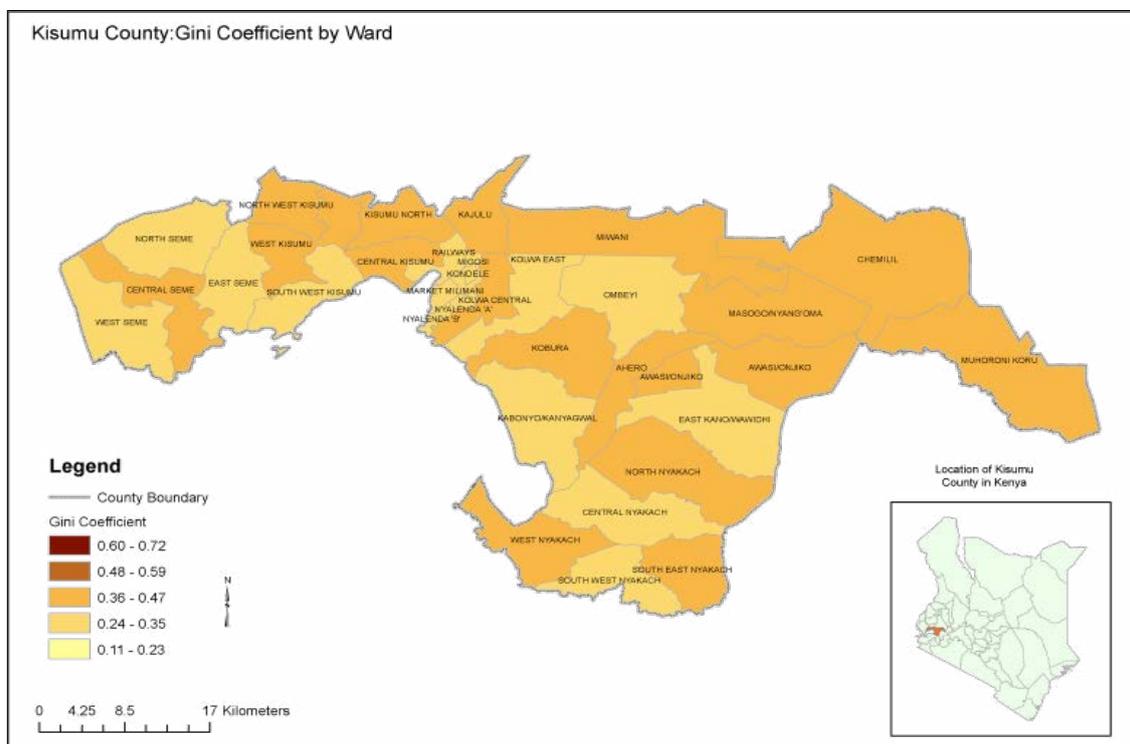


Figure 1: Map of Kisumu County

Source: <https://softkenya.com/kenya/wp-content/uploads/2012/05/Kisumu-County-Map.png>

Population Size and Composition

The population of the county was estimated at 968,909 persons with 474,687 males and 494,222 females in 1999, accounting for 51% of the total population.³ This population was projected to total 1,145,749 in 2017. According to the 1999 Kenya Population and Housing Census, there are 226,719 households in the County of which 23.4% are female headed. The youths make up a population of 370,679 which is 48.9% males and 51.1% females. The older persons in the county are 45,935 where 44% are males and 56% are females. There are 32,000 children in labour, 35,000 orphans and 52,519 persons with disability of whom 53.6% are females and 46.4% are males.⁴

According to the Kisumu County Integrated Development Plan, 2013-2017, in terms of proportion to total population, those between 0 to 14 years are 43.5%, those between 15 to 64 years are 53.3% and those aged 65 to 80+ years account for 3.2%. Children below 15 years constitute 42% of the population, with youth aged 15-24 years constituting 22% of the population⁵

Economy of Kisumu County

The main economic resources are agricultural land, fisheries and water. The key economic activities are therefore subsistence farming, livestock keeping, fishing and farming (sugarcane and small scale farming). The rate of poverty in Kisumu County is estimated at 45% with an average dependency ratio of 100:87⁶. The 2017 Analysis of Kenya Integrated Household Budget Survey (KIHBS) shows that 45% of people in the County are living in extreme poverty⁷.

3 Kisumu County Data Sheet <http://www.kisumu.go.ke/download/5>

4 ibid

5 County Govt of Kisumu. Kisumu County Integrated Development Plan, 2013-2017

6 Kisumu County Gender Mainstreaming Strategic Plan 2013/14 -2017/18.

7 <https://data.humdata.org/dataset/kenya-county-poverty-rates-estimates-based-on-kihbs-data-for-constituencies-in-2005-6>

The Kisumu County Fact Sheet gives very high poverty indicators as follows: absolute poverty (60%), urban poor (70.05%) and rural poor (63%).⁸

Education and Literacy

The Kisumu County Integrated Development Plan, 2013-2017 indicates that literacy levels are high in Kisumu County. Overall, the County has a literacy level of 85% and 81% for males and females respectively. Of those above 15 years of age, 90.8% can read, 83.4% can write and 83.1% can read and write.⁹ Total primary school enrolment is estimated at 240,538 and secondary school at 113,324 with a dropout rate of 33.6%.¹⁰

Health

There are 88 health facilities in Kisumu County. The average distance to each facility is about 6.4kms. The doctor-patient ratio is 1:44,634 while the nurse- population ratio is 1:2,383.¹¹ Early marriage is common in the county. Overall, 12 per cent of women age 15-49 years are married before the age of 15, and 42 per cent were married before the age of 18 years in Kisumu County.¹²

Among those in the 20-49 year age group, 14 per cent are married before the age of 15 years.¹³ Nationally, 15% of women age 15-19 have already had a birth while 18 percent have begun childbearing (had a live birth or are pregnant with their first child).¹⁴

8 <http://www.kisumu.go.ke/download/5>

9 County Govt of Kisumu. Kisumu County Integrated Development Plan, 2013-2017

10 Kisumu County Data Sheet <http://www.kisumu.go.ke/download/5>

11 Kisumu County data sheet <https://kisumu.go.ke/download/5>

12 Kenya National Bureau of Statistics 2013. Kisumu County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi, Kenya: Kenya National Bureau of Statistics.

13 ibid

14 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya National AIDS Control Council Nairobi,

Prevalence of early childbearing is highest in the Nyanza region at 22.2% compared to the national average of 18.1% among 15-19 year teenagers.¹⁵ For Kisumu County, the proportion stands at 15.4% HIV prevalence in Kisumu is 3.4 times higher than the national prevalence at 19.9% (Kenya HIV Estimates 2015).¹⁶

The Kisumu County Gender Mainstreaming Strategic Plan 2013/14 -2017/18, suggests that HIV prevalence could be higher at 18.7%. The impact of HIV and AIDS continues to be felt in most sectors of the economy in the county with the economically active population (20-49) years being the most affected.

According to Kenya HIV 2016 County Profiles by NACC/NASCOP (2016)¹⁷, by the end of 2015, a total of 144,303 people were living with HIV in Kisumu County with 22% of them being young people aged 15-24 years and 6% being children under the age of 15 years. HIV related deaths are also high, approximately, 3,400 adults and 1,000 children died of AIDS-related conditions in 2011. The estimated number of new HIV infections in the county is 7,100 among adults and 903 among children annually.

Overall, almost half (49%) of the population of women aged 15-49 years in Kisumu County believe that their husbands/partners have a right to hit or beat them for at least one of a variety of reasons.¹⁸

Kenya Medical Research Institute Nairobi, Kenya National Council for Population and Development Nairobi, Kenya March 2015 Kenya Demographic and Health Survey 2014 Key Indicators 15 *ibid*

16 National AIDS Control Council 2016. Kenya HIV County Profiles 2016. Nairobi

17 *ibid*

18 Kenya National Bureau of Statistics 2013. Kisumu County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi,

The common reasons reported for justifying domestic violence towards women are neglecting the children (39%), arguing with him (24 per cent), going out without telling him (23 per cent), refusing to have sex with him (17 per cent) or burning the food (10%).¹⁹ The total Kisumu county budget estimate for health for the financial year 2016/2017 was Ksh. 2,567,888,768.²⁰ No budget line item dedicated for supporting adolescent SRHR/HIV initiatives.

1.4.2 Profile of Homa Bay County

Location and administrative units

Homa Bay County is in South-Western Kenya along Lake Victoria where it borders Kisumu and Siaya Counties to the north, Kisii and Nyamira Counties to the east, Migori County to the south and Lake Victoria and the Republic of Uganda to the west. The county covers an area of 4,267.1 Km² inclusive of the water surface which on its own covers an area of 1,227 km².

Administratively, Homa Bay County is divided into eight sub-counties namely Kasipul, Kaonde, Karachuonyo, Rangwe, and Homa Bay town, Ndhiwa, Mbita and Suba. It has 19 divisions, 116 locations and 226 sub location.

Kenya: Kenya National Bureau of Statistics.

19 *ibid*

20 County Government Of Kisumu (2016) Kisumu County Budget Estimates Fiscal Year 2016/2017

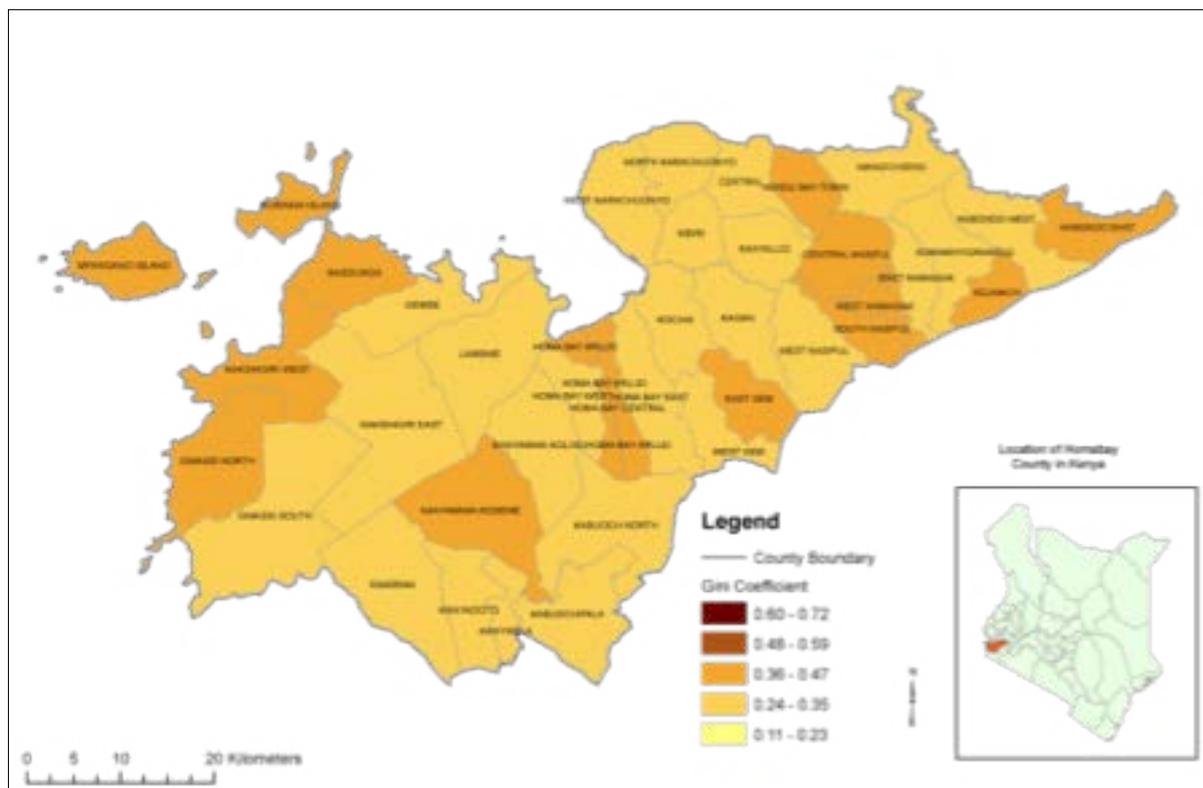


Figure 2: Map of Homa Bay County

Source: http://inequalities.sidint.net/kenya/wpcontent/uploads/sites/2/2013/09/HomabayCounty_GiniCoefficient.png

Population Size and Composition

Based on projections from the 2009 Kenya Population and Housing Census, Homa Bay County has an estimated population of 1,038,858 persons consisting of 498,472 males and 540,386 females by the end of the year 2012. This population is projected to rise to 1,177,181 persons in 2017. Of this total, 564,843 will be males while 612,338 will be females. Per the Homa Bay County Integrated Development Plan, 2013 – 2017, in the county, 48.8% of the population consists of persons aged between 0 and 14 years, 27.5% comprises of youth aged between 15 and 29 years (15-24 years constitute 21%) and 3.6% constitute the aged population (65+ years).²¹

Economy of Homa Bay County

The main economic activities in Homa Bay are fishing and fish trade, agriculture (crop and livestock farming), commercial business and small scale industries. Other major activities and employment of the residents of Homa Bay County are public service, small scale trading including hawking, groceries vending, fish trade. Several youths are involved in the transport industry as touts, drivers, Boda boda (motor bike riders) and motor boat attendants, taxi and minibuses services²².

²¹ 2015 KNBS Population Projections

²² Homa Bay County Integrated Development Plan, 2013 – 2017

The Poverty Levels in the County exceeds 50% and age dependency ratio is at 100:107. Overall, about 56 per cent of children aged 5 -14 years in Homa Bay are engaged in child labour.²³ Of all children involved in child labour, 98 per cent are attending school(ibid).

Education and Literacy

The literacy rate in Homa Bay County stands at 64% with males accounting for 66 per cent and females 54 per cent. The highest literacy rates were recorded in Homa Bay Town and the lowest literacy rates were recorded in Suba sub counties. The vast majority of the illiterate are persons who either have not attended school at all or dropped out before attaining upper primary school education.

The highest literacy rate was observed within the age range 15-24 in 2011 with 74.3% of this population found to be literate.²⁴ The primary school population is projected for 2017 is projected to be 271434, secondary school at 113,730.²⁵ The completion rate for girls in primary schools in Homa Bay County is at 54% while slightly over half (52%) of girls progress to secondary school.²⁶

23 Kenya National Bureau of Statistics. July 2013. Homa Bay County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi, Kenya: Kenya National Bureau of Statistics

24 ibid

25 County Government of Homa Bay 2013. 'A County Of Choice' First County Integrated Development Plan 2013-2017

26 Kenya National Bureau of Statistics (2013). Homa Bay County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi, Kenya: Kenya National Bureau of Statistics

Health

Homa Bay county has 211 health facilities including nine tier-three hospitals and four mission hospitals. The doctor population ratio stand at 1:4,000 while the nurse population ratio stands at 1:1,500.²⁷ Teenage pregnancy is Homabay County is estimated at 33.3, the second highest nationally (national average at 18.1).

According to KDHS 2014, the median age at first marriage among women age 25-49, was at 17.5 and median age at first marriage among men age 30-54 at 23.8.²⁸ In Homa Bay County, 16% of women aged 15-49 years are married before age 15 and 58 per cent of 20-49 years are married before age of 18 years.²⁹

One in every four (25 per cent) adolescent girls of ages 15-19 years old in Homa Bay are currently married or in union. About 40% of girls aged 15-19 in the county have begun childbearing.³⁰ The total estimated budget for health for the financial year 2016/2017 was Ksh. 2,128,210,152 with no specific line item for ASRH.³¹

27 ibid

28 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya, National AIDS Control, Council Nairobi, Kenya, Kenya Medical Research Institute Nairobi, Kenya , National Council for Population and Development Nairobi, Kenya , The DHS Program, ICF International Rockville, Maryland, USA . December 2015. Kenya Demographic and Health Survey 2014

29 Kenya National Bureau of Statistics (2013). Homa Bay County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi, Kenya: Kenya National Bureau of Statistics.

30 ibid

31 County Government of Homa Bay (April 2016). Medium Term Expenditure Framework Draft Estimates Of Recurrent And Development Expenditure Of The County Government Of Homa Bay For The Year Ending 30th June, 2017

According to NACC/NASCOP (2016)³² HIV prevalence in Homa Bay is nearly 4.5 times higher than the national prevalence at 26.0%. The HIV prevalence among women in the County is higher (27.8%) than that of men (24.0%), indicating that women are more vulnerable to HIV infection than men in the County³³.

Homa Bay County contributed to 10.4% of the total number of people living with HIV in Kenya, and is ranked the second highest nationally. By the end of 2015, a total of 158,077 people were living with HIV in the County, with 22% being young people aged 15-24 years and 6% being children under the age of 15 years. Approximately 548 children and 2,759 adults died of AIDS-related conditions in 2015. There was a decrease of 56% of HIV-related deaths among the children aged below 15 years and a decrease of 19% among adults aged 15 years and above since 2013 in the County.³⁴

According to the KDHS 2014, 49.5% of married women in Nyanza had experienced physical or sexual violence. According to KNBS (2013) a large proportion (70 percent) of women aged 15-49 years in Homa Bay County report that their husband/partner has the right to hit or beat them.³⁵ Among the reasons the women cited as justification for this violence include: child neglect (55%), 'if she argues with him' (48%), 'if she goes out without telling him' (37%), or 'if she refuses sex with him' (34%) (ibid).

32 Kenya HIV County Profiles 2016

33 Kenya HIV Estimates 2015

34 ibid

35 Kenya National Bureau of Statistics (2013). Homa Bay County Multiple Indicator Cluster Survey 2011, Final Report. Nairobi, Kenya: Kenya National Bureau of Statistics.

2.0 Study Design and Methodology

This section outlines the approach used for this study. It contains research design, the sample selection, research tools/instruments, data collection, management and analysis. The research process started with the development and adoption of the study concept note and data collection tools.

Research Design: This was a cross sectional descriptive survey study employing mixed methods approach utilizing both quantitative and qualitative techniques for data collection and analysis. Baseline data were collected primarily among adolescents and young people aged 15 to 24 years, stakeholders and partners based on DREAMS Innovation challenge result areas.

2.1 DREAMS Innovation Challenge target population

The DREAMS Innovation challenge project targets 15,000 orphaned and vulnerable adolescent girls aged 15-24 years within 75 Community Based Organizations and widow support groups drawn from each of the 15 Constituencies of Kisumu and Homa Bay Counties. It further targets to impact additional 75,000 AGYW; 5000 from each of the 15 Constituencies through radio talk shows, sports tournaments, magnetic theatre, and crowdsourcing and medico-legal clinics. The solution will also impact 15,000 adolescent boys and young men whose involvement has a direct impact on the sexual and reproductive wellbeing of the adolescent girls.

2.2 Sampling and sample size determination

The study was conducted in Kisumu and Homa Bay Counties in purposively selected sites where DREAMS innovation Challenge is implemented by KELIN. A total of 75 CBOs spread over the 15 constituencies (5 CBOs per constituency) in Kisumu and Homa Bay Counties were preselected by KELIN were targeted. These CBOs were selected by KELIN based on; their legal status, focus on orphaned and vulnerable girls, and engagement with land rights issues. The CBOs had signed a Memorandum of Understanding with KELIN to support the implementation of the DREAMS Innovation Challenge. The study population included adolescent girls and boys and young men and women varied by age and gender. The study respondents were mobilized through the 75 CBOs working with KELIN in Kisumu and Homa Bay Counties. The inclusion criteria for the respondents were:

- Orphaned and vulnerable adolescent girls (varied by age group i.e. younger adolescents 15-17 years and young adults 18-24years, location and in and out of schools);
- Adolescent boys (varied by age group i.e. younger adolescents 15-17 years and young adults 18-24years, location and in and out of schools);
- Resident within the CBO catchment area;
- Consent/assent to participate in the study.

Sampling for Quantitative Interviews

The list of the 75 preselected CBOs formed the sampling frame for the study.

These CBOs were spread across 15 constituencies in Kisumu and Homa Bay Counties. At a precision level of 5% and 95% level of confidence, a total of 375³⁶ orphaned and vulnerable adolescent girls aged between 15 and 24 years were targeted to form the sample size. Another 375 adolescent boys aged between 15 and 24 years were targeted across the two counties. These sample sizes were determined separately for boys and girls to ensure that their perceptions and opinions are captured separately. The sample size for both AGYW and adolescent boys were determined as follows:

Sample size determination

$$SS = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Where:

Z = Z value (1.96 for 95% confidence level)

p = percentage of picking a participant, expressed as decimal (50% used for sample size needed)
 c = confidence interval, expressed as decimal (0.05 = ±5%)

$$SS = \frac{1.96^2 * (0.5) * (1-0.5)}{0.05^2} = 384.16$$

Correction for Finite Population

$$New SS = \frac{SS}{1 + (SS - 1)/pop}$$

³⁶ <http://www.surveysystem.com/sscalc.htm#two>

Where: pop = population (15000 AGYW/adolescent boys targeted)

$$\text{New SS} = \frac{384.16}{1 + (384 - 1)/15000}$$

= 374.59 approximately 375 AGYW/adolescent boys

To get a better spread of the respondents across different socio cultural settings, 5 AGYW and 5 adolescent boys were randomly selected from each of the 75 CBOs.

Sampling for Qualitative Interviews

Purposive sampling combined with snowballing was used to select participants for the qualitative study. A total of 12 Focus Group Discussions³⁷ were conducted among adolescent boys and girls who were not included in the quantitative survey. The FGDs for young people were homogeneous based on age range (15-24 years) and sex. The FGDs comprised of groups of between 8 -10 participants. In total 51 adolescent boys and 64 AGYW participated in the FGDs.

³⁷ 5 FGDs with girls in the 2 counties (2 each with younger adolescent girls and older adolescent girls per county), 4 FGDs with younger adolescent boys (1 per county) and older adolescent boys (1 each per County) and 3 mixed group FGDs with adult stakeholders (1 in Kisumu County and 2 in Homa Bay County). The FGDs were varied by rural and urban locations, islands and mainland.

A total of 14 Key Informant interviews with selected groups of project stakeholders and partners were conducted. Key-informant interviews were conducted with members of the judiciary, Luo Council of elders, County Health Team member, Court Users Committees member, and Civil Society Organizations, widows, lawyer, Member of County Assembly, Ministry of Health, and Ministry of Lands officers.

Identification and mobilization of these stakeholders was done in liaison with KELIN M&E officer and two Kisumu based staff.

2.3 Data collection

Training of Research Assistants (RAs): Young qualified male and female research assistants, aged between 20-30 years, conversant with the study sites, language and cultural settings were recruited and trained on research ethics, community entry, data collection methods, obtaining consent and maintaining confidentiality.

During training, research assistants conducted role plays to sharpen their skills. It was deemed that use of young people in data collection would elicit better responses from the respondents due to the closeness in age. Female data enumerators interviewed female respondents while male enumerator interviewed male respondents.

Pretesting of study instruments: Study instruments were pre-tested among similar adolescent girls and boys as the target study population in a community setting in Homa Bay County.

This allowed the research team to make appropriate adjustment to the tool based on the pre-test experience as elicited from the assessment of the filled questionnaires and qualitative data collected and feedback provided by the young RAs during the debriefing session after the exercise.

The study tools were also reviewed by KELIN stakeholders including a lawyer, two CBO representatives, Ministry of health CACC representative, young orphaned girls, and a KELIN Board Member for input and stakeholder buy-in.

Quantitative data: A total of 5 orphaned and vulnerable adolescent girls and young women and 5 adolescent boys were mobilized by each CBO based on study inclusion criteria.

To collect quantitative data in this study, standard, structured questionnaire was utilised. The questionnaire included both close-ended and open-ended questions. The questionnaires were pre-coded, for easier computerised data entry and processing for analysis.

Trained enumerators administered one on one interviews after obtaining consent/assent from the study participants for the adults and consents from parents and CBO contact persons and assent from respondents aged 15-17 years. The purpose of the study was clearly explained and consent and assent obtained for minors participating in the study.

Respondents were given an opportunity to ask questions. One on one interviews were conducted at private corners, away from ears drop of anyone within the compound of the CBO offices.

The completed questionnaires were presented to the field supervisors at the end of the field day to ascertain that they were well filled and then securely kept for the data analysis. Debriefing was constantly carried out to iron out any issues during the fieldwork. A total of 778 young people (boys – 378 and girls - 400) participated in the quantitative study.

Qualitative data: A total of 26 qualitative interviews (FGDs- 12, KII – 14) were conducted, tape recorded and transcribed verbatim. This was done by two RAs with one of them taking notes and the other moderating the discussion.

The purpose of the study was clearly explained and consent obtained for participation and recording of the discussions. Ground rules for the discussions were explained and agreed upon and respondents given an opportunity to ask questions. The transcripts were submitted for analysis. In total, 51 adolescent boys and 64 AGYW participated in the qualitative study.

Data analysis

Quantitative data from the field were entered in excel spreadsheet package from where they were cleaned and then imported into SPSS version 20 for analysis. Open ended questions in the tool were coded and entered for analysis.

The quantitative analysis of the study focused on 778 young people aged between 15-24 years sampled from Kisumu and Homa Bay Counties. The unit of analysis was the gender differentials of the participants providing the differentiation on AGYW and adolescent boys although age and County specific desegregation have been considered in the analysis.

Analysis of qualitative data used a tentative coding framework developed through reading of 5 FGD and 5 KII transcripts as well as the topic guides. A final thematic framework was then developed after review of the data and the research question into QDA Miner Lite software (2011)³⁸.

Limitations

The study had a number of limitations:

1. Time constraints in planning for data collection execution of the exercise.
2. All respondents in the quantitative survey were recruited through the CBOs limiting access to only those presented to the research team for interviews.



3.0 Study Findings

This section presents results from the study findings. First are presented literature review findings, followed by quantitative and qualitative findings from the field assessments in Kisumu and Homa Bay Counties.

3.1 Findings from literature review

Sexual Reproductive Health and Rights in Context

The World Health Organization notes that reproductive health (RH) is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes. Sexual and reproductive health (SRH) is a human right, essential to human development.

Notably, prioritizing sexual and reproductive health and rights is crucial in achieving progress on the overall health as stipulated in the Sustainable development agenda. According to the Kenya National Adolescent Sexual and Reproductive Health Policy (2015)³⁹ Sexual, Reproductive Health and Rights is defined as the exercise of control over one's sexual and reproductive health linked to human rights and includes the right to: (i) Reproductive health as a component of overall health, throughout life cycle, for both men and women; (ii) Reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of one's children, right to access information and means needed to exercise voluntary choice; (iii) Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and (iv) Sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

SRH concerns include death and disability related to pregnancy, abortion and childbirth, sexually transmitted infections, HIV and AIDS, and reproductive tract diseases. Kangas, Haider and Fraser (2014)⁴⁰ shows that sexual and reproductive rights are essential since access to safe, affordable and effective methods of contraception provides women with the opportunity to make informed decisions about their lives.

Sexual and Reproductive Health Rights in Kenya

Policy and legal environment

Notably, sexual and reproductive health is both a human right and human development issue. This right is guaranteed in various international and regional human rights conventions as well as national laws and policies.

³⁹ RoK/MoH (2015) National Adolescent Sexual and Reproductive Health Policy.

⁴⁰ Kangas, A., Haider, H., and Fraser, E. (2014). Gender: Topic Guide. Revised edition with E. Browne. Birmingham: GSDRC, University of Birmingham, UK. Retrieved from <http://www.gsdrc.org/topic-guides/gender/gender-based-violence/>

Per the United Nations International Conference on Population and Development-Cairo (ICPD) of 1994, sexual and reproductive health rights (SRHR) embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents.

Kenya has a favourable policy and legal environment for promotion of SRHR. At the national level, Article 43 of the Constitution of Kenya 2010 provides that “every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.”

The constitution also underscores the importance of prioritizing the needs of vulnerable and marginalized groups in provision of health care. In addition to the Constitution, Kenya has several Acts of Parliament, strategies and policies that seek to promote and protect sexual and reproductive health rights.

These include; Sexual Offences Act 2003, Children’s Act 2001, Prohibition of Female Genital Mutilation Act 2011, Marriage Act 2014 which outlaws marriages below 18, National Reproductive Health Policy, 2007, National Reproductive Health Strategy 2009-2015; Adolescent Reproductive Health and Development Policy 2003; National Condom Policy and Strategy (2009-2014); Contraceptive Policy and Strategy (2002-2006); Contraceptive Commodities Procurement Plan (2003-2006); Contraceptive Commodities Security Strategy (2007-2012); National School Health Policy 2009; Return to school policy for teenage girls after birth, Female Genital Mutilation/Cutting Policy,

Third Kenya National AIDS Strategic Plan 2009/10 to 2012/13, Kenya AIDS Strategic Framework -KASF 2014/15-2018/19, National Reproductive Health and HIV and AIDS integration Strategy- August 2009, National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans 2007, National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya, August 2010.

Regarding Adolescent sexual and reproductive health rights (ASRHR), following the ICPD (1994), the Kenyan government and development partners have come up with numerous policies, guidelines and strategies to make reproductive health services available, accessible, acceptable and affordable to young people. To demonstrate its commitment to addressing the issues affecting adolescents, Kenya is a signatory to several international and regional human rights treaties and declarations.

The subsequent section provides a snapshot review of selected policy and legal frameworks that have been developed and/or adopted in Kenya to address adolescents SRHR and HIV and AIDS challenges.

The Constitution of Kenya 2010 provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care (Article 43 (a)). It further outlines that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependents (Articles 43(2) and 3).

In recognition of previously centralized services that have undermined access to services including health services, Article 6 (3) on devolution and access to services lays emphasis on enhancing access to services in rural and remote areas.

Article 53 of the Constitution of Kenya 2010 protects the rights of adolescent children to health care, protection from abuse and neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour. In all the interventions and matters concerning the child, their best interests are paramount. These rights are also protected in the Children's Act 2001.

The Children Act 2001 makes provision for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children. It also makes provision for the administration of children's institutions, gives effect to the principles of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

The Sexual Offences Act 2006 recognizes that 40-60 per cent of reported sexual assaults are committed against girls aged 15 years and below. It further adds that although both boys and girls can be victims of sexual abuse, girls are up to three times more likely to be sexually abused than boys.

The Sexual Offences Act 2006 (SOA) provides strong legal protection for victims of sexual violence (rape, defilement, child trafficking, child prostitution, child pornography, and other related issues).

The Act clearly establishes that sexual offences are acts of violence and lays emphasis on bringing the perpetrators to justice. Section 35 of the Sexual Offences Act contains provisions on access to free medical treatment for victim/ survivors of sexual offences in any public hospital or institution or other designated/gazetted institution.

The Reproductive Health Bill 2014 aims at: provision of reproductive health services to adolescents, without parental consent being mandatory; provision to of adolescent-friendly reproductive health and sexual health information and education which are confidential, comprehensive, non-judgmental and affordable reproductive health services. The Bill also seeks to ensure that policies are developed to protect adolescents from physical and sexual violence and discrimination including cultural practices that violate the reproductive health rights of the adolescents.

Adolescent Reproductive Health and Development Policy of 2003 recognizes that the optimal health of the adolescent population in Kenya is crucial to increase productivity. As such, it aims to address the various challenges facing adolescents in Kenya. The Policy aimed at bringing adolescent health issues into the mainstream of health and development.

The key objectives are: - to promote and protect adolescent reproductive rights and to create an enabling legal and social-cultural environment that facilitates the provision of information and services for adolescents and youth.

The National Adolescent Sexual and Reproductive Health (ASRH) Policy 2015 acknowledges that sexual rights are part of human rights and that adolescents have a right to, adequate, accessible Sexual reproductive health services (SRH) and appropriate sexual health education and information on the and other measures that enhance their sexual and reproductive rights.

The ASRH 2015 policy intends to bring adolescent sexual and reproductive health and rights issues into the country's mainstream health and development agenda. It also seeks to create an enabling legislative, judicial and social-cultural environment that facilitates the provision of Sexual health information and services for adolescents and youth.

It pledges to promote and protect adolescent reproductive rights; strengthen inter-sector coordination and networking in the field of adolescent health and development; and enhance participation of adolescents in reproductive health and development programmes.

The Kenya Reproductive Health Policy 2007 focuses on enhancing adolescent sexual and reproductive health and reduction of the impact of harmful practices, sexual abuse and violence. The policy also sought to improve the reproductive health of adolescents and ensure adolescents and the youth have full access to sexual and reproductive health information.

It also sought youth friendly reproductive health services and to promote a multi-sectoral approach in addressing adolescents sexual and reproductive health needs and strengthen partnerships with non-state actors to ensure adolescents had access to reproductive health services and information.

National Gender and Development Policy 2015 provides to ensure that education programmers including special education such as CSE are more gender responsive in curricula, training and learning materials.

The Basic Education Act 2013 is mandated to ensure every child has access to free and compulsory basic education is vested in the Cabinet Secretary. This Act forms the basis of reforms in the education sector that also draw from Sessional Paper No. 14 of 2012; Kenya Vision 2030; Medium Term Plan II (2013-2018) and the Constitution of Kenya 2010.

Education Sector Policy on HIV and AIDS (2013) provides for: the prevention of new HIV infections among learners and education staff at all levels; comprehensive treatment, care and support for learners, OVC and youth below 24 years and education staff living with HIV; HIV and AIDS stigma and discrimination; and, managing the HIV and AIDS response at all levels within the education sector.

The policy also formalizes the rights and responsibilities of every person involved directly or indirectly, in the education sector with regard to HIV and AIDS – the learners, parents/ guardians, care givers, educators, managers, administrators, support staff and civil society.

School Re-entry Policy 1994 by the Ministry of Education provides for school re-admission for girls who become pregnant who would like to continue with their education.

The policy provides for unconditional return of such girls to school, assistance from school administrators for re-admittance to other schools to avoid psychological and emotional suffering, and intensive guidance and counselling for affected girl, parents, teachers and other girls in the school.

Kenya AIDS Strategic Framework 2014/2015 – 2018/2019 aims at improving National and County legal and policy environment for protection and promotion of the rights of priority and key populations and people living with HIV.

It seeks: to remove barriers to access of HIV and SRH and rights information and services in public and private entities; to reduce and monitor stigma and discrimination, social exclusion and gender-based violence and improve access to legal and social justice and protection from stigma and discrimination among all PLWHA in all age groups.

Vision 2030: Second Medium Term Plan 2013 – 2017 proposes the establishment of integrated one stop sexual and gender based violence response centers in all healthcare facilities in Kenya.

The Kenya Fast-track Plan to End HIV and AIDS among Adolescents and Young People 2015-2017 seeks to harmonize the implementation of HIV responses to end AIDS among young people. The operational plan of this initiative focuses on fast-tracking the HIV response to end new HIV infections, AIDS related deaths, and stigma and discrimination among young people.

National Education Sector Plan Volume One: Basic Education Programme Rationale and Approach 2013 – 2018 focuses on improvement of education quality. Some of the specific targets of the Plan are: to improve schooling and learning outcomes; and, development of relevant skills.

Implementation of this plan is helping reduce early and unplanned pregnancies among adolescents. It aims at reducing and gradually eliminating child abuse and gender based violence in learning institutions, increasing equality among learners from different social, national or ethnic backgrounds and providing information and service for adolescents to address SGBV.

The National Plan of Action for Children (NPAC) 2015 addresses child survival, development, protection and participation alongside coordination mechanisms for delivering child focused services in the country.

National Guidelines on Management of Sexual Violence in Kenya 2014 highlights that an adolescent survivor of sexual violence has a right to Sexual and Reproductive Health Rights (SRHR) recognized by the law. These include the right to: - access reproductive health care for treatment and information on medical care; willingly press a charge of rape, sexual abuse with the police; and access to legal services and legal representation.

Also, they have a right to be treated, credibility, being notified of any scheduled court proceedings, and are also allowed to be represented in court by a relative, guardian or professional if physically unable to be present in person. They are also allowed to recover from the violation at their own pace.

National Guidelines on Provision of Youth Friendly Services identifies models of youth friendly service provision, national standards to be observed, and range of services to be provided.

The Kenya HIV Testing Services Guidelines 2015 calls for HIV Testing services to be offered to all the adolescents and youth from the age of 15 years, requesting for HIV testing on their own, even where there are no signs of such children being emancipated minors.

New Guidelines on the Treating and Preventing HIV Infection 2016 provides guidelines on the use of antiretroviral drugs for treating and preventing HIV Infection, and recommendations for a public health approach based on the World Health Organization (WHO) Consolidated Guidelines⁴¹.

Key areas covered in the guidelines include a summary of HIV testing and linkage recommendations, standard care for people living with HIV (PLHIV), antiretroviral therapy for all children, adolescents and adults living with HIV including special populations; prevention of mother to child transmission of HIV; patient centered differentiated care; adherence and monitoring; and the use of ARVs in pre-exposure prophylaxis among HIV uninfected persons at risk of HIV acquisition.

Antiretroviral therapy is now recommended for HIV negative persons to prevent acquisition of HIV and is now called Pre-exposure prophylaxis (PrEP).

This intervention is accessible at specific HIV

41 Ministry of Health, National AIDS & STI Control Programme. Guidelines on use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya 2016. Nairobi, Kenya: NASCOP, July 2016. Print.

prevention and treatment service delivery settings under close supervision of NASCOP and County Health Teams and is available to people at high risk of HIV infection.

PrEP uses antiretroviral drugs (ARVs) to protect HIV-negative people from HIV before potential exposure to the virus. When taken consistently and correctly, PrEP is very effective as shown by various Clinical trials.^{42, 43, 44} Truvada⁴⁵ is currently the only drug approved for use as PrEP. Based on the recognition that PrEP potentially has population-wide benefits, in 2015 the World Health Organization (WHO) released new guidelines and a policy brief recommending that PrEP should be offered as a choice to people who are at substantial risk of HIV infection⁴⁶.

Initially PrEP was only recommended for certain key affected populations such as sex workers, men who have sex with men and people who inject drugs⁴⁷. However, it was established that this kind of mapping of PrEP beneficiaries excluded people who are at significant risk but do not fit in to one of these groups.

42 McCormack, S. et al (2014) 'Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomized trial' *The Lancet* 387(10013):53-60

43 Baeten, J.M. et al (2012) 'Antiretroviral Prophylaxis for HIV-1 Prevention among Heterosexual Men and Women' *New England Journal of Medicine* 367(5):399-410

44 Grant, R.M. et al (2010) 'Pre - exposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men' *New England Journal of Medicine* 363:2587-2599

45 Truvada is a single pill that is a combination of two ARVs, tenofovir and emtricitabine.

46 World Health Organization (WHO) (2015) 'Policy brief: WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP)'

47 Baeten, J. et al (2012) 'Antiretroviral Prophylaxis for HIV-1 Prevention among Heterosexual Men and Women' *New England Journal of Medicine* 367(5):399-410

Evidence from literature indicates that PrEP is effective if used correctly; is cost effective and has demand. Kenya and South Africa are the first African countries to begin implementing a PrEP strategy, and to date, have employed small-scale pilot projects to start introducing PrEP. PEPFAR's DREAMS initiative also includes a PrEP component for young women and adolescent girls⁴⁸. Awareness for PrEP is however low. It is however important that any programme offering PrEP provides the service as part of a combination package of other HIV prevention initiatives, and does not replace other, more effective methods like condoms.

Multi-sectoral Standard Operating Procedures (SOPs) for Sexual Violence Prevention and Response in Kenya 2013 outlines roles for the Ministry of Education and the Teachers Service Commission with regard to prevention of and response to sexual violence within schools.

Sessional Paper No. 3 on Population Policy for National Development (2012) sought to support the implementation of the RH Policy and its Implementation Plan as well as other policies that promote attainment of reproductive health and reproductive rights of adolescents and youths within the framework of the new Constitution.

The All in Campaign was launched by The President of the Republic of Kenya in February 2015 to fast track reductions in AIDS-related deaths and new infections among adolescents towards ending the AIDS epidemic by 2030.

⁴⁸ The United States President's Emergency Plan for AIDS Relief (PEPFAR) 'Innovation Challenge Fact Sheet' [accessed 1 January 2016]

During the launch the President called for the revision of the school curriculum to ensure that young people have access to adequate health information.

The Ministry of Education together with development partners and stakeholders have initiated the development of guidelines for reviewing existing curricula and integration of CSE to reduce incidences of SGBV, teenage pregnancies and prevention of HIV infections among young people.

Kenya is also a signatory to the *Convention on the Rights of the Child (CRC)*. Per the CRC, adolescents and the youth have a right to health and development (Article 12 of CRC). Children have rights to access information (Article 17 of CRC) which include reproductive health information; the right to privacy and confidentiality (Article 16 of CRC); need to be protected from abuse, neglect and exploitation (CRC article 19, 32-36 & 38).

States are further required to adopt special measures to ensure physical, sexual and mental integrity of adolescents especially those with disabilities that are particularly vulnerable to abuse and neglect.

The CRC also calls upon States to take measures to reduce maternal mortality and morbidity arising from early pregnancies among adolescents and the youth with reproductive health treatment and should have health services available including unsafe abortions. Since Adolescents have a right to the highest attainable standard of health that must be guaranteed by the State.

Summary of existing policy and legislative gaps

The literature review of Sexual Reproductive Health policies and rights indicates that Kenya has a favorable policy and legal framework in place. However, there is need to address the gaps in policy implementation to bring Adolescent Sexual and Reproductive Health and Rights issues into the mainstream of health and development. Such gaps include:

(a) Inadequate attention being paid to the SRHR needs in provision of appropriate mediums of information, communication and service delivery for adolescents. This has resulted in lack of adequate uptake of SRH information and services among young girls especially in the rural areas. This requires creation of awareness and information on SRHR;

(b) Limited knowledge of legal rights and information regarding sexual health and risks, especially around termination of pregnancy and access to emergency contraception as well as access to the justice system to seek redress for SRHR violations. Consequently, there is need for the judicial systems and/or non-state actors in the Human rights sector to offer legal literacy programmes on SRHR;

(c) Continued sexual exploitation and violence among young girls and adolescents in Kenya despite the existence of both national and international legal, policy and institutional frameworks aimed at safeguarding the sexual and reproductive rights of all Kenyans. There is need for serious implementation of the provisions in the policies and law regarding adequate reporting and prosecution of the offenders especially when children and adolescents are the complainants;

(d) Despite formulation of relevant education sector policies in HIV and AIDs, there remain challenges in comprehensively addressing the needs of young people living with HIV in school setting. Among the key challenges young people living with HIV face in schools are disclosure, stigma and discrimination, access to health services in schools as well as appropriate support, guidance and counselling in school settings. There is need to address these emerging issues through the provision of comprehensive sexuality education in schools; and,

(e) Addressing the barriers to provision of adequate adolescents' reproductive health services including: social; cultural and religious beliefs and practices; low status of women in decision making; low male involvement in family planning; infertility, poverty; weak health management systems; and, inadequate funding.

Some definitions

Adolescents: These are persons aged between 10 and 19 years.

Orphan: A child below 18 years of age whose mother (maternal orphans) or father (paternal orphans) or both (double orphans) are dead.

Source: RoK/MoH (2015) National Adolescent Sexual and Reproductive Health Policy.

This magnifies the need for SRHR advocacy in the communities to change harmful gender norms, negative stereotypes and concept of masculinity. It also means empowering young people to know and exercise their SHR rights.

The Kenya National Commission on Human Rights [KNCHR] (2012)⁴⁹ emphasizes that a human rights-based approach acknowledges that sexual and reproductive rights cannot be realized without the realization of other broader human rights, for example, the right to information, privacy and confidentiality and education.

Sexual and Reproductive Health and Rights Status of Adolescents in Kenya

According to the World Health Organization (WHO), an adolescent is any person between the age of 10 and 19 years. Adolescence is a critical developmental period when many young people begin to define and clarify their sexual values and, often, start to experiment with sexual behaviors. Per UNFPA (2014) there are more young people in the world than ever before: an estimated 1.8 billion people are between ages 10 and 24 years.

In Kenya, young people constitute a significant proportion of the population, where 43% of the population is younger than 15 years and about 9.2 million are adolescents aged 10-19 years, representing 24 percent of the population (GoK and KNBS 2010). This large proportion of young people has major demographic, health, social and economic implications. Adolescence is a period marked by significant growth, remarkable development and changes in the life course for boys and girls, filled with vulnerabilities and risks as well as opportunities.

49 Kenya National Commission on Human Rights (2012) Realizing Sexual and Reproductive Health Rights in Kenya: A myth or reality? http://www.knchr.org/Portals/0/Reports/Reproductive_health_report.pdf

Save the Children (2014)⁵⁰ asserts that Adolescent Sexual and Reproductive Health and Rights (ASRHR), reflects a rights-based approach to sexual and reproductive health.

These rights are the sexual rights of every human being as outlined in the Declaration of Human Rights and the UN Convention on Child Rights (CRC). NASCOP/KEMRI (2015)⁵¹ note that adolescents in general are considered vulnerable because of their inability to make autonomous decisions hence the need to safeguard their interests.

Adolescents' vulnerabilities may be aggravated by: - their family status e.g. being orphaned or adolescent head of households; economic status e.g. adolescents living in poverty, street adolescent or adolescent in street families; their work e.g. adolescents exploited for sex; and adolescents who abuse/use drugs and substances.

Therefore, paying attention to adolescents' health and education is a lifetime investment that is likely to have positive effects on behaviour and lifestyle during the entire course of their life (UNFPA and Population Council, 2006)⁵². Hence, there is a need for research to inform on interventions targeting adolescents in vulnerable situations to safeguard and protect their SRH welfare.

50 Save the Children (2014) adolescent sexual & reproductive health and rights (ASRHR) update August 2014. Retrieved from: <http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/ASRHR%20UPDATE%202014.PDF>

51 National AIDS and STI Control Programme (NASCOP) & Kenya Medical Research Institute (KEMRI) (2015). Vulnerable Adolescents: Guidelines for Conducting Adolescents Sexual and Reproductive Health Research in Kenya.

52 United Nations Population Fund (UNFPA) and Population Council (2006). Investing when it Counts: Generating the evidence base for policies and programs for very young adolescents; Guide and tool kit.

Early sexual debut and getting married at a young age have been found to be associated to susceptibility to STIs including HIV infection and/or unwanted pregnancies as well as unsafe abortions. Age specific fertility rates for adolescent aged 15-19 in Kenya lay at 96 per 1000 women while that of those aged 19-24 year lay at 206 per 1000 women, the highest among all the five-year reproductive age groups of 15-49.⁵³

The Total Fertility Rate for Kisumu stands at 3.6, Homa Bay at 5.2 in comparison to the national average of 3.9.⁵⁴ According to the KDHS 2014, 15% of women age 20-49 had first sexual intercourse by age 15, 50 percent by age 18, and 71 percent by age 20.

Men have an earlier sexual debut than women, a pattern that holds true for most age groups. For example, 22 percent of men age 20-49 had first sexual intercourse by age 15, 56 percent by age 18, and 76 percent by age 20. The median age at first sexual intercourse among men age 20-49 (17.4 years) is also slightly lower than that among women (18.0 years)⁵⁵ Additionally, the percentage of women married by age 15 appears to be declining; 9 percent of women age 45-49 were married by age 15, as compared with 2 percent among those age 15-19.⁵⁶

53 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya, National AIDS Control Council Nairobi, Kenya, Kenya Medical Research Institute Nairobi, Kenya, & National Council for Population and Development Nairobi, Kenya. March 2015. Kenya Demographic and Health Survey 2014 Key Indicators Nairobi

54 *ibid*

55 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya, National AIDS Control Council Nairobi, Kenya, Kenya Medical Research Institute Nairobi, Kenya, National Council for Population and Development Nairobi, Kenya, The DHS Program, ICF International Rockville, Maryland, USA. December 2015 Kenya Demographic and Health Survey 2014

56 *ibid*

In Kisumu, most of the youth are sexually experienced (73.5%) with most of the first sexual experiences occurring within the age group 15-19 years (Oindo, 2002)⁵⁷. Kisumu County Integrated Development Plan, 2013-2017 identifies early marriages as a challenge.

Regarding teenage pregnancy, 33% of girls aged 15-19 years in Homa Bay County have begun childbearing with 2.1% being pregnant with their first child and 31.2% having ever given birth, compared to 3.4% and 14.7%, respectively, at the national level.

In Kisumu County, teenage pregnancy and motherhood is high with 15.4 percent of adolescent women age 15-19 years have had a live birth (KNBS and ICF Macro 2014). Unintended pregnancy is one of the main causes of adolescent girls dropping out of school in Kisumu County.

It is estimated that 2 out of 6 girls in Kisumu County drops out of school due to unintended pregnancy.⁵⁸ The Kenya National School Health Policy (2009) recognizes the need to inform students on SRH and provide them with necessary skills to avert unwanted pregnancies, disease or sexual violence.

It also recognizes that girls have a right to education during and after pregnancy. The school Re-entry policy provides for re-admission into schools of girls who drop out due to pregnancy.

57 Oindo, M. L. (2002). Contraception and sexuality among the youth in Kisumu, Kenya. *African Health Sciences*, 2(1), 33-39.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2141560/>

58 End teenage pregnancy in Kisumu County by Okun Oliech Tue 14th Jun 2016

<https://www.standardmedia.co.ke/ureport/story/2000205151/end-teenage-pregnancy-in-kisumu-county>

Teenage pregnancies often result from low use of contraceptives and/or unmet need for contraceptives. In Homa Bay County, 3 in 5 (56%) currently married adolescent girls aged 15-19 use modern contraceptives which is high compared to 2 in 5 (37%) at national level. There is still an unmet need for contraceptives among currently married girls in Homa Bay.

About 1 in 10 (11%) currently married adolescent girls aged 15-19 would like to avoid pregnancy but are not using a modern contraceptive method compared to 23% at national level. Notably between 20% and 30% of never married young people in the region did not use a condom during their last sexual encounter.

This is of concern given the high HIV prevalence in the region. For Kisumu County, the contraceptive usage peaks among married women in the 30-34 age groups and is lowest for adolescent girl's ages 15-19 years. Oindo (2002) found that there is a high level of knowledge (99.2%) of contraceptive methods and a positive attitude towards contraception yet the level of contraceptive use is relatively lower (57.5%) even for the sexually active 15-14 year olds.

The County has unmet need for family planning that stands at 23.2 percent (12.6 for spacing and 10.6 for limiting) among currently married women in reproductive age with adolescents been worst hit⁵⁹. HIV is one of the most common SRH problems experienced by adolescents and youth. Adolescents living with HIV face unique challenges as they transition to adulthood because they are less likely to be in school, likely to be orphaned, lack appropriate services and are often unable to negotiate contraceptive use or even access contraceptive methods.

59 KNBS and ICF Macro, 2014.

There is evidence of disproportionate impact of HIV on adolescent girls and women. Kenya's epidemic disproportionately affects women, who account for 59.1 per cent of adults living with HIV. Amongst people between 15-49 years of age, HIV prevalence of females is at 8 per cent, which is nearly twice that of males at 4.3 per cent in 2012 (The Kenya Aids Epidemic Update, 2012)⁶⁰. The odds of being infected increase during the transition from adolescence to adulthood. Overall, adolescents between the ages of 10 and 19 years represented about nine percent of persons living with HIV and 13 percent of all HIV-related deaths in Kenya.

It is reported that HIV testing rates for Kenya are lowest among adolescents between 15-19 years (49.8%), with only 23.5 percent reporting awareness of their status (National Adolescent Sexual and Reproductive Health Policy 2015)⁶¹. Homa Bay and Kisumu counties are adversely affected by HIV and AIDS.⁶² Kenya AIDS Indicator Survey (KAIS) 2012, HIV prevalence was higher among women (16.1%) than among men (13.9%) in Nyanza region compared to nationwide prevalence of women (6.9%) and among men (4.4%).

Impediments to realization of SRHR for adolescents and young people in Kenya

Various factors impede the full realization and enjoyment of the SRHR by adolescents and young people. These barriers include socio-economic, cultural, informational, political as well as legal factors.

60 The Kenya Aids Epidemic Update 2012, National AIDS and STI Control Programme.

61 National Adolescent Sexual and Reproductive Health Policy 2015. Retrieved from: <http://aphrc.org/wp-content/uploads/2015/09/Ministry-of-Health-ASRH-Booklet-Final-1.pdf>

62 The Kenya Aids Epidemic Update 2012, National AIDS and STI Control Programme

The resultant outcome of these factors is violations of SRH rights especially of adolescent girls and young women. Socio-economic barriers entail child-headed households, child labour, burden of care on the girl child, exposure to multiple sex partners for source of income, inaccessibility to affordable health services, early school drop-out, lack of social security and protection.

Despite the potential benefits of universal access to SRHR to wellbeing and economics, FAO (2014)⁶³ observes it is not fully realized in many parts of the world. An estimated 222 million women in developing countries have an unmet need for contraceptives, either because the services are unavailable or cannot be accessed, or because of social barriers such as the need for parental or spousal consent (World Watch Institute, 2012)⁶⁴.

While much has been done to improve access to sexual and reproductive health and rights (SRHR) information, services and supplies among older adolescents in Kenya, there is a commonly held belief that young girls and boys under the age of 15 are 'too young' to need SRHR⁶⁵.

A report by Kenya National Commission on Human Rights (2012) inquiring into violations of SRH rights among Adolescents and youths in Kenya show that adolescents and youths lack easy access to quality and friendly SRH including STI services, safe abortion services, antenatal care and skilled attendance during delivery.

63 FAO, 2014. The Female Face of Farming. Retrieved from: <http://www.fao.org/gender/infographic/en/>

64 World Watch Institute (2012). Investments in Women Farmers Still Too Low. Retrieved from: <http://www.worldwatch.org/investmentwomen-farmers-still-too-low-0>

65 <http://www.impatientoptimists.org/Posts/2014/08/Improving-sexual-and-reproductive-health-and-rights-for-young-adolescents-in-Kenya>

Unmet need of women's and girls' sexual and reproductive health and rights manifests in high levels of maternal mortality and morbidity, HIV and AIDS, unintended pregnancy and unmet need for contraceptives, as well as in challenges to accessing other health services such as safe abortion and post abortion care.⁶⁶ NASCOP/KEMRI (2015) indicates that high unmet FP need among sexually active adolescent and young women results in unwanted pregnancies, school drop-out, early marriages, abortions, and greater dependency on sex partners.⁶⁷

Unmet need for FP continues to be a problem among adolescents. According to the KDHS 2014, current contraceptive use of any method for those aged 15-19 was at 40.2%, the lowest for all age groups in the reproductive age fold 15-49. For those aged 20-24, current use was at 53.5. The current use for all women in reproductive age group stood at 62.4 in Kisumu and 46.7 for Homa Bay.

Fifteen percent of women age 15-19 have already had a birth, and 3 percent are pregnant with their first child⁶⁸. Among issues associated with low use of RH services are stigma and discrimination especially in public health facilities, ignorance of available services, peer pressure and perceptions of high cost or unavailability of those services.

66 Briefing Cards: Post-2015 Development Agenda, Universal Access Project. Retrieved from <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>

67 National AIDS and STI Control Programme [NASCOP] & Kenya Medical Research Institute [KEMRI](2015). Guidelines for Conducting Adolescents Sexual and Reproductive Health Research in Kenya.

68 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya, National AIDS Control Council Nairobi, Kenya, Kenya Medical Research Institute Nairobi, Kenya, National Council for Population and Development Nairobi, Kenya, The DHS Program, ICF International Rockville, Maryland, USA. December 2015 Kenya Demographic and Health Survey 2014

An emerging trend in family structures due to the HIV and AIDS epidemic are child-headed households. Poor, vulnerable and impoverished adolescents in these households are increasingly vulnerable to SRHR violations due to the effects of the disease on the household economy.

Cultural barriers include; forced and early marriages, gender inequalities: discrimination against girls in education and in inheritance, wife inheritance, polygamy, tolerance of Sexual and Gender Based Violence⁶⁹, tolerance of intergenerational sex, and breakdown of traditional norms and customs on sexuality counselling within the community.

These undermine the quality of life of adolescents and young people in the family. Socio-cultural barriers largely take the form of restrictive social norms associated with adolescent and youth sexuality that prevent young people from seeking and accessing SRH information services and rights for fear of stigma, social pressure, or embarrassment.

Also, cultural practices and gender norms can restrict empowerment of women and infringe on the rights of the girl child by promoting preferential treatment for boys.⁷⁰

69 SGBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. GBV is not synonymous for violence against women and girls even though it is widely recognized that GBV is normally perpetrated against women and girls by men and boys. This acknowledgment of men and boys as the predominant perpetrators of GBV does not exclude them as victims of GBV as well. Even though GBV, often get used interchangeable with violence against women, this is not the definition of the term. This fluidity of use however speaks to the subordinate role of women in society, which often leaves them as victims. There are many forms of GBV and most commonly, they are categorized to include: sexual violence, sexual exploitation and abuse (SEA), domestic violence, economic violence and emotional violence (UNDP/Restless Development, 2013).

70 2013 Kenya adolescent Reproductive Health and development policy implementation assessment Report. Retrieved from <http://www.prb.org/pdf13/kenya-policy-assessment-report.pdf>

Moreover, some sociocultural and religious practices condone sexual discrimination and harmful practices against girls and young women, including female genital mutilation/cutting (FGM/C), early marriage, and forced marriage after pregnancy.

According to the Kenya Demographic and Health Survey 2014 women and girls are more likely to experience gender-based violence (GBV) than men and boys. Among those aged 15-19 and 20-24 years, 31.6 % and 43.9% respectively had ever experienced physical violence.⁷¹

The survey further shows that for those aged 15-19 and 20-24 years, 6.5% and 12.6% had respectively experienced sexual violence.⁷² NASCOP/KEMRI (2015) contends that Sexual and Gender-Based Violation (SGBV) is highest among adolescent and young Women.

Kangas, *et.al*, (2014) shows that SGBV increases biological vulnerability to HIV, reduces ability to negotiate for safer sex, with long-term psychosocial outcomes that impact sexual risk taking behavior. Transactional sex typically involves multiple partners and large age differences (usually between older men and younger women or girls). The younger women (and men) generally have lower negotiating power to insist on condom use.⁷³

71 Kenya National Bureau of Statistics Nairobi, Kenya, Ministry of Health Nairobi, Kenya, National AIDS Control Council Nairobi, Kenya, Kenya Medical Research Institute Nairobi, Kenya, National Council for Population and Development Nairobi, Kenya, The DHS Program, ICF International Rockville, Maryland, USA. December 2015 Kenya Demographic and Health Survey 2014

72 *ibid*

73 Kangas, A., Haider, H., & Fraser, E. (2014). Gender: Topic Guide. Revised edition with E. Browne. Birmingham.

Socio-cultural causes of SGBV include: gender-specific socialization; cultural definitions of appropriate sex roles; expectations of roles within relationships; belief in the inherent superiority of males; values that give men proprietary rights over women and girls; notion of the family as the private sphere and under male control; customs of marriage (bride price/dowry); and acceptability of violence to resolve conflict.⁷⁴

Sexual and gender-based violence has implications for aspects of health policy and programming, from primary care to reproductive health programmes.⁷⁵ Not only do women carry a substantial burden of illness and likelihood of death because of physical and sexual violence, but violence also worsens other health conditions, including increasing the opportunity for HIV transmission.

A study conducted by FIDA-K in 2012 indicated that in Kisumu County, the major form of GBV was forced wife inheritance. Accordingly, women were forced to be inherited at the risk of eviction or disinheritance. The study further identified child sexual exploitation as a prevalent form of GBV in Kisumu County. It was noted that in Kisumu, girls as young as 13 years were in the streets and patronized various nightclubs. The Kisumu County Integrated Development Plan, 2013-2017, highlights high incidence of gender-based violence as one of the challenges in Kisumu East sub-county.

The national legal framework for SGBV draws guidance from the Constitution of Kenya 2010. Article 27 (3) of the constitution promotes equal treatment for men and women, including the right to equal opportunities in political, economic, cultural and social spheres. It prohibits any form of discrimination.

74 United Nations Children's Fund (UNICEF) (2000), *Domestic Violence Against Women and Girls*, Innocenti Research Center: Florence, Italy.

75 Heise, L., 'Ending Violence against Women' (1999) 4 *Population Series* 6, available at <http://www.inforforhealth.org/pr/111/violence.pdf>

The Constitution promotes the right to human dignity for every person (Article 28) and prohibits subjection to any form of violence in public or private sphere (Article 29 (c)). Some few counties, including Kisumu, have County Committees for GBV/Gender embedded with youth and social issues.

The ability to access information is one of the fundamental facets of SRHR. This access to the requisite information on SRHR can bolster the ability of adolescent girls and young women to attain optimal levels of SRH as well as to seek justice for violation of rights. KNCHR (2012) observed that generally, adolescents and youths lack relevant accurate information on sex, sexuality and reproductive health. Young people who lack complete and correct SRH information may be unaware of their own need for SRH services, uncertain about safety and reliability of SRH services, and consequently, unwilling to use them.⁷⁶

Access to Justice for SRHR Violations

Kenya resolves criminal cases and violations through the formal or informal justice systems. Formal justice systems refer to all those systems set out or recognized by the law and backed by government sanctions such as the judiciary, administrative tribunals, the prisons, police and correction systems while traditional, community and customary justice systems have been described as informal, non-state, non-official or non-formal justice systems.⁷⁷ Customary justice systems refer to all dispute resolution mechanisms that develop from the customs and other customary practices of a group of people.

76 Ramez L., Prada E., Singh S., Bixby L., and Bankole A. (2008). *Ensuring a Healthier Tomorrow in Central America: Protecting the Sexual and Reproductive Health of Today's Youth*. New York: Guttmacher Institute.

77 Muigua, K., & Francis, K. (2015). Alternative Dispute Resolution, Access to Justice and Development in Kenya. *Strathmore LJ*, 1, 1. Retrieved from: <http://www.strathmore.edu/sdrc/uploads/documents/books-and-articles/Paper%20on%20Traditional%20justice%20terminology.pdf>

Community justice systems use of 'local community initiatives' consistent with the Constitution in resolving land disputes.⁷⁸

Prevalence Data on Different Forms of Violence against Women

Lifetime Physical and/or Sexual Intimate Partner Violence: 41 %. [*Proportion of ever-partnered women aged 15-49 years experiencing intimate partner physical and/or sexual violence at least once in their lifetime*]. Source: Kenya National Bureau of Statistics (KNBS) and ICF Macro, 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro.

Physical and/or Sexual Intimate Partner Violence in the last 12 months: 34 %. [*Proportion of ever-partnered women aged 15-49 years experiencing intimate partner physical and/or sexual violence in the last 12 months*]. Source: Kenya National Bureau of Statistics (KNBS) and ICF Macro, 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro.

Lifetime Non-Partner Sexual Violence : 4 % [*Proportion of women aged 15-49 years experiencing sexual violence perpetrated by someone other than an intimate partner at least once in their lifetime*]. Source: Kenya National Bureau of Statistics (KNBS) and ICF Macro, 2010. Kenya Demographic and Health Survey 2008-09. Calverton, Maryland: KNBS and ICF Macro.

Child Marriage: 26 %. [*Percentage of women aged 20 to 24 years who were first married or in union before age 18*]. Source: UNICEF global databases 2016, based on DHS, MICS and other nationally representative surveys.

Female Genital Mutilation/Cutting: 27 %. [*Percentage of girls and women aged 15 to 49 years who have undergone FGM/C*]. Source: UNICEF global databases 2016, based on DHS, MICS and other nationally representative surveys.

On the other hand, traditional dispute resolution mechanisms may refer to those mechanisms that have long been practiced by communities and passed from one generation to the other and can be regarded as a subset of customary dispute resolution mechanisms as they are based on customary laws of ethnic groups practiced since time immemorial⁷⁹.

Sexual and Gender Based Violence (SGBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. GBV is not synonymous with violence against women and girls even though it is widely recognized that GBV is normally perpetrated against women and girls by men and boys.⁸⁰

This acknowledgment of men and boys as the predominant perpetrators of GBV does not exclude them as victims of GBV as well. There are many forms of GBV and most commonly, they are categorized to include: sexual violence, sexual exploitation and abuse (SEA), domestic violence, economic violence and emotional violence.⁸¹

Kenya's Constitution and various policies guarantee protection from SRHR violations. For instance, section 74 of the Constitution prohibits torture, inhuman and any degrading treatment.

79 *ibid*

80 UNDP/Restless Development (2013). Access to Justice Programme: Baseline report Submitted to UNDP on November 7, 2013

81 UNDP/Restless Development (2013). Access to Justice Programme: Baseline report Submitted to UNDP on November 7, 2013

78 *ibid*

SRHR violations such as rape, defilement, GBV, female genital mutilation/cutting, domestic violence and widow inheritance constitute inhumane treatment. However, despite the existence of the requisite policies and legislation to deal with SRHR rights violations and crimes, failure to fully implement the policies and prosecute perpetrators, even in situations where they are known, and where circumstantial evidence is available, is rife in Kenya.

This is an indication of a lack of access to justice to victims and survivors of SRHR violations majority of whom are adolescent girls and young women. Yet access to justice is integral to improving SRH and achieving broader development goals. UNDP (2005)⁸² defines access to justice as the ability of people to seek and obtain a remedy through formal or informal institutions of justice for grievances in compliance with human rights standards.

A national public inquiry conducted in 2011 by KNHRC documented numerous reproductive rights violations experienced by vulnerable and marginalized groups, including adolescents and youth. The report delineates that these violations manifest in discrimination and stigma, harassment and mistreatment, difficulties in accessing the facilities, lack of access to information, lack of involvement in medical decisions affecting them, unaffordability of the health services, among others.⁸³

⁸² United Nations Development Programme, Programming for Justice: Access for All: A Practitioner's Guide to a Human Rights-Based Approach to Access to Justice, Bangkok, UNDP.

⁸³ UNDP (2013), Strengthening Judicial Integrity through Enhanced Access to Justice: Analysis of the national studies on the capacities of the judicial institutions to address the needs/demands of persons with disabilities, minorities and women, Slovak Republic. UNDP.

Similarly notes that the lack of access to justice and unequal treatment can be caused by various factors, including discrimination, poverty, low institutional trust or confidence in the process, lack of capacity, language barriers, weak access to information, or living in remote areas with a lack of judicial facilities.

The KNHRC (2012) report concluded from that there is high prevalence of sexual violence in Kenya and that survivors of sexual violence experience multiple barriers to accessing remedies. These barriers include a lack of integrated services, lack of awareness of the existence of services, especially of post-rape services, stigma and shame associated with sexual violence, unaffordable services, and the complex and often humiliating justice system.⁸⁴

Land and Property Rights

Until the new Constitution was adopted in 2010, customary law irrespective of its discriminatory nature was applicable to a wide range of matters with numerous negative consequences for women in terms of inheritance, property rights, marriage, and adoption.

The valuing of the boy child over the girl child has had a detrimental effect on girls' pursuit and access to education, nutrition, security and inheritance. Control of women's bodies and sexuality has resulted in diverse forms of gender-based violence including early marriage, FGM/C, wife inheritance, forced pregnancies, rape and abductions.

⁸⁴ *ibid*

Control of women's labour and visualizing women as property has also helped to sustain practices such as dowry, polygamy, wife inheritance, restriction on mobility, and violence against women.⁸⁵

Despite the new laws in Kenya, women's social and economic status continues to be largely defined by customary rules that are deeply rooted in diverse communities in Kenya.⁸⁶ Kangas, *et.al.* (2014) points out that, access to resources and stable property rights is highly gendered in many parts of the world.

Women and girls suffer from inequitable land rights and experience restricted access to resources and inheritance. Infringement of rights to resources may adversely affect women's ability to access other resources or services and further expose women to violations including those relating to SRH.

Orphanhood and vulnerability

Globally, 16.6 million children below 18 years of age have lost 1 or both parents to HIV; with 90% of these orphans residing in sub-Saharan Africa.⁸⁷ Literature indicates great associations between orphan hood with poorer health outcomes, educational attainment, and economic disadvantage, making this population a key concern.⁸⁸

85 Government of Kenya (GoK)/UNICEF (2014) Situation Analysis of Children and Adolescents in Kenya

"Our Children, our Future" UNICEF, Nairobi, Kenya, 2014. Retrieved from: https://www.unicef.org/kenya/SITAN_2014_Web.pdf

86 FIDA (2013). Advancing Women's Rights in Kenya. Nairobi Federation of Women Lawyers Kenya (FIDA Kenya).

87 Joint United Nations Programme on HIV/AIDS (UNAIDS) Global Report: UNAIDS Report on the Global AIDS Epidemic 2010. Joint United Nations Programme on HIV/AIDS (UNAIDS); Geneva, Switzerland: 2010. Available at: http://www.unaids.org/globalreport/global_report.html. Accessed May 24, 2013.

88 United Nations Children's Fund (UNICEF) The Framework for the Protection, Care, and Support of Orphans and Vulnerable Children

In addition, there is a larger group of adolescents and children with increased vulnerability due to severe overall household poverty or illness in the family, affecting their overall well-being and development (*ibid*).

Almost 3 million children under the age of 15 are living with HIV or AIDS, over 2.7 million of them in sub-Saharan Africa⁸⁹. More than 14 million children under the age of 15 have lost one or both parents to AIDS, the clear majority of them in sub-Saharan Africa (*ibid*). Previous estimates in Kenya have found that approximately 3.6 million⁹⁰ children are orphaned or are vulnerable, and represent almost one-fifth of the total population aged <18 years⁹¹. It has been estimated that 1.1 million, or 44%, of these children have been orphaned due to HIV⁹², having lost either 1 or both of their parents to the disease. A study by Lee *et al.*, 2016 on orphans and vulnerable children in Kenya based on a total of 9189 households indicates that, there were a total of 16,126 children aged <18 years living in these households, where 14.4% (n = 2362) of these children met their definition of OVC⁹³.

Living in a World With HIV and AIDS. United Nations Children's Fund (UNICEF); New York, NY: 2004. Available at: http://www.unicef.org/aids/files/Framework_English.pdf. Accessed May 24, 2013.

89 UNICEF Orphan estimates

90 Ministry of Planning, National Development, and Vision 2030, Kenya. Kenya Social Protection Sector Review. Ministry of State for Planning, National Development, and Vision 2030; Nairobi, Kenya: 2012. Available at: http://www.vision2030.go.ke/cms/vds/Kenya_Social_Protection_Review_Final.pdf. Accessed May 24, 2013.

91 National AIDS Control Council (NACC), National AIDS and STI Control Programme (NASCOP). The Kenya AIDS Epidemic Update 2012. NACC, NASCOP; Nairobi, Kenya: 2011. Available at: <http://www.nacc.or.ke/>. Accessed May 24, 2013.

92 Kenya National Bureau of Statistics (KNBS) Kenya Population and Housing Census. KNBS; Nairobi, Kenya: 2010. Available at: <http://www.knbs.or.ke>. Accessed May 24, 2013.

93 Orphans defined as children who were <18 years of age who had lost 1 or both their parents. Double orphans (both parents dead) or single orphans (1 parent dead). Maternal and paternal orphans used to describe whether the child had lost the mother or the father, respectively. Vulnerable child as one whose parent(s), living in or outside of the child's household, or any adult (aged ≥18 years), living in the child's same household, had been chronically ill. Chronic illness defined as the condition of being very ill for at least 3 months in the past 1 year before the survey.

OVC households, or households with at least 1 OVC, comprised 11.7% of all the households interviewed. Among the 1104 OVC households, more than half fell in the lowest 2 quintiles for household wealth, and approximately one-fifth of OVC households had experienced moderate or severe hunger.

The average size of an OVC household was 5.4 members, compared with 3.9 members for non-OVC households ($P < 0.0001$). Thirty-nine households had both orphaned and vulnerable children and approximately half (52.3%) of all the OVC households had ≥ 2 OVC.

Among all OVC, 71.1% were orphaned (single and double), and 28.9% were found to be vulnerable. Like the non-OVC, three-fourths of the OVC lived in rural areas, and approximately half of all the OVC resided in the Nyanza (27.4%) and Rift Valley (26.0%) regions (Ibid). Among the orphans, 15.1% had lost both their parents.

About 41.5% of these double orphans lived in the Nyanza region. Single orphans represented 84.9% of all the orphans. The majority resided in the Nyanza (28.2%) and Rift Valley (27.9%) regions. Overall, 93.9% of the school-aged single orphans had ever attended school.

Maternal orphans comprised 17.3% of all single orphans, and paternal orphans were 82.7%. Among single orphans, 5.9% reported that the parent who died had HIV infection. These results attest to the gravity of the OVC issue in Nyanza region. With an HIV prevalence of 5.6% among adults⁹⁴ and antiretroviral therapy (ART) being taken

94 Kimanga DO, Ogola S, Umuro M, et al. Prevalence of HIV infection, trends, and risk factors among persons aged 15–64 years in Kenya: results from a nationally representative study. *J Acquir Immune Defic Syndr.* 2014; 66(suppl 1): S13–S26. [[PMC free article](#)] [[PubMed](#)]

by 61% of people who are clinically eligible,⁹⁵ the number of orphans and vulnerable children (OVC) will most likely continue to increase well into the future more so since AIDS remains the leading cause of death of adults in Kenya⁹⁶.

Orphans face many adverse effects due to their status. A review of the status of orphans in various districts in Zimbabwe by Chandiwana (2009) revealed that the main threats to orphans include: A shortage of material resources such as food, school stationery, clothing, shelter, blankets, school uniforms and sanitary wear for girls; Child labour; Lack of access to school; Rape and Rape and sexual violation, emotional or physical abuse.

The large number of OVC in Zimbabwe has had a huge impact on the resource base of communities, placing a significant strain on the extended family, especially on grandparents (⁹⁷; ⁹⁸). In some parts of the country, such as Zvimba, as many as 75% of the school-going population are classified as OVC.

Deteriorating circumstances due to the family's increasing poverty level and the impact of HIV and AIDS expose children to exploitation and abuse, while escalating crime and social disorganization are also contributing factors to the increasing numbers of OVC.

95 Odhiambo J, Kellogg TA, Kim AA, et al. Antiretroviral treatment scaleup among persons living with HIV in Kenya: results from a nationally representative survey. *J Acquir Immune Defic Syndr.* 2014; 66(suppl. 1): S116–S122. [[PMC free article](#)] [[PubMed](#)]

96 World Health Organization (WHO) World Health Statistics 2013. World Health Organization (WHO); Geneva, Switzerland: 2013.

97 Chandiwana, B. (2009) (Ed). Situational analysis of orphaned and vulnerable children in eight Zimbabwean districts. Cape Town: HSRC Press.

98 Strelbel, A. (2004). The Development, Implementation and Evaluation of Interventions for the Care of Orphans and Vulnerable Children in Botswana, South Africa and Zimbabwe. A Literature Review of Evidence-based Interventions for Home-based Child-centred Development. Cape Town: HSRC Press. Available at: www.hsrcpublishers.ac.za.

A recent study undertaken jointly by government of Kenya and UNICEF on the extent of child sex exploitation in the coast region indicate that some 10,000 – 15,000 girls living in coastal areas are involved in casual sex work – up to 30% of all 12-18 year olds living in those areas.

A further 2,000 – 3,000 girls and boys are involved in full-time year around commercial sex activity in the coast region. The study found out that sex workers include children whose basic needs cannot be met by family for reasons like unemployment, under-employment and loss of one or both parents⁹⁹.

The reaction of families and communities to the plight of these children has been compassionate and remarkably resilient. However, they are struggling under the strain. To date, few resources are reaching families and communities who are providing this front-line response, and little attention is given to orphans and vulnerable children in most national development agendas. Moreover, donors have yet to put forth comprehensive programmes on this issue¹⁰⁰.

Orphans are approximately 13% less likely to attend school than non-orphans. Double orphans are most likely to be disadvantaged.¹⁰¹ Nyanza region has the highest percentage of children who have experienced the death of their father; 9 percent of these children are living with their mother, and 3% are living with neither parent.¹⁰²

99 The Extent and Effect of Sex Tourism and Sexual Exploitation of Children on the Kenyan Coast; A study conducted by UNICEF and Government of Kenya in 2006)

100 UNICEF, (2004). The framework for the support protection, care of orphans and vulnerable children living in a world with HIV and AIDS. Available at <http://www.unicef.org/aids/fi>

101 Monasch, Roeland^a; Boerma, J Ties^b 2004. AIDS: Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries. AIDS: [June 2004 - Volume 18 - Issue - pp S55-S65](#)

102 KNBS (Kenya National Bureau of Statistics), Ministry of Health (MOH), National AIDS Control Council (NACC), Kenya Medical Research Institute (KEMRI), National Council for Population and Development (NCPD), & ICF International (2015). Kenya Demographic and Health Survey 2014. Calverton, Maryland: KNBS, MOH, NACC, KEMRI, NCPD and ICF International.

Strategies in the care and support of OVC and vulnerable children

Addressing the needs of orphans and vulnerable children (OVC) and mitigating adverse effects of the growing OVC population worldwide is a key area of focus for national governments and international stakeholders that acknowledge this as an issue with social, economic, and human rights dimensions. Consequently, many state, faith based, private, community and civil society organisations have come up with various strategies to address the needs of the OVC.

National response

Kenya considers OVC as a priority population in the national response to the HIV epidemic. However, despite this recognition of the need to provide age-appropriate services and protection to the OVC population, much is still unknown about its size, its characteristics, the proportion receiving support services, and what its social and developmental outcomes are. The Kenya National AIDS Strategic Plan III for 2009–2013 outlines strategies for improving the welfare of OVC through educational, economic, and social support, and 8.4% of the plan's total budget was allocated to OVC programming¹⁰³. In the past social security grants helped vulnerable and impoverished people meet basic needs. Various social protection programs and social safety net targeting OVC households have thus been established throughout the country, and cash transfers have been used to promote school attendance and health service use by OVC.¹⁰⁴

103 National AIDS Control Council (NACC) Kenya National AIDS Strategic Plan 2009/10-2012/13: Delivering on Universal Access to Services. NACC; Nairobi, Kenya: 2009. Available at: <http://www.nacc.or.ke/>. Accessed February 10, 2013.

104 Garcia M. The Cash Dividend: The Rise of Cash Transfer Programs in Sub-Saharan Africa. World Bank; Washington, DC: 2012. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDS/IB/2012/03/01/000386194_20120301002842/Rendered/PDF/672080PUB0EPI0020Box367844B09953137.pdf. Accessed May 24, 2013.

A rapid assessment, analysis and action planning process (RAAAPP) conducted in 2004 identified the need to urgently develop a National Plan of Action (NPA) to address the needs of OVC and to guide OVC interventions in the country. Based on RAAAPP recommendations a Draft National policy on OVC was developed to express and mobilize political will, provide a moral compass, offer a blueprint for activities and coordinate interventions and specify roles for all sectors.

After the development of the draft policy on OVC, the National Steering Committee on OVC spearheaded the development of the NPA on OVC that would actualize the policy. The process was broadly consultative and stakeholders were involved in every stage.

The National Plan of Action (NPA 2015) was established to address the needs of OVC and to guide OVC interventions in the country. The national Plan of Action outlines 7 Priority Service Areas (PSAs) that provide a basis for OVC intervention. These include:

- a. Strengthen the capacity of families to protect and care for OVC;
- b. Mobilize and support community based responses;
- c. Ensure access for OVC to essential services, including but not limited to education, health care, birth registration, psychosocial support and legal protection;
- d. Ensure that improved policy and legislation are put in place to protect the most vulnerable children;
- e. Create a supportive environment for children and families affected by HIV and AIDS;
- f. Strengthen and support national coordination and institutional structures;
- g. Strengthen national capacity to monitor and evaluate programme effectiveness and quality;¹⁰⁵

¹⁰⁵ National Plan of Action (POA), 2007-2010.

NPA Objectives include: To increase family based care and retention of OVC within family/ household set up; To increase care and support of OVC by communities; To increase access by OVC to essential services including but not limited to education, health care, nutrition, birth registration, legal aid, and reproductive health; To ensure that appropriate policies and legislation for protection and care of OVC are in place and operational; To create a supportive environment for children and families affected by HIV and AIDS and To increase the capacity of government and other institutional structures to coordinate OVC interventions.

Community based interventions

Traditionally, communities have their own structure for caring for children in need of care across cultures. This has mostly happened through extended family or kinship members, usually a granny or aunt. Although this is still prevalent today, the forms of these family structures have evolved with time competing with new interests and demands of the time. Consequently, the capacity of families to take in extended family orphans is diminishing.¹⁰⁶ Community interventions for children who have been orphaned or rendered vulnerable take many forms, including educational assistance, home-based care, legal protection and psychosocial support.

¹⁰⁶ Harber, M. (1998) Who Will Care for the Children? Social Policy Implications for the Care and Welfare of Children Affected by HIV/AIDS in KwaZulu-Natal. Research Report No. 17. Durban: University of Durban, School of Development Studies.

Key Findings from An assessment by Boston University Center for Global Health and Development in collaboration with University of Nairobi Institute for Development Studies in August 2009

- Exact number of OVC not known.
- UNAIDS: 1.4 million orphans.
- NACC: 2.4 million orphans; 1.2 million due to AIDS.
- UNGASS report: 100,000 children living with HIV.
- UNICEF: 1.9 million OVC.

National Response:

- National OVC Policy, National Plan of Action, and a National OVC Steering Committee, Cash subsidy to households caring for OVC.
- Support community based responses to increase OVC access to essential services
- USG/PEPFAR Support: OVCs reached = 533,700
- From 23 organizations sampled 78% of OVC services are provided by NGOs; and 91% are funded by foreign donors. 63% indicated inadequate funding as a major challenge.

Major gaps in the OVC knowledge base include inadequate data on:

- Magnitude and characterization of the OVC population
- Effectiveness and impact of OVC interventions
- drivers of children's vulnerability and effective interventions

TYOLOGY OF APPROACHES TO THE CARE OF CHILDREN ORPHANED BY AIDS AND OTHER VULNERABLE CHILDREN

The following extract provides a summary of the kinds of services available to OVCs

1. Independent orphan household: orphan children living on their own, without any formal help.
2. Informal /Non-statutory foster care: informal care offered by community members to vulnerable children in their area. This can also be seen as indigenous care.
3. Community based support structures: income generation or awareness programmes, which identify and support children and their caregivers.
4. Home-based care and support: care offered to chronically ill people (adults and children) is extended to the dependants of the patients.
5. Statutory adoption and foster care: services provided by the Child Welfare Services and residential settings.
6. Non-statutory residential care: private homes opened to vulnerable children.
7. Statutory residential care: street children's shelters, government places-of-safety and children's homes either in cottage formation or dormitory style.

Source: UNICEF, 2001. Approaches to caring for children orphaned by aids and other vulnerable children essential elements for a quality service by Heidi Loening-Voysey and Theresa Wilson. Report Prepared for the United Nations Children's Fund (UNICEF) by the Institute for Urban Primary Health Care (IUPHC) February 2001.

The text box below illustrates some of the **approaches to the care of children orphaned by AIDS, and other vulnerable children.**

The text below illustrates a summary of 5x5 Model in care of OVC.

Promising practices

The 5x5 Model

This model sets forth five areas of impact for comprehensive interventions that are necessary for helping young OVC survive and thrive: (1) food and nutrition; (2) child development, inclusive of physical (gross and fine motor development), cognitive (language and sensory development), and socio-emotional (addressing psychological and emotional development); (3) economic strengthening; (4) health; and (5) child protection. Within each of these areas, there are five levels of protection: The individual child, the family/caregivers, the child care setting, the community (including health and municipal services), and national policy wider policy environment, with a focus on national ministries of health and education.

Under the 5x5 model, while the child is the central focus, the child care setting, from nursery to formal school since such settings provide cost effective opportunities to deliver integrated services to a number of children at once. A second target for intervention after the child is the caregiver and the child's family, with an emphasis on enhancing parenting skills and improving household economic security. Central to the 5x5 model is building the capacity of childcare centers to facilitate early childhood development and education while empowering caregivers and communities to improve the lives of young OVC and their families. Advocacy around these interventions should ultimately lead to changes in the larger policy environment to reflect recognition of early childhood development as a national priority.

Source: USAID, CARE and Hope for African Children Initiative, Promising Practices: promoting Early Childhood Development for OVC in Resource Constrained Settings: The 5x5 Model.

3.2. Findings from field assessments

Socio Demographic Characteristics

A total of 378 boys and 400 young girls were interviewed in the quantitative study. The socio-demographic profile of young people is presented Table 1.

Socio Demographic Characteristics	Male		Female	
	N	%	n	%
Age Groups (in years)				
15-17	153	42.5	155	41.1
18-20	114	31.7	116	30.8
21-24	93	25.8	106	28.1
Current marital status:				
Single	329	98.5	294	91
Married	5	1.5	29	9
Has ever-attended school:				
Yes	364	98.9	386	99.5
No	4	1.1	2	0.5
Respondents' Religion:				
None	4	1.1	1	0.3
Catholic	88	23.4	84	21.1
Protestant	267	71	295	74.1
Orthodox	8	2.1	12	3
Islam	9	2.4	6	1.5
Has ever worked for pay:				
Yes	207	54.8	153	38.3
No	171	45.2	247	61.8
Orphan - hood and Vulnerability:				
Both Mother and Father Alive	113	30.5	130	33.8
Total Orphan	85	23.0	74	19.2
Partial Orphan, Mother Alive	120	32.4	138	35.8
Partial Orphan, Father Alive	52	14.1	43	11.2
Leisure activity:				
Games & Sports	300	79.4	241	60.3
Read	200	52.9	246	61.5
Watches movies	154	40.7	140	35.0

Socio Demographic Characteristics	Male		Female	
	N	%	n	%
Age Groups (in years)				
Attend religious activities	129	34.1	173	43.3
Goes to parties	59	15.6	56	14
Drink alcohol	28	7.4	42	10.5
Goes to clubs	24	6.3	21	5.3
Take drugs	13	3.4	14	3.5

Table 1: Socio-demographic profile of boys and girls interviewed

The socio-demographic profile of young people interviewed shows no major differences across gender as shown in Table 1. Majority of the boys and AGYW interviewed were aged 15-17 years (boys – 42.5%, girls – 41.1%). About 31.7% of adolescent boys and 30.8% of girls and young women interviewed were aged 18-20 years. Majority of the young people interviewed (males - 98.5%, females – 91.0%) were single at the time of the study. Proportion of both adolescent boys and AGYW who were single was significantly higher across the two counties of Kisumu and Homa Bay.

Level of Education and Literacy of the young people in Homa Bay and Kisumu Counties

Majority of both males and females interviewed had ever attended school (males – 98.9%, females – 99.5%). Almost all young people interviewed (96% of males and 97% of AGYW) reported being able to read. About 26% of males and 28% of females had incomplete or no primary school education. Among those interviewed in the survey, about 57% of males and 50% of females were still in school at the time of the study as full-time students (see Figure 1).

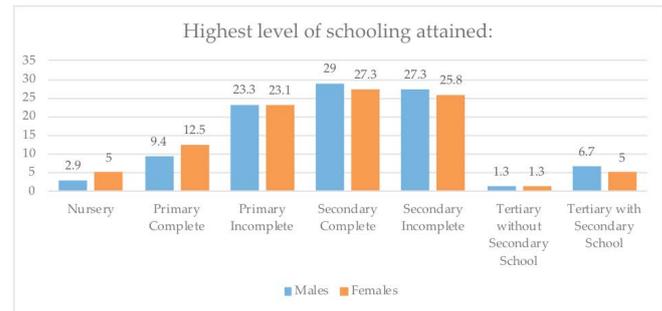


Figure 3: Highest level of schooling attained

Religion and Religiosity among young people in Homa Bay and Kisumu Counties

A profile of young people by religion revealed that majority of the respondents were protestants (males – 71.0%, females – 74%) followed by Catholics (males – 23%, females – 21%).

The frequency of attending religious services amongst those interviewed showed similar trends across gender as majority of the young people interviewed confirmed attending religious services at least once a week (males – 83%, females – 87%). Most of the young respondents consider religion very important in their lives (males – 62%, females – 68%) and just about 36% of males and 32% of females consider religion as important.

Young people by their Engagement in Paid work in Homa Bay and Kisumu Counties

The employment profile of the young people interviewed shows that majority of males compared to AGYW have ever worked for pay (males – 55%, females - 38%) with median age at first paid work being 16 years for males and 18 years for females.

Males reported lower ages at first work for pay (7 years) compared to females at 10 years. Over half (51%, n=105) of the young males interviewed were working for pay at the time of the interview compared to about 38% (n=59) of the young females interviewed.

For the young people working for pay at the time of the interview, the median hours of work in a day was 7 hours and 5 days in a week for males and 8 hours a day and 5 days a week for females implying that females were working longer compared to males for the same kind of work for which they were being paid for. Males reported working a maximum of 12 hours a day compared to a maximum of 14 hours a day for some females.

Young people engaged in different kinds of paid work. These include:- domestic work, farm labour, fishing, boda boda transport, hawking, and local business among many others. Most of the males (31%) mainly engaged in farm labour as paid work. For AGYW interviewed, the most common type of paid labour was hawking or local small businesses (39%). About 15% of the adolescent boys interviewed engaged in hawking (15%) and *boda boda* riding (15%).

For the most common types of paid work reported, majority of the young people interviewed were paid daily (males – 74%, females - 51%) followed by monthly (males – 23%, females – 33%). Most of those who were paid daily were males since they were mostly engaged in farm labour and *boda boda* riding. The median amount of payment made for the work done was KES 400 a day for males and KES 500 a day for females.

Among the young people interviewed, about 46% males and 38% of the females were looking for employment at the time of the interview with about 52% of the males and 59% of the females not looking for any employment at the time of the survey. Bivariate analysis shows that the proportions of males who have ever worked for pay was significantly higher in Homa Bay (68%, n=119) compared to Kisumu (43%, n=87).

This proportion was however significantly lower among the AGYW in both counties (Homa Bay – 46%, Kisumu – 30%). In terms of ages of young people who have ever worked for pay, 50% (76) of males aged 15-17 years, 54% (61) of males aged 18-20 years and 73% (68) of males aged 21-24 years have ever worked for pay. On the other hand, 21% (33), 42% (49) and 65% (69) of females aged 15-17 years, 18-20 years and 21-24 years had worked for pay. Proportion of both males and females who have worked for pay was significantly higher among young people aged 18 – 20 years.

At the time of the survey, about 64% (76) and 32% (28) of males in Homa Bay and in Kisumu Counties were engaged in paid work while 54% (53) and 11% (49) of the AGYW in Homa Bay and Kisumu Counties were engaged in paid work. About 43% (33) of boys aged 15-17, 67% (41) of boys aged 18-20, and 44% 21-24 years had ever worked for pay at the time of the study. Among the girls, 18% (6) of those aged 15-17 years, 37% (18) 18-20 years and 49% of those aged 21-24 years reported to have ever worked for pay. Proportion of both young men and AGYW were significantly higher in Homa Bay compared to Kisumu Counties and among those aged 18-24 years.

Orphan hood Status and Family Support Systems in Homa Bay and Kisumu County

Regarding the vulnerability of the young people interviewed, most of the respondents were partial orphans (males – 46.5%, females – 47%) – see Table 5 - with 69.8% of the males who were partial orphans not having their fathers alive compared to 76.2% of the females. About 23.0% of the males and 19.2% of the females were total orphans.

Majority of the young people whose biological fathers were alive lived with them in the same household (males – 78%, females – 61%) with a similar trend being reported among young people whose mothers were alive (males – 77%, females – 65%). In both the cases where biological father or mother is alive, fewer girls compared to boys lived with them in the same household. For partial orphans or those young people with both parents, poverty was the most common vulnerability.

Of the young people in both the counties, 88% (52), 79% (42) and 57% (21) of young men aged 15-17 years, 18-20 years and 21-24 years lived with their biological fathers in the same households compared to about 71% (44), 67% (38) and 38% (17) of AGYW in the same age categories living with their biological fathers. About 82% (74), 75% (57) and 74% (40) young men aged 15-17 years, 18-20 years and 21-24 years compared to 70% (73), 68% (54) and 52% (52) of AGYW in the same age categories were still living in the same household with their biological mothers. Fewer young people aged 18-20 years are living with their biological parents compared to those aged 15-17 years. Age is thus associated with whether a young person stays with their biological parents or not.

Young people and leisure activities in Homa Bay and Kisumu Counties

Young people engage in various leisure activities. Study findings show that males participated in a range of leisure activities which mainly included: games and sports (79%), reading (53%), watching movies (41%) and attending religious activities (34%).

For females, the most common leisure activities they take part in are: -reading (62%), games and sports (60%), attending religious activities (43%) and watching movies (35%). Young people also engage in music, art and design, social interactions such as visiting friends and relations as well as social media interactions. In addition to these, females also like mentoring each other through motivational speaking. The young people in the study reported engaging in these activities occasionally.

For the young people who engaged in sports and games, majority of the males engaged in football (77%), volleyball (8.2%) and athletics (3.6%) while for females 46% engaged in football, 26% in netball, and 13% in volleyball as is depicted in Table 2. Most of the young people engage in sporting activities in schools (males – 48%, females – 40%) though a significant number of males compared to females engaged in sports through established clubs. Home and open grounds were the other places where young people engage in sports and games for leisure.

Common SRHR problems affecting orphaned and vulnerable adolescent girls

The common reproductive health and justice challenges confronting orphaned and vulnerable adolescent girls in Kisumu and Homa Bay Counties according to the qualitative assessment include: challenges of managing menstruation and personal hygiene; lack of sanitary towels affecting school attendance for the young girls; low levels of knowledge on contraceptive, unprotected early sexual activities, unplanned pregnancies, unsafe abortions and increased risks of STI and HIV infections; school drop-outs leading to early marriages; sexual abuse including rape and defilement by guardians; lack of information and guidance on sex, sexuality, growing up and sexual reproductive health rights.

Other challenges include lack of skill for managing peer pressure, drug abuse and trafficking, poor performance resulting in class repetitions, idleness and hopelessness, psychological trauma and attitude associated with death of parents and weakened family support.

“...Another point is, failure to afford the sanitary pads can make them have low esteem as others will be laughing at her after soiling her uniform. This will make her not go to school. Some undergo a lot from home. Some also have developed bad characters, due to bad mentality about who murdered their parents; this also hinders them from attending school.” FGD participant, Seme Elders, Kisumu.

“We have got the STI diseases ... HIV & AIDS, Food Shortage.” Participants, Mixed adults FGD, Kasipul South, Homa Bay

“...they give birth prematurely, not only the boda boda riders that impregnate them, but also some of the relatives that they stay with can abuse them sexually. FGD participant, Seme Elders, Kisumu.

The main issues around land and property rights for young people in Homa Bay and Kisumu Counties were established to be: - lack of awareness of land and property rights, for those aware, lack of money to file cases on land and property violations, disinheritance and abandonment after the death of parents or guardians. This was compounded by poverty, corruption making it difficult for perpetrators to be brought to justice, poor decision making due to disempowerment and ignorance about their land and property rights.

Qualitative study findings show that some cultural beliefs and practices are perceived to contribute to disinheritance of young people especially girls of their property as they ‘promote’ an agenda of male superiority; in addition many of the children whose parents died of HIV and AIDS are stigmatized and discriminated against. This affects them psychologically leading to increased cases of orphaned and vulnerable children running away from homes seeking shelter in small towns, on the streets and in criminal gangs consequently leaving the land they are entitled to behind for their relatives to take up.

These findings show deep entrenchment of patriarchal system where the orphaned girls were not listed as land and property owners in judicial cases. This leads to loss of their property and land rights under the watch of even those considered as potential watchdogs such as chiefs.

“There are cases where after the death of the parents the orphans may be forced into the streets becoming street children.” FGD, Young Girls, Jiu Pachi CBO, Kisumu.

“The orphaned girls some of them act as head of families and due to this process, you find that they are still young in decision making.

They are not empowered as far as decision making is important. So sometimes we find that the male patriarch does not give opportunity in the community to have some say over the land that their parents left for them so sometimes you find that the land is either sold or used without proper consent because they perceive that they are still young and they do not have that ability to have say so they are always overlook their right of land..."
Participants, Mixed FGD with adults in Kasipul South, Homa Bay

"They are involved in selling drugs so that they can meet their basic needs." **FGD participant, Young Girls, Jiu Pachi, Kisumu.**

"At least a man will talk, and his voice will be heard. They also believe that girl child should not inherit anything like land" **FGD participant, Young Girls, Mwangaza Kisumu.**

"Inheritance-land which affects women and children more as men die early due to HIV/AIDS related issues. Uncles apply for succession without declaring the orphaned children or widows. Again, Chiefs write letters only recognizing the men. They are driven by cultural socialization where the girls are believed not to inherit land. We try to sensitize them to include all living and dead members of the family to ensure they are taken care of by all the family members. Sometimes they believe the women are the cause of the husband's death.

Land issues are common and difficult to deal with especially where there are no title deeds so taking over that land becomes an issue. Law of succession talks about children of the deceased but there is little awareness of these issues in the community and orphans are intimidated not to claim their rights. **Key informant interview Judicial Officer Homa Bay.**

3.2.1 Knowledge and attitude on sexual and reproductive health and rights components

Common Sources of information on SRH – Puberty, Pregnancy and Relationships among young people in Homa Bay and Kisumu Counties

Young people have varied sources of information on SRH issues. The survey asked young people to state their main sources of information on puberty, pregnancy and relationships among other sexual reproductive health issues that affect them. Survey findings established that the most common source of information for young people on puberty include: the school teacher (male – 85%, female – 85%) members of the family for (males 51.6%; females- 41.5%) and mother (males-36%; females-60%).

Sources of information on pregnancy for young people were: school teachers (males - 85%, females – 75%) followed by friends (males-33%; females-34%) and mothers (females (58%; males 29%). School teachers were also the most common as a source of information on relationships for young people (males – 71%, females – 61%) followed by friends for males (49%) and mother for females (53%) and finally mother for males (53%) and friends for females (51%).

The study established that young people rely on various mass media platforms for information on puberty, pregnancy and relationships. Results are displayed in Table 2.

Sources of information on SRH Issues:	Puberty		Pregnancy:		Relationships:	
	Male, % (n)	Female, % (n)	Male, % (n)	Female, % (n)	Male, % (n)	Female, % (n)
People as Sources of information:						
School teacher	84.9% (321)	85.3% (341)	85.2% (322)	75.3% (301)	70.6% (267)	60.8% (243)
Mother	36.2% (137%)	60.3% (241)	28.8% (109)	57.5% (230)	31% (117)	52.8% (211)
Father	16.4% (62)	9.0% (36)	10.6% (40)	8.3% (33)	14% (53)	7.8% (31)
Brother	19.8% (75)	13.5% (54)	15.6% (59)	10.0% (40)	25.1% (95)	14.8% (59)
Sister	6.3% (24)	22.8% (91)	8.7% (33)	23.0% (92)	9.3% (35)	27.3% (109)
Other family	16.7% (63)	27.0% (108)	8.2% (31)	13.5% (54)	7.7% (29)	12.0% (48)
Members	51.6% (195)	41.5% (166)	32.0% (121)	30.5% (122)	28% (106)	26.5% (106)
Friends	0.0% (0)	0.0% (0)	33.1% (125)	33.8% (135)	49.2% (186)	50.8% (203)
Peer Educators	0.0% (0)	0.0% (0)	8.5% (32)	8.3% (33)	10.6% (40)	10.8% (43)
Mentors	0.0% (0)	0.0% (0)	4.5% (17)	4.0% (16)	5.6% (21)	5.5% (22)
CHV	0.0% (0)	0.0% (0)	11.6% (44)	7.8% (31)	2.4% (9)	3.3% (13)
Medical Doctor	9.0% (34)	8.0% (32)	7.4% (28)	10.3% (41)	3.7% (14)	3.0% (12)
Other Health Care Providers	0.0% (0)	0.0% (0)	7.9% (30)	6.0% (24)	4.2% (16)	4.0% (16)
Elders	7.1% (27)	4.0% (16)	4.0% (15)	3.3% (13)	3.7% (14)	2.3% (9)
Widows	0.3% (1)	0 (0.0%)	2.6% (10)	1.8% (7)	3.2% (12)	1.5% (6)
Neighbors	11.4% (43)	7.8% (31)	5.8% (22)	5.8% (23)	0.5% (2)	0.3% (1)
Other People	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	1.2% (4)
Social Media Sources:						
TV	59.5% (225)	59.0% (236)	61.6% (233)	60.3% (241)	54.2% (205)	55.0% (220)
Radio	80.7% (305)	78.5% (314)	81% (306)	78% (312)	79.9% (302)	81.5% (326)
Facebook	21.7% (82)	19.8% (79)	21.4% (81)	20.0% (80)	24.3% (92)	21.3% (85)
SMS(phone)	6.3% (24)	6.3% (25)	7.4% (28)	7.8% (31)	7.9% (30)	6.8% (27)
WhatsApp	11.9% (45)	11.5% (46)	0.5% (2)	0.8% (3)	13.8% (52)	12.5% (50)
Twitter	2.6% (10)	3.0% (12)	13.2% (50)	16.5% (66)	8.2% (31)	8.0% (32)
Instagram	2.6% (10)	1.3% (5)	2.6% (10)	3.0% (12)	2.6% (10)	1.3% (5)
Sanitary pads packets	0.5% (2)	2.8% (11)	0.0% (0)	1.0% (4)	5.6% (21)	6.0% (24)
Book/magazine	31.5% (119)	37.5% (150)	34.7% (131)	38.5% (154)	33.1% (125)	38.8% (155)
Films/Videos	8.2% (31)	7.5% (30)	5.0% (19)	7.0% (28)	9.8% (37)	9.3% (37)

Table 2: Media sources of information on sexual and reproductive health issues

The most common mass media sources of information on puberty among young people are radios (males - 81%, females - 79%), Televisions (males - 60%, females - 59%) and books or magazines (males - 32%, females - 38%) in that order. The trend was similar also for common sources of information on pregnancy among young people that is Radio (females - 80%, males - 82%), Television (males - 54%, females - 55%) and books or magazines (males - 35%, females - 39%).

On relationships, the trend was the same for proportion of young men and women where the most common source of information was established to be radio (males - 80%, females - 82%), television (males - 54%, females - 55%) and books or magazines (males - 33%, females - 39%).

Important and preferred sources of information on SRH – Puberty

The results are presented in Table 3.

Source of information:	Male, % (n)	Female, % (n)
Most Important source of information on Puberty (person):		
School Teacher	50.8% (187)	43.6% (170)
Mother	14.7% (54)	27.4% (107)
Friends	12.2% (45)	7.9% (31)
Father	6.3% (23)	-
Brother	3.5% (13)	-
Sister	-	4.9% (19)
Other Family Members	-	5.4% (21)
Media source:		
Radio	48.4% (177)	46.5% (180)
TV	21.3% (78)	25.3% (98)
Books/Magazines	17.8% (65)	2.3% (9)
Instagram	-	16.8% (65)
Facebook	5.7% (21)	4.1% (16)
WhatsApp	3.0% (11)	
Most Important source of information on Pregnancy (Person):		
School Teacher	48.6% (179)	35.1% (134)
Mother	12.8% (47)	32.5% (124)
Friends	10.9% (40)	3.9% (15)
Other Family Members	5.4% (20)	3.9% (15)
Peer Educator	4.1% (15)	2.6% (6)
Media source:		
Radio	38.4% (139)	36.2% (142)
TV	35.9% (130)	32.4% (127)
Twitter	14.9% (54)	19.4% (76)

Source of information:	Male, % (n)	Female, % (n)
Facebook	5.8% (21)	4.6% (18)
Others	1.9% (7)	2.6% (10)
The most Important source of information on relationship (Person):		
School Teacher	32.6% (120)	23.5% (93)
Mother	14.1% (52)	33.7% (133)
Friends	22.3% (82)	
Peer Educator	6.8% (25)	
Father	5.7% (21)	
Other Family Members		17.0% (67)
Brother		7.8% (31)
Friends		6.6% (26)
Mass media source		
Radio	37.5% (141)	39.8% (159)
TV	27.9% (105)	24.8% (99)
Books/Magazines	17.6% (66)	22.5% (90%)
Facebook	7.7% (29)	5.0% (20)
WhatsApp	3.2% (12)	2.8% (11)

Table 3: Most Important source of information on SRH topics

As shown in Table 3 of the sources of information mentioned, school teacher (51%), mothers (15%), friends (12%), fathers (6%) and brothers (3.5%) remain the most important source of information on puberty for males from the study area in that order among other sources. For females, school teachers (44%), mother (27%), friends (8%), other family members (5.4%) and sisters (5%) were considered important in that order.

On the most preferred source of information on puberty, males were found to prefer school teachers (43%) and their friends (17%) with the school teachers remaining the most preferred source of information for females (30%) followed closely by mothers at 29%.

The most important media source of information on puberty for males interviewed was radio (49%), TV (21%) and books or magazines (18%) in that order while for females, it was radio (47%), TV (25%), Instagram (17%) and Facebook (4%) as illustrated in Table 3. On average, the most preferred media source of information for young people interviewed was the radio (male - 36%, females - 42%) followed by TV (female -26%, male - 25%).

On pregnancy, the school teacher (males -49%, mother -35%), mother (13%, 33%), and friends (males - 11%, females - 4%) remained the most important people sources of information for both the males and females interviewed – see Table 3. School teachers (males – 31%, females – 31%) and friends (females - 22%, females - 22%) remain the first and the second most preferred source of information on pregnancy for both males and females.

For mass media sources, radio (male – 38%, female – 36%) and TV (male – 36%, female – 32%) were the most important source of information on pregnancy. The trends were established to be similar among males and females as far as the most preferred media source of information on pregnancy were: radio (males – 39%, females – 40%) followed by TV (male – 29%, female – 28%) and books or magazines (females - 11%, males – 12%) among many other media sources of information.

School teacher remained the most important source of information on relationships among males (33%) followed by friends (22%) and mothers (14%) in that order while for the females, mothers (34%), school teachers (24%) and other family members (17%) rank higher as the most important source of information for the females – see Table 3 above.

In terms of the most preferred source of information on relationships, school teacher (27%) and friends (26%) were in the first and second position for males and mothers (31%) and friends (19%) for females respectively.

The most important media source of information on relationships for both males and females were: Radio (males – 38%, females – 40%, Television (males – 28%, females – 25%) and books or magazines (males – 18%, females – 23%) in that order for males and females interviewed. In terms of the most preferred media source of information on relationships, radio (males – 34%, females – 42%) and television (males – 29%, females – 25%) still ranked higher for both the male and females interviewed in the study.

The most important media source of information on puberty for males interviewed were radio (49%), TV (21%) and books or magazines (18%) in that order while for females, it was radio (47%), TV (25%), Instagram (17%) and Facebook (4%) as illustrated in Table 3. Overall, the most preferred media source of information for young people interviewed was the radio (male - 36%, females – 42%) followed by TV (female -26%, male - 25%).

On pregnancy, the school teacher (males -49%, mother -35%), mother (13%, 33%), and friends (males - 11%, females - 4%) remained the most important people sources of information for both the males and females interviewed – see Table 3. School teachers (males – 31%, females – 31%) and friends (females - 22%, females - 22%) remain the first and the second most preferred source of information on pregnancy for both males and females.

For mass media sources, radio (male – 38%, female – 36%) and TV (male – 36%, female – 32%) were the most important source of information on pregnancy.

Similar trends were established for both males and females as far as the most preferred media source of information on pregnancy were concerned: most preferred source was radio (males – 39%, females – 40%) followed by TV (male – 29%, female – 28%) and lastly books or magazines (females - 11%, males – 12%).

School teacher remains the most important source of information on relationships among males (33%) followed by friends (22%) and mothers (14%) in that order while for the females, mothers (34%), school teachers (24%) and other family members (17%) rank higher in terms of important source of information– see Table 3.

Overall, in terms of the most preferred source of information on relationships, school teacher (27%) and friends (26%) were in the first and second position for males and mothers (31%) and friends (19%) for females respectively.

The most important media source of information on relationships for both males and females were: Radio (males – 38%, females – 40%, Television (males – 28%, females – 25%) and books or magazines (males – 18%, females – 23%) in that order for males and AGYW interviewed. Radio (males – 34%, females – 42%) and television (males – 29%, females – 25%) still ranked higher for both the male and females interviewed in the study in terms of the most preferred media source of information on relationships.

Access to a mobile phone

Proliferation of mobile phone usage in the Kenya has increased access to a variety of information on different issues including sexual and reproductive health issues. Young people particularly use mobile phone for communication and accessing social media. The baseline survey investigated access to mobile phones in Kisumu and Homa Bay Counties. Findings show that most young people have access to a mobile phone (males – 91%, females – 86%) with females having lower access. Of the young people with access to mobile phones, majority were in control of the said mobile phones (males – 77%, females – 61%) with about 16% fewer females than males having such control. This was followed by parents and guardians as controllers of mobile phone access for both the males (19%) and females (30%) interviewed as shown in Figure 4.

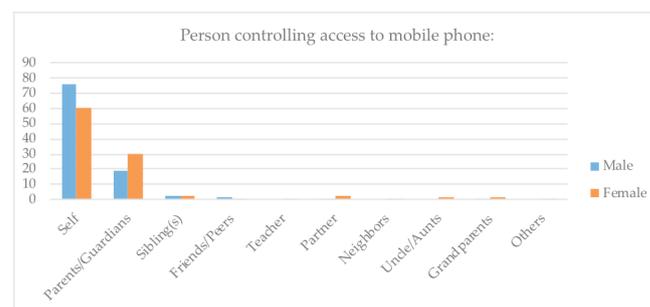


Figure 4: Person controlling access to mobile phone

Lessons on sexual reproductive health in schools

Among the young men and AGYW interviewed, majority (males – 89%, females – 92%) had ever attended lessons on sexual reproductive health such as puberty, SRH systems, or relationships between boys and girls.

In fact, most those interviewed confirmed having attended classes on puberty; pregnancy and relationships during their current or previous days in school (males – 98%, females – 97%). Majority of the males and females interviewed also felt that lessons on sexual reproductive health in schools are important and that more classes on SRH males – 93%, females – 94%) should be provided - see Table 4.

Lessons on puberty, pregnancy and relationship in school:	Male		Female	
	n	%	N	%
Was in a school with lessons on puberty, SRH systems and on relationships between boys and girls:				
Yes	330	88.5	364	91.5
No	43	11.5	28	7
Not Sure	0	0.0	6	1.5
Has ever attended classes on puberty, pregnancy and relationships:				
Yes	322	97.9	357	97
No	7	2.1	10	2.7
Not Sure	0	0.0	1	0.3
Thinks classes on SRH topics are important for Adolescents and young people:				
Yes	323	98.5	360	98.1
No	2	0.6	5	1.4
Not Sure	3	0.9	2	0.5

Table 4: Participation in lessons on puberty, pregnancy and relationship in school

Knowledge of a girl's safe days

A basic understanding of the reproductive cycle is important for successful use of coitus-related methods of contraception such as the rhythm method.¹⁰⁷

107 KNBS (Kenya National Bureau of Statistics), Ministry of Health (MOH), National AIDS Control Council (NACC), Kenya Medical Research Institute (KEMRI), National Council for Population and Development (NCPD), & ICF International (2015). Kenya Demographic and Health Survey 2014. Calverton, Maryland: KNBS,

The successful practice of such methods depends in large part on understanding when during the ovulatory cycle a woman is most likely to conceive. (ibid) Both boys and girls in the survey were asked about knowledge of a girl's safe days. Results are presented in Figure 5.

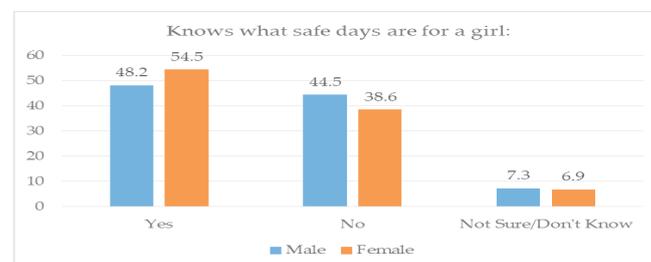


Figure 5: Knowledge on safe days for girls

Results displayed in Figure 3 indicate that Females were slightly more likely to know what safe days were (54%) compared to males (48%). On the other hand almost half (45%) of males and 39% of females interviewed did not know what safe days were for the girls.

3.2.2 Relationships and sexual activities among young people in Homa Bay and Kisumu Counties

To understand the relationships and sexual activities of the young people in both Homa Bay and Kisumu Counties, the general perceptions of young people on relationships and sex was sought. Young people were exposed to several statements to gauge their general perceptions on relationships and sex. Understanding these perceptions was critical in understanding the levels of awareness of young people of issues around relationships and sex and how this helps inform their sexual activities.

MOH, NACC, KEMRI, NCPD and ICF International.

Results from the quantitative survey show that nearly all male (99%) and female (99%) respondents disapproved of incest. Equally, nearly all (males – 99%, females – 98%) disapprove of the exchange of sex for food. Most of the male (90%) and female (87%) respondents disapprove of sexual harassment.

Over two thirds of the respondents believed that girls should remain virgins until they get married (males - 76%, females - 74%) and boys remain virgins until they marry (males - 73%, females - 70%). More than half of female and male respondents in the study indicated agreement with the statement that *“most girls who have sex before marriage regret it afterwards* (males - 56%, females - 57%).

On the other hand, a significant proportion displayed negative perceptions with 35 % males and 29% females indicated that they believed that *if a wife dies, it is OK for the husband to marry the sister of the deceased*. Over half of young people in the survey felt that it is alright for boys and girls to kiss, hug and touch each other (males - 55%, females - 55%).

These proportions increased to 61% of males and 63% of females who felt that there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each. It is therefore notable that although over two thirds of respondents observe the need to abstain from sex till marriage, an almost equal majority still approve of premarital sex suggesting for the need of appropriate programming strategies to tap into these inconsistent notions.

Further, majority of respondents (males - 79%, females - 81%) in the survey concurred with the statement that sometimes boys can force a girl to have sex if he loves her. These results suggest the need for appropriate messaging to counter these perceptions.

The study sought to establish the proportion of young people in sexual relationships. This baseline survey established that more than half of adolescent girls and boys and young men and women were in a sexual relationship (male; 58%, n=219), female 60%, n=238). Most of the young people currently in a sexual relationship had on average one sexual partner though cases of multiple partners were also recorded.

The males in relationships recorded between 1 and 5 partners while the females had between 1 and 3 partners. Most of the males (48%) were in a relationship with someone the same age as them while 39% were in a relationship with someone younger than them. Majority of females on the other hand were in sexual relationship with someone older than them (51%) or the same age as them (47%). This implies that a big proportion of young girls and boys are in a sexual relationship with someone older than them.

Disaggregation of young people in sexual relationships by age revealed that about 43% (66), 67% (76) and 77% (72) of the young men aged 15-17 years, 18-20 years and 21-24 years were at the time of the study in a sexual relationship. On the other hand, about 42% (66), 73% (85) and 82% (87) of the AGYW in the same age categories were at the time of the study in a sexual relationship.

Bivariate analysis showed that the association between age and current relationship status of young people was significant. More of the older young people aged between 18-24 years were at the time of the study in a sexual relationship compared to those aged 15-17 years.

Perceptions on seriousness of current relationship varied. Over a third of both girls and boys considered their current relationships as important and could lead to marriage (males; 36%, female; 35%); followed by casual (27%; males and 23%-females) or serious but with no marriage intentions (27%-males; 21%-females).

Notably the proportion of the females who considered their relationships as either casual (23%) or serious but with no marriage intentions (21%) was slightly lower compared to males who had the same perception regarding their relationship as shown in Table 5. Age is significantly associated with perception of young people towards their current relationships.

Older males and females aged 20-24 years (males -55% (n=36), females - 45% (n=38)) consider their relationships as important and could lead to marriage compared to those below aged 15-17 years (males -17% (n=9), females - 18% (n=11)).

Description of current relationship with partner:	Male		Female	
	N	%	n	%
Casual	53	27.3	52	22.9
Serious but no marriage intentions	53	27.3	47	20.7
Important/Might lead to marriage	70	36.1	81	35.7
Engaged to be married	7	3.6	29	12.8
Not Sure	11	5.7	18	7.9
Total	194	100.0	227	100.0

Table 5: Description of current relationship with partner

Majority of the young people interviewed confirmed having had some physical contact such as holding hands, hugging or kissing with their partner (males - 87%, females - 87%); having ever touched partner's vagina or penis with hand (males - 62%, females - 62%) and having had their vagina or penis touched by partner with his/her hand (males; 61%, females; 66%).

On the other hand, slightly over half of them reported having engaged in sexual intercourse (males - 50%, females - 54%). In all instances, the trend in proportion of the young people involved in these physical encounters was almost similar across the different genders as presented in Table 6.

Intimacy Experiences:	Male		Female	
	n	%	n	%
Has had some physical contact such as holding hands, hugging or kissing with partner	192	87.3	209	87.4
Has ever touched partner's vagina or penis with hand:	136	62.4	149	62.3
Has had their vagina or penis touched by partner's hand:	134	61.2	156	65.8
Has ever had sex:	190	50.3	216	54.0

Table 6: Young peoples' physical intimacy experiences

Age disaggregation of sexual encounters among young men revealed that of the young people who have had sex, 30% (46) were aged 15-17 years, 59% (67) aged 18-20 years and 77% (72) aged 21-24 years old compared to 30% (47), 67% (78) and 83% (88) of the AGYW in the same age categories respectively. There is a significant relationship between age and experience of a sexual encounter among young people.

Proportion of young men and AGYW who have ever had a sexual encounter increases with age thus more young people aged 18-24 years are engaging in sex compared to those aged 15-17 years. It is however important to note that a considerable number of minors have made their sexual debut. For the young people who have ever engaged in sexual intercourse, the median age at first sexual intercourse was 17 years for both males and females.

Survey results established that about 16% of males and 24% of females had ever had sex with a person much older than them. Unlike for self-reporting on ever had sex which was low, reporting on friends who had ever had sex was higher.

Reporting on friends who have ever had sex is often used in surveys as a proxy for sex related activities of the respondents. Cumulatively, about 82% of the male and 80% of female study respondents reported that a few, or some or many of their friends had ever had sex. These results are illustrated in Figure 6.

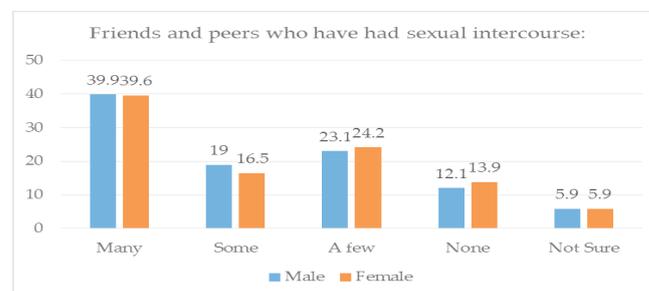


Figure 6: Friends and peers who have had sexual intercourse

For those who reported having had sex, the study investigated the working status of sexual partners. As depicted in Figure 7, majority of the young men in the study reported that their sexual partners were fulltime students (61%) while for girls their partners were employed (49%).

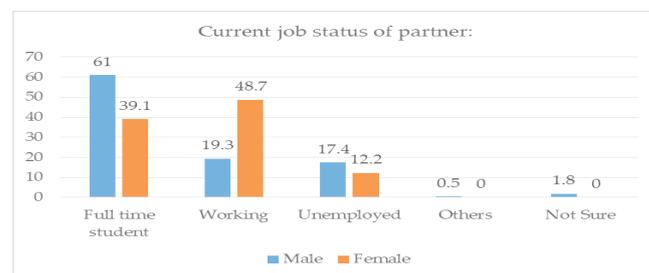


Figure 7: Current job status of partner with whom respondents had sexual intercourse

The motives for engaging in sexual encounters with older persons were: for economic gains (26%); it makes them feel nice (19%); and for other reasons (19%) in that order for the young men and for economic gain (24%), protection (20%) and because it made them feel nice (20%), in that order for the young women.

These findings resonate with the results from the qualitative assessment that most young people in Homa Bay and Kisumu Counties engaged in sexual activities at an early age due to economic reasons. Findings report exchange of sex for money, favors and gifts (free transport from *boda-boda* riders), basic commodities (food, shelter, and clothing) school fees and protection (including from neighbors). Qualitative study findings reported high sexual activities during night discos (including at disco *matanga*- funeral discos) in the rural areas especially during festive seasons.

“According to me, in this generation there is the issue of having sexual relationships with sugar daddies and sugar mummies due to peer pressure to have nice clothes and” FGD participants, Mixed Adults, Kasipul South, Homa Bay

“School going children lack basic needs like education, school uniforms, and books. Such children are taken advantage of by other boys who offer them food /drinks for exchange for sex. Such men can be promiscuous hence can give girls pregnancy or HIV. Girls with mothers or parents some offer their children good or nice things like good clothing but others the orphans do not have even an advantage hence go into immoral sex.” FGD Participant, Mixed Adults, Katinda Self-help group, Kisumu

“Poverty is also the leading cause of HIV. Like the fishermen, they sleep around with young girls in exchange of money... another thing is, these orphans have a lot of needs. They can go out, and have intercourse in exchange for those needs. They go to discos and get men to satisfy their needs.... these orphans tend to mix with others, thinking that they can get security from them and end up in drug abuse.” FGD participant, Elders, Seme, Kisumu.

Young people and pregnancy

The survey sought to establish whether the respondents had ever impregnated a girl (for boys) or ever been pregnant (for girls) and the outcome of the resulting pregnancy. About 17% of males who had ever had sexual intercourse with a woman had resulted in pregnancy. On the other hand, more females (86%) of the AGYW who reported ever having had sex with a man reported that the activity resulted in a pregnancy. These results suggest high levels of unprotected sexual activity and risks of pregnancy and STIs especially for the AGYW. Most of the girls (84%) reported that the pregnancies had resulted into live births. Among the males who reported ever impregnating a girl, half (50%) of them reported that the pregnancies resulted into a live birth. The other pregnancy outcomes for men who had ever impregnated a girl were:-pregnancy terminated/aborted (35%, n=9), girl currently pregnant (16%, n=3) and 4% (1) not sure of the pregnancy outcome. For the AGYW who had ever gotten pregnant, the outcomes were: live births (85%, n=72), currently pregnant (7%, n=6), pregnancy terminated through abortion (4%, n=3) and stillbirth and miscarriage (2% a piece).

3.2.4 Young people and SRHR information and services in Homa Bay and Kisumu Counties

Young People and Contraception

The study established contraceptive methods known by the young people. Results are displayed in Table 7.

Contraceptive Mentioned:	Male, n (%)			Female, n (%)		
	Yes (spont.)	Yes(prompt)	No	Yes (spont.)	Yes(prompt)	No
Pills	35% (131)	42% (157)	24% (90)	40% (161)	48% (191)	12% (48)
Injection	26% (96)	51 (190)	24% (90)	41% (165)	48% (191)	11% (43)
Condoms	40% (151)	52%(195)	8% (31)	39% (157)	54% (217)	6% (25)
Emergency Contraceptive Pills	10% (38)	41% (152)	49% (183)	12% (48)	52% (206)	36% (143)
Withdrawal	1% (4)	37% (128)	61% (210)	1% (3)	33% (117)	67% (239)
Periodic Abstinence	4% (14)	44% (154)	52% (180)	5% (18)	46% (169)	49% (178)

Table 7: Spontaneous and prompted knowledge of method of contraception

Among the young men, condoms were spontaneously mentioned by 40%; pills by 34.7%; injection by 25.5% and emergency. Contraceptive pills by 10.2%, periodic abstinence and withdrawal were cited by less than 5% of the young men interviewed. Most of the young women interviewed spontaneously mentioned injections (41%), pills (40%) and condoms (39%). These results indicate low levels of awareness of contraceptive methods by vulnerable AGYW with withdrawal and periodic abstinence recording the lowest proportions.

Regarding the source of contraceptive majority of the young people interviewed who mentioned knowing any contraceptive method confirmed knowing where to get injections (males – 72%, females - 85%), pills (males – 69%, females – 79%) and condoms (males – 66%, females – 71%) among other contraceptive methods (see Figure 8). For each of the contraceptive, more females compared to males knew where to get such methods particularly emergency contraceptives, IUCD and implants.

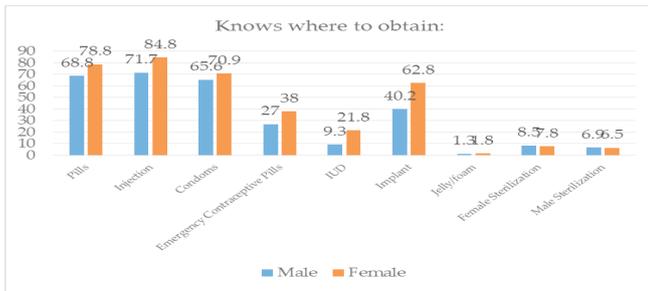


Figure 8: Knowledge of where to obtain method

The most commonly used contraceptive method for young people was condoms (males – 63%, females – 51%). About 44% of the young men and 46% of the women interviewed confirmed having ever used condoms at some point in their life.

Results indicate the decision on the choice of contraceptive method for majority of the young people interviewed was determined jointly with their partners (males – 64%, females – 59%) or individually (males – 25%, females – 32%), or by either their partners, siblings or other people (males 13.3%- and females- 8.6%). From the foregoing, women were more in control of their own contraceptive choices when compared to their male counterparts.

Access and utilization of Health service by young people in Homa Bay and Kisumu Counties

Findings from the qualitative study revealed that young people seek a wide range of sexual reproductive health services from the health facilities in both Homa Bay and Kisumu Counties. These include: contraception particularly the e-pill and condoms; STI screening, treatment and counseling; HIV testing, counseling and treatment; pregnancy testing, antenatal services,

SRH counseling; breast and cervical cancer screening; post abortion care services; ante-natal care services; menstrual counseling, pregnancy tests, and voluntary medical male circumcision. However, access and utilization of to these services are however hampered by low knowledge levels of the availability of these services, poor health seeking behavior compounded by fear of health care providers in public health facilities from where these services are provided for free more specifically contraceptive methods.

The findings further demonstrate that most of the young people seeking health services from public facilities do so when they have been brought from schools (adolescent girls in school specifically) for other health services. Most of the young people out of school seem to use the public facilities as a last resort when they are very seriously ill – a time during which they seek SRH services. Most young people fear seeking reproductive health information and services from public health facilities. This is due to perceived unfriendliness of the services, negative service provider attitudes, lack of confidentiality and privacy and fear of meeting parents and guardians at the health facilities.

The findings indicate that adolescents and young people rely on getting information and services on SRHR from the media sources, chemists or private clinics, peers and community health workers than from the staff at the public health facilities where they can access the same for free. These are preferred because they are fast in service delivery, maintain anonymity and do not ask for parental/guardian escorts and/or consent to provide SRH services.

Some young people, mostly due to poverty, go to traditional herbalists for treatment of STIs including inducing abortion. This lack of utilization of the family planning commodities available for young people in the public health facilities have were reported to lead to expiry of health commodities consequently leading to wastages across most of the public health facilities.

" Our chemists within Kisumu report to us that there is a high number of young girls buying the EC pills every Friday and Monday yet we have this EC pills in our facilities for free. In fact, last year, a good number expired in our public facilities... Most of them [AGYW] come here when they've been asked to come by their parents and guardians or very sick. The majority are brought from schools when they get sick in school. Most of those out of school fear coming and if they come they come when they are very sick. Many of them prefer to go over the counter they buy drugs because they fear... like even these young girls who engage in unprotected sex they always go over the counter to buy this e-pill ..." **Key informant interviews, MOH, Kisumu.**

"...they fear going there it's because of our staff attitude, so our staff also need to be trained on how to handle the young people. When they come and tell you that I had unprotected sex not to impose our values on them. Actually we should just support them and after we give them we tell them fine we give you the EC pill but then we have to on a regular mode if you don't want to get pregnant then you should protect yourself but most of our staff are not well trained on how to handle adolescents on matters relating to sexual reproductive health." **Key informant interview, MOH official Kisumu.**

Discussion on contraception

Most young people confirmed discussing contraception with their sexual partners (males – 79%, females – 85%). Among these, about 89% of young men and 88% of young women in sexual relationships reported having discussed contraception before sexual intercourse as shown in Figure 9.

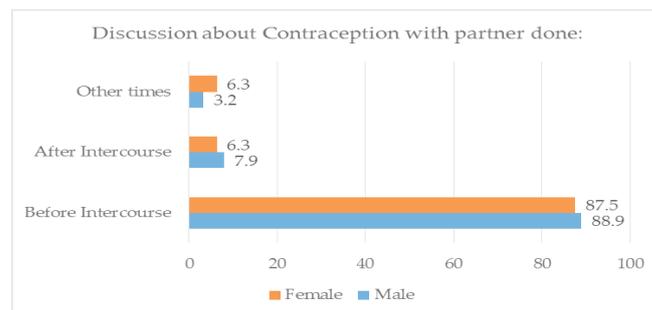


Figure 9: Discussion about Contraception with sexual partner

The proportions of those reporting ever having discussed contraceptives with sexual partner were similar in proportion to those who had ever used a method to delay pregnancy (males - 90%, females – 92%).

On the frequency of use among the young people who had ever used a method to delay pregnancy, over two thirds (69%-males; 62%- females) always used them while 30% of males and 38% of the females used them some of the time suggesting possible exposure to risks of STI including HIV infection and unplanned pregnancies.

Contraception source and use by young people in Homa Bay and Kisumu Counties

The contraceptive use among the young people in Homa Bay and Kisumu Counties is summarized in Table 8 below.

Method most frequently used by young people and their partner (s):	Male		Female	
	n	%	n	%
Condom	134	35.4	144	36.0
Pill	15	4.0	17	4.3
Injection	10	2.6	26	6.5
Withdrawal	2	.5	4	1.0
Safe period	4	1.1	7	1.8

Table 8: Contraceptive method frequently used by young people

As presented in Table 8, the most commonly used contraceptive method among the young people and their sexual partners was the male condom (males – 35%, females – 36%) followed by pills (4.0% - males and 4.3% - females), injection (2.6% - males and 6.5 %- females) while other methods methods of contraceptives like safe days, withdrawal recorded proportions of less than 2% for both vulnerable adolescent girls and young women and boys interviewed.

For the contraceptive methods frequently used by young people interviewed in the study, the most common source was the government health facilities (males -29%; females-31%); shops (males - 15%, females – 17%) and pharmacy (males – 11%, females – 13%) as depicted in Figure 10.

Notably, the most common sources of contraceptives used by the young people were also the most preferred sources of such methods i.e. government health facility (males – 24%, females – 26%), shops (males – 5%, females – 6%) and pharmacy (males – 4.0%, females – 4.5%).

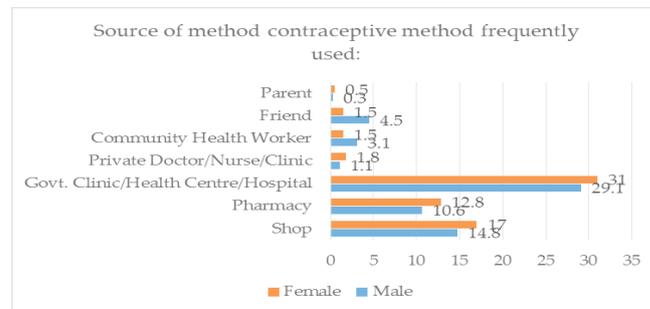


Figure 10: Source of contraception method frequently used by young people

Knowledge Levels and past experience with Sexually Transmitted Infections

Majority of the young people interviewed (91% -males and 91% - females) reported knowing at least one STI. The most commonly known STIs were syphilis (86% of males and 83% of females), gonorrhoea (76% of males and 76% females) and HIV and AIDS (48% of males 52% of females). The results show that just about half of both male and female respondents know HIV as an STI.

The study further investigated knowledge about STI symptoms known by young people. Knowledge of STI symptoms is critical for early diagnosis and treatment. As shown in Figure 11, the most common signs and symptoms of STDs in men known by majority of the young people were pain during urination (49% of male and 40% of females), discharge from the penis (48% of males and 37% of females), and ulcers or sores (46% of males and 35% of females).

More females (26.8%) than males (15%) interviewed did not know of any signs and symptoms of STIs in men.

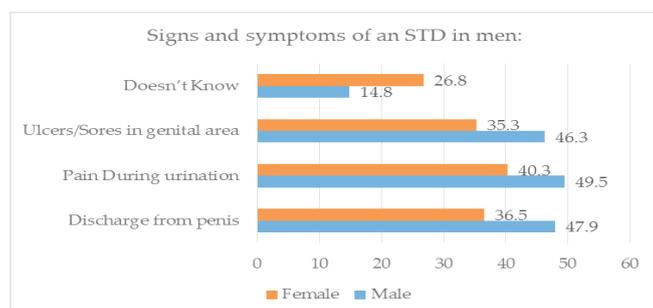


Figure 11: Signs and symptoms of STD in men

The signs and symptoms of the STIs in women known were; pain during urination (39% of males and 39% of females), discharge from vagina (38% of males and 38% of females) and ulcers/sore around the genitalia (36% of males and 33% of females).

An equal proportion of males and females (29% each) did not know any signs and symptoms of sexually transmitted infection among women. Results show low levels of knowledge on signs and symptoms of STD for both men and women. This has programmatic implications to increase awareness creation and possible service uptake whenever symptoms are detected.

Despite the high sexual activity among young people interviewed (as presented earlier) the number of young people who reported contracting sexually transmitted infections was generally very low. From the responses obtained, about 6% (n=12) of men and 13% (n=32) of women reported ever contracting an STI.

Among those who have experienced sexually transmitted diseases, most of them reported multiple occurrences with males recording slightly higher occurrence rates than the females (males - 54%, females – 43%). In light of the results on low knowledge of signs and symptoms of STIs, it is possible that many young people may not be aware they have an STI and therefore require treatment.

Results from the qualitative study show that young people seek medical treatment for illness when it is too late or severe which gives credence to this observation. Similarly, reports of STI recurrence is a reflection of frequent high risk unprotected sexual activities requiring appropriate preventive interventions on awareness creation and correct and consistent condom use.

For those who had ever contracted a sexually transmitted disease, all males reported they had sought treatment while about 95% of the women had sought treatment indicating cases of untreated STIs. Government hospitals were the most common source of treatment for those who had suffered from an STI (males -88 %; n=7- and females- 76 %; n=16). Other avenues reported were shops, pharmacy, private doctors or private clinics.

Those who had ever contracted an STI, were asked if their sexual partners accessed treatment. The results show that over two thirds (males 67% (n=6); females 68% (n=13)) reported that their partners received treatment.

However, a significant proportion (33% of male and 16% of female), reported that their partners did not receive treatment. Lack of treatment increases risks of recurrence hence the need for sensitization on the importance of couple STI screening and treatment.

Knowledge and Perceptions on HIV Counseling and Testing

On young people’s knowledge on HIV and AIDS, about 99% of the adolescent boys and 99.8% of the AGYW had ever heard about HIV and AIDS. Perception of risk for HIV infection among the sexually active young people was (see Figure 10) 61% for adolescent boys and 65% for AGYW. Slightly more females compared to males were worried about contracting the diseases from their sexual partners. For those who had ever been worried about contracting STIs from their partners, over half had very high level of concern of this happening (males 58%, females 58%). On the other hand, 33% of the young men and 35% of the AGYW were moderately concerned and about 9% of the males and 11% of the females were less concerned about contracting an STI or HIV from their sexual partners. Lack of perceived risk for HIV and STI infection among AGYW and boys implies the need for awareness to address this.

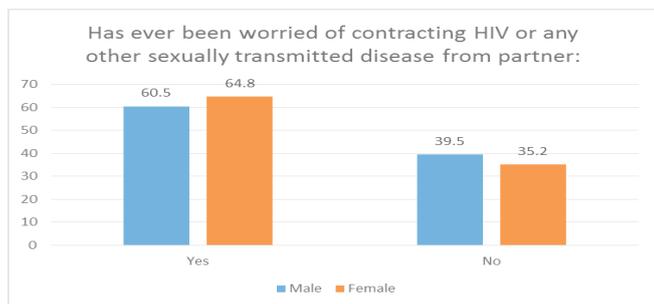


Figure 12: Perceived risk of contracting HIV and STD from sexual partner

The study sought to understand HIV testing practice among the AGYW and adolescent boys and young men. HIV testing was disaggregated by age of the young people.

The findings revealed that about 81% (104), 87% (95) and 91% (81) of the young men aged 15-17 years, 18-20 years and 21-24 years respectively, had been tested for HIV before the survey compared to 84% (113), 88% (97) and 95% (99) of the AGYW in the same age categories. There was a significant relationship between HIV testing and age of AGYW but not adolescent boys. Among AGYW, older females were more likely to have been tested than younger females.

The majority of male (90%) and female (90%) respondents reported knowing that there was something that could be done to reduce the risk of HIV through condom use during sexual intercourse (males 59%, females 57%) and abstinence from sexual intercourse (males 54%, females 51%). Pre-exposure prophylaxis (PrEP) was mentioned by slightly less than 2% of the adolescent boys and AGYW while Post-Exposure Prophylaxis (PEP) by 1% each. Other ways of reducing HIV infection reported include: being faithful to one partner, avoiding sharing of unsterilized sharp objects, and male circumcision. The results point to very low level of awareness of PrEP as a method of HIV prevention which calls for more promotion efforts.

Limited knowledge on PrEP was also confirmed from the qualitative study where it emerged that the lack of awareness was limiting access and its use in HIV prevention services.

Discussions during the baseline study validation workshop showed that agencies working in the two counties were creating awareness about PrEP in the communities including among young people. More efforts need to be put in place to reach AGYW.

“We have heard about it but, we don’t understand... We just know it’s something to do with post exposure or...” FGD participant, Young Girls, Homa Bay Town.

Perceptions of young people on HIV and AIDS

A set of statements were read out to the young people to gauge their perceptions on HIV and AIDS. The results are summarized in Table 9 below.

Perceptions regarding HIV and AIDS	Male, n (%)			Female, n (%)		
	True	False	Don’t Know	True	False	Don’t Know
HIV infection can be prevented	93.9% (352)	5.3% (20)	0.8% (3)	93.7% (374)	5.5% (22)	0.8% (3)
A person with HIV always looks emaciated or unhealthy in some way	33.6% (126)	63.2% (237)	3.2% (12)	35.1% (140)	61.7% (246)	3.3% (13)
People can take a simple test to find out whether they have HIV	97.9% (366)	1.9% (7)	0.3% (1)	96.2% (384)	2% (8)	1.8% (7)

Table 9: Perceptions of young people regarding HIV and AIDS

94% of males and 94% females interviewed observed that the statement “ HIV infection can be prevented was true. An overwhelming majority (98% of males and 96% of females) observed that the statement “ people can take a simple test to find out whether they have HIV” was true. Over two thirds (63% of males and 62% of females) observed that the statement “a person with HIV always looks emaciated or unhealthy in some way” was false as illustrated in Table 9. Observation on the last statement shows that more efforts are required to address this perception on HIV and AIDS.

Young people’s attitudes and perception regarding condoms and condom use in Homa Bay and Kisumu Counties

Perceptions of young people on condom use

A number of statements were read to the study participants during interviews to measure their perceptions on condoms and condom use. The results indicate mixed reactions to the various statements. Majority of the young people believe that condoms are an effective method of preventing pregnancy (males – 75%, females -76%). Similarly, the majority (89% of males and 90% of females agreed with the statement that “a girl can suggest to her boyfriend that he uses a condom;” 85% of males and 88% of females agreed that “a boy can suggest to his girlfriend that they use a condom;” 79% of males and 81% of females agreed with the statement that “condoms are an effective way of protecting against HIV and AIDS;” 68% of males and 70% of females agreed with the statement that “condoms are suitable for casual relationships” and, 57% of males and 59% of females agreed with the statement that “condoms are suitable for steady, loving relationships.”

It is interesting to note that only slightly over half of the respondents in the study feel that condoms should be used in steady relationships perhaps pointing to the need for condoms as a dual method of protection. Table 10 below illustrates perceptions on condom use.

Perceptions Regarding condom use	Male, n (%)			Female, n (%)		
	Agree	Don't Know	Disagree	Agree	Don't Know	Disagree
Condoms are an effective method of preventing pregnancy:	75.3% (280)	3.8 (14)	21% (78)	76.3% (299)	3.1% (12)	20.7% (81)
Condoms can be used more than once:	15.4%(57)	9.2% (34)	75.5% (280)	13.7% (54)	9.4% (37)	76.9% (303)
A girl can suggest to her boyfriend that he use a condom:	88.7% (330)	4.8% (18)	6.5%(24)	89.6% (353)	5.6% (22)	4.8% (19)
A boy can suggest to his girlfriend that he use a condom:	85% (317)	7.2% (27)	7.8% (29)	87.6% (345)	5.8% (23)	6.6% (26)
Condoms are an effective way of protecting against HIV and AIDS:	79.1% (295)	4.0% (15)	16.9% (63)	81.4% (320)	3.1% (12)	15.5% (61)
Condoms are suitable for casual relationships:	68.0% (253)	13.2% (49)	18.8% (70)	70.4% (276)	11.7% (46)	17.9% (70)
Condoms are suitable for steady, relationships:	56.7% (211)	16.9% (63)	26.3% (98)	58.8% (230)	14.6% (57)	26.6% (104)
It would be too embarrassing for someone like me to buy or obtain condoms:	36.2% (135)	7.2% (27)	56.6%(211)	35.6% (140)	6.6% (26)	57.8% (227)
If a girl suggested condoms use to her partner, it would mean that she didn't trust him:	23.7% (88)	12.9% (48)	63.4% (236)	19% (74)	12.1% (47)	68.9% (268)
Condoms reduce sexual pleasure:	21.0% (78)	36.9% (137)	42% (156)	18.6% (72)	36.2% (140)	45.2% (175)

Table 10: Perceptions regarding condom use among young people:

Majority of the young people disagreed with statements on three issues; “condoms can be used more than once” (76% of males and 77% females), “it would be too embarrassing for someone like them to buy or obtain condoms” (57% of males and 58% females), and *if a girl suggested using condoms to her partner, it would mean that she didn't trust him* (63% of males and 69% females). These results raise concern about young people's perceptions on condoms that require addressing through awareness creation.

Access and use of Condoms among young People

Knowledge and access to condoms among young people was also investigated. The results are illustrated in Figure 13.

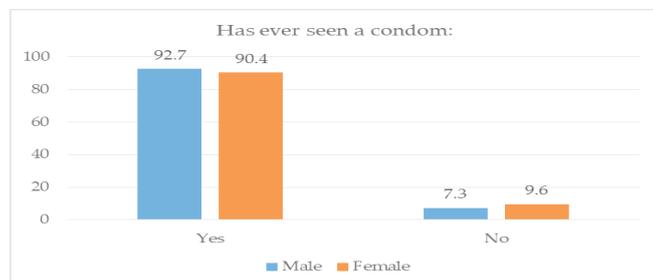


Figure 13: Frequency of young people who had ever seen a condom

There was near universal knowledge on what condoms are (males – 99%, females – 97%) though just about 93% of the males and 90% of females confirmed having ever seen a condom.

Condom use by young people

Majority of the young people interviewed had used a condom (males - 73%, females – 80%). Results in Figure 14 actually show that more males (7%) compared to females reported ever used a condom.

For the young people who had ever used a condom, just about a third (31%) of the males and 26% of the females reported having experiencing condom split or breakage during sexual intercourse. This suggests the need for awareness creation on correct condom use for young people.

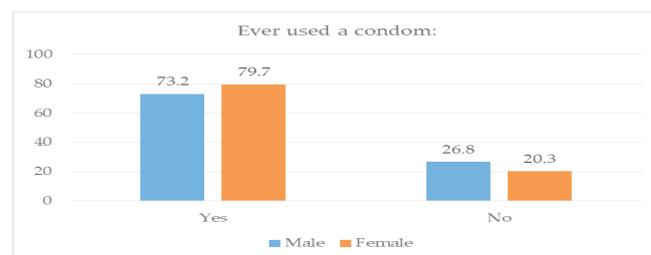


Figure 14: Frequency of ever use of condoms by young people

Awareness of Pre-Exposure Prophylaxis (PrEP)

Study results show that level of awareness of PrEP was low with just about 18% of the young men confirming having heard about it. The proportion was slightly higher for the young girls with 22% reporting having heard about PrEP (see Table 11 below).

Among the young people who confirmed having heard about PrEP, only 31% knew how PrEP is used with the remaining 69% reported not knowing how can used.

Has ever heard about (PrEP):	Male		Female	
	n	%	n	%
Yes	65	17.9	82	21.7
No	298	81.9	294	77.8
Not Sure	1	.3	2	.5
Total	364	100.0	378	100.0

Table 11: Awareness of Pre-Exposure Prophylaxis (PrEP)

In results presented earlier, when the young men had been asked about what can be done to reduce the risk of HIV infection, only 2% of both young men and women each mentioned the use of Pre-Exposure Prophylaxis (PrEP).

These results indicate that even among those young people who reported awareness of PrEP, its use in HIV prevention was not well understood. Among those who had heard about PrEP, 87% (n=33) of male and 67% (n=43) of females reported that it could be accessed from government health facilities, 7.9% of males and 14.1% of females reported private health facilities; less than 10% of the respondents cited drop-in-centers run by NGOs (2.6% - males and 4.7% - females), VCT centers (4.7% - females) and chemists (2.6% males – 6.3% females).

3.2.5 Access to health information and services in Homa Bay and Kisumu Counties

Adolescence period is a paradox, considered the most healthy period of growing up, yet fraught with many dangers attributed to growing up, sexual exploration, albeit. Unprotected with multiple partners that predisposes teenagers to risks of diseases, and even death.

This study investigated whether the respondents had visited a health facility for a range of SRHR services over the year preceding the survey. As presented in Figure 15 less than half (37% of males and 47% of females) reported ever visiting a health facility or doctor for services or information on contraception, pregnancy, abortions or STIs in the last 12 months before the study.



Figure 15: Ever visited health facility for SRH services and information

The study further investigated reasons for choice of facilities last visited for SRHR information and services. Results show arrange of considerations for visiting the facilities including; proximity in distance (23% of males and 26% of females); affordability (7% of males and 12% of females), youth friendliness (5% of males and 8% of females), accessibility (4% of males and 5% of females) and privacy and confidentiality (4% of males and 3% of females) as shown in Figure 16 below.

It is interesting to observe these low proportions of elements traditionally considered as principle considerations for young people seeking health services. It could be argued that these considerations are taken in different measures for orphaned and vulnerable adolescents. But again, it could be due to the nature of health seeking behavioral patterns of seeking services when it is too late such that distance remains the primary consideration.

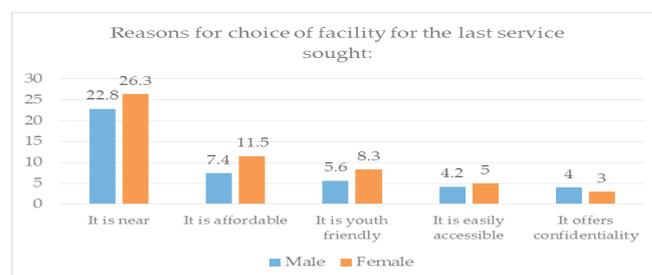


Figure 16: Reasons for choice of facility for the last service sought

Among the young people who had visited a health facility for information or services on sexual reproductive health, almost half sought contraceptive methods (males – 51%, females - 47%).

This was followed by information or services around STIs for men (20%) and pregnancy test (18%) and mother and child health clinics for women (18%). Other services sought by AGYW were termination of pregnancies and gynecological examination.

The study investigated whether young people visiting health facilities over the last 12 months preceding the survey read or received any information or services on contraceptives. The results are presented in Figure 17 below.

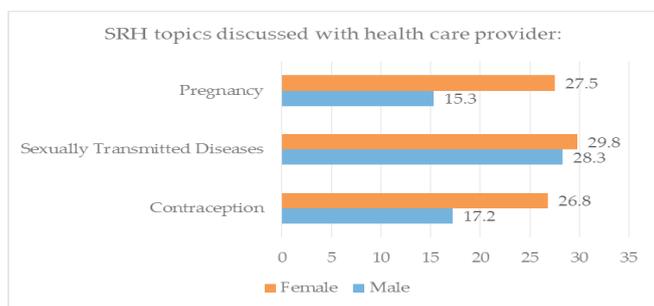


Figure 17: SRH topics that medical health care provider discussed with respondent

Just about 27% of males and 37% of females reported seeing a poster on contraception, 8% of male and 15% of females reported receiving a brochure on contraception, 13% of male and 22% of females reported receiving contraceptives.

Among those who attended consultations with a health providers, 28% of males and 30% of females discussed STIs with the service provider, 15% of males and 28% of females discussed pregnancy while 17% of males and 27% females discussed contraception (see Figure 17above).

Results further indicate that most young people seek STI treatment from government health facilities (85% of males and 86% of females) private health facilities and doctors (17% of males and 19% of females) and pharmacies (8.2 % of males and 8% of females) as illustrated in Table 12 below.

Sources of treatment of STIs for young people:	Male		Female	
	N	%	n	%
Shop	2	.5	5	1.3
Pharmacy	31	8.2	32	8.0
Government HF's	322	85.2	343	85.8
Private Doctor/ HF's	65	17.2	76	19.0
Herbalist	20	5.3	15	3.8

Table 12: Sources of treatment for STIs

Investigation on satisfaction with services received at the last visit to health facility in the last 12 months preceding the survey show that the majority (95% of males and 92% of females) reported that their questions had been adequately answered, 90% of males and 84% of females reported that there was enough confidentiality, and 83% of males and 77% of females reported feeling comfortable enough to ask questions.

3.2.6 Young people and Sexual and Gender based Violence and related laws in Kisumu and Homa Bay Counties

Sexual and Gender Based Violence

This study investigated knowledge and attitude of young people on sexual and gender based violence. The majority of the young people (males; 79%, females; 74%) reported having heard about SGBV.

Most of the respondents in the study described sexual and gender based violence as violence against victims because of their gender and that is sexual in nature such as rape, molestation and other forms of sexual harassment.

As shown in Table 13, common forms of violence known by the young people were: domestic violence (male; 69%, females; 69%), fights within the community (males; 54%, females; 51%) as well as sexual and gender based violence (males; 43%, females; 41%), violence against women (males; 37%, females; 35%) and fighting in school (males; 32%, females; 29%).

Forms of violence known:	Male		Female	
	N	%	n	%
Domestic Violence	259	68.5	277	69.3
Sexual and gender based violence	162	42.9	162	40.5
Violence against women	138	36.5	139	34.8
Fighting in the community	205	54.2	205	51.3
Fighting in school	122	32.3	115	28.8

Table 13: Forms of violence known by young people

According to the majority of those interviewed (males; 74%, females; 78%), cases of sexual and gender based violence were common in Kisumu and Homa Bay Counties. The most common form of violence within the communities in these counties were noted as: battering of men and women (males; 69%, females; 66%), rape (males; 64%, females; 64%), use of abusive language on girls and women (males; 27%, females; 19%), defilement (males; 21%, females; 23%), early and forced marriages among girls (males; 12%, females; 12%) and trafficking of children and harmful traditional practices such as FGM.

Avenues where SGBV occur in the community

The avenues where SGBV occur in the community are presented in the Figure below.

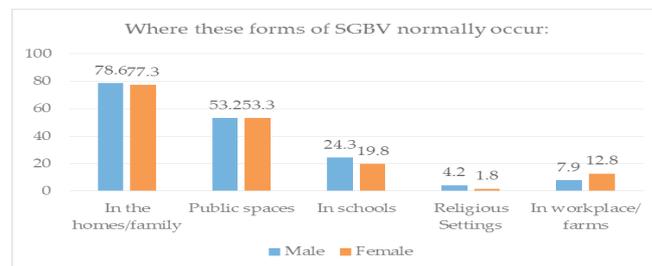


Figure 18: Places/spaces where SGBV against young people normally occurs

Avenues where SGBV occurred varied. Results show that the different forms of violence were perpetrated by people within the family (males; 79%, females; 77%) and public spaces (males; 53%, females; 53%). It also occurred in schools, work places, religious settings, entertainment joints and other dark places, bushes and political rallies as illustrated in Figure 18.

Exposure to Sexual and Gender Based Violence

Young people were asked about exposure to SGBV. Results show that females were almost twice more likely (13%; n=47) to have ever experienced SGBV than young men (7%; n=24). Male study respondents reported sexual harassment in schools (25.0%; n=4), sexual harassment by family members (18.8%) and sexual molestation (18.8%) and rape (12.5%; n=2).

On the other hand, female respondents reported being beaten by their partners because of sex (32.5%; n=13), rape (20.0%; n=8) or sexual harassment in schools (15%; n=6) and defilement (7.5% (n=3) and molestation (7.5% (n=3).

Other forms reported by less than 5% of the respondents were sexual harassment at the work place, in church and in other public places. On discussion of SGBV in the community less than half of all respondents (males; 45%, females; 47%) reported that issues around SGBV are commonly discussed in the community.

Qualitative study findings allude to the high incidences of SGBV in the two Counties. Sexual and gender based violence was particularly singled out by all groups to be very prevalent, ranging from battery and mistreatment, defilement, and rape.

Divorce and forceful eviction of orphans were also identified as prevalent. Yet again there seems to be silence about some incidences of injustice that go unreported due to low self-esteem, embarrassment and fear of the under-privileged positions of the OVCs.

“Very prevalent. Almost weekly. Wife battering also very prevalent. Main culprits...Victims mostly minors girls in high schools especially day schools are mostly by boda boda. Underage girls for example we have case of an old man from [name of a place] accused of repeated wife battering” **Key Informant Interview, CID, Nyabende Kisumu.**

“Very high. A week cannot go without a case in neglect, incest, rape and abandonment. At least two monthly.” **Key Informant Interviews, Gender Based Violence Officer, Ahero Police Station Kisumu**

“Right now, such things like rape cases are too much because when you stay with orphans, they don’t get free to share whatever they pass through, to give earlier solutions, you might find a case where something like rape has happened to her, but she is not free to say.” **FGD Participant, Seme Elders, Kisumu.**

Results from qualitative assessment confirm the high cases of SGBV in the communities. In Homa Bay County (specifically Ndhiwa, Mbita and Suba areas), cases of early marriages were reportedly on the rise while in Ahero area, up to 3 cases of rape, defilement and other sexual and gender based violence cases were reported daily. AGYW in these counties were exposed to different forms of sexual and gender based violence.

The findings from the qualitative assessments further show that cultural practices like widow inheritance expose the orphaned and vulnerable children to maltreatment. Indeed, it was reported that many of orphans were stigmatized and discriminated against due to the HIV and AIDS associated with the death of their parents.

“There are cases where after the death of the parents the orphans may be forced into the streets becoming street children.” **FGD, Young Girls, Jiu Pachi CBO, Kisumu.**

Avenues for resolving SGBV in the community

The survey sought to establish who at the community level was responsible for resolving SGBV issues involving orphaned and vulnerable adolescent girls and young women.

Findings show that chiefs (males – 97%, females – 90%), the police (males – 76%, females – 63%) and community elders (males - 79%, females - 50%), social workers (males - 27%, females - 29%) and women leaders (males – 4%, females – 17%) were cited for their roles in resolving SGBV issues.

The survey further sought to establish young people’s knowledge of avenues for addressing the sexual and gender related violence in the communities.

The young people noted availability of police protection (males – 81%, females – 79%), medical facilities (males - 72%, females – 72%) and local administration such as chiefs (males – 69%, females – 58%); safe homes for SGBV victims (males – 26%, females – 24%); family support units (males; 24%, females; 32%); and paralegal services (males; 22%, females; 21%). Of these services, majority of the young men and women have at least used local administration (males; 51%, females; 46%), and safe homes for sexual and gender based violence survivors (males; 39%, females; 31%).

Available SGBV services in the community:	Male		Female	
	n	%	N	%
Safe home for SGBV victims	12	25.5	16	23.9
Family support unit	12	23.5	23	31.5
Paralegal Service	11	22.4	13	21.3
Medical Facilities	85	72.0	106	71.6
Police protection	83	80.6	106	79.1
Local Administrators	45	69.2	45	57.7

Table 14: Availability of SGBV services in the community

Access to justice for SGBV victims in Homa Bay and Kisumu Counties

Among those who had at least reported an SGBV add a comma after case 71% of males and 79% of females reported that the services they received were youth friendly. About 8.2% (22) of the men and 6.8% (20) of young women interviewed had not reported any cases of SGBV to the channels they knew when they needed to.

For those who did not report any SGBV cases to the available and known channels, the main reasons for males not reporting were: perception of heavy fines likely to be charged on the survivors (100%); perceived ineffectiveness of the structures (63%, n=10) and lack of trust in the structures (60%, n=9).

For females, the main reasons for not reporting were; lack of trust in the structures (44%, n=8), perpetrators in some instances being the members of the said structures (33%, n=6) and the perception of the structures not being effective (11%, n=2). This suggests the need for more efforts on creating awareness on the rights of survivors and steps and procedures in seeking SRH justice at the community level.

The qualitative results indicate that lack of awareness of the actions to take and existing laws to address cases of sexual and gender based violence was reported as the most common challenge affecting young people’s access to justice whenever cases of sexual and gender based violence occurs.

“Defilement ... People marrying minors for example 15 years. This is common here with rice farmers especially during harvesting of rice” FGD participant, Young boys, Ahero Kisumu.

“One major legal issue is you as an orphan has been violated sexually but there’s no proper channel for her to take her grievances. If you go to the chief, they tell you sexual offences are not at our local levels. There are no serious people who can come to get your matters addressed so that justice can be done at the end of the day. It is very rampant. Some happen under the Table. You find a child has been defiled then the village elder says ‘let us solve this one at our local level’ yet it’s something that requires a legal action so that that child can get his or her rights [and] so that he or she can feel that justice has been given but that doesn’t happen.”

Key informant interview, Lagnet Theatre, Ahero Kisumu.

For those who reported the cases, 57% of the young men reported the cases to a member of their family with 29% of young men reporting the cases to the police. Among the young men, local administrators such as the chiefs and their assistants and teachers were important people they reported. AGYW reported to the police (33%), a member of the family (29%), teachers (17%) and local administrators (13%).

Over two thirds of AGYW who had ever reported an incidence of SGBV indicated that they would report to the same structure in future because they felt: the services provided them were very good (50%); they were provided protection against the perpetrator (13.6%); and, their issues were settled in secret something they were happy or okay with (13.6%) among other reasons. Among male respondents, the reasons why they would report to the same structure was because: the previous cases had been given proper care; they received justice; and were compensated.

Among the young people who had ever reported a sexual and gender based violence to any of the channels available at the community level, 57% of the young men and 38% of females would not report to the same structure again. They cited lack of privacy, unfriendly services, and lack of protection from the perpetrators as reasons for not going back to the same structures.

Results show some of the negative consequences associated with sexual and gender based violence mentioned by the respondents. These include; shame (males – 84%, females – 85%) followed by increased cases of STIs/AIDS (male - 58%, females – 58%) and unplanned pregnancies (males – 57%, females – 57%) among many others – see Table 15.

Negative consequences of SGBV:	Male		Female	
	N	%	N	%
Shame	168	84	185	84.9
Increase STI/HIV	220	58.2	232	58
Unplanned pregnancy	214	56.6	226	56.5
School dropout	137	36.2	126	31.5
Physical Injuries	106	28	125	31.3
Death	101	26.7	100	25
Early marriage	79	20.9	64	16
Trauma	49	13	65	16.3
Suicide	36	9.5	47	11.8
Stigmatization	32	8.5	52	13
Exclusion from the community	31	8.2	30	7.5
Abortion	30	7.9	33	8.3

Table 15: Negative consequences of SGBV according to the young people

Most of the young people (males – 52%, females – 44%) in the study observed that there were customary practices in the community against sexual and gender based violence. These include reporting sexual and gender related cases to the police or elders (males – 94%, females – 91%), fines levied on the perpetrators of such violence (males-61%, females-54%), public shame (males - 57%, females – 44%) among other practices.

The study further asked young people about their participation in SGBV activities in their communities. Results show that most young people in the study areas reported not be involved in events or activities aimed at addressing SGBV issues in the community (males; 78%, females; 71%).

They however observed that they knew where most of these activities took place. These mainly took place at community centers (males; 67%, female; 66%). Other forums were held in schools, health facilities, and churches by NGOs.

3.2.7 Awareness of Sexual Reproductive Health Laws

About 18% and 21% of young men and women respectively were aware of any laws or acts of parliament on sexual and gender based violence in Kenya. About 82% of adolescent boys and 79% of AGYW did not know or were not sure they knew of any law on sexual and gender based violence. Based on the spontaneous responses almost half of the young people who responded to the question were aware of the 2010 constitution (males; 50%, females 48%) while about 33% of the males and 43% of the females interviewed reported the Domestic Violence Act 2017. Awareness of selected laws is indicated in Table 16 below.

Table 16: Awareness of laws against SGBV

If aware of any laws against SGBV:	Male, n (%)			Female, n (%)		
	Yes (spont)	Yes (Prompt)	Don't Know	Yes (spont)	Yes (Prompt)	Don't Know
The Domestic Violence Act, 2007	32.7% (18)	27.3% (15)	40.0% (22)	43.3% (29)	16.4% (11)	40.3% (27)
National Adolescent Sexual & Reproductive Health Policy, 2015	12.2% (6)	14.3% (7)	73.5% (36)	8.2% (5)	18.0% (11)	73.8% (45)
The School Health Policy, 4/1/2017	4.3% (2)	13.0% (6)	82.6% (38)	6.1% (3)	8.2% (4)	85.7% (42)
The Sexual Offences Act, 2012:	27.1% (16)	22.0% (13)	50.8% (30)	36.2% (25)	18.8% (13)	44.9% (31)
The 2010 Constitution	50.0% (32)	28.1% (18)	21.9% (14)	48.4% (30)	32.3% (20)	19.4% (12)
National Guidelines on the Management of Sexual Violence, 2014	4.3% (2)	17.0% (8)	78.7% (37)	3.6% (2)	16.1% (9)	80.4% (45)
National Reproductive Health Policy, 2007	8.3% (4)	4.2% (2)	87.5% (42)	5.6% (3)	1.9% (1)	92.6% (50)
The National Reproductive Health Strategy 2009-2015	2.2% (1)	6.5% (3)	91.3% (42)	2.0% (1)	3.9% (2)	94.1% (48)
The Adolescent Reproductive Health and Development Policy, 2015	8.2% (4)	8.2% (4)	83.7% (41)	1.9% (1)	5.8% (3)	92.3% (48)
The National Condom Policy and Strategy (2009-2014):	4.3% (2)	2.1% (1)	93.6% (44)	11.1% (6)	5.6% (3)	83.3% (45)
The Contraceptive Policy and Strategy (2002-2006):	4.3% (2)	2.1% (1)	93.6% (44)	4.1% (2)	0.0% (0)	95.9% (47)
The Contraceptive Commodities Procurement Plan (2003-2006)	0.0% (0)	4.4% (2)	95.6% (43)	0.0% (0)	4.0% (2)	96.0% (48)

If aware of any laws against SGBV:	Male, n (%)			Female, n (%)		
	Yes (spont)	Yes (Prompt)	Don't Know	Yes (spont)	Yes (Prompt)	Don't Know
The Contraceptive Commodities Security Strategy (2007-2012)	0.0% (0)	4.4% (2)	95.6% (43)	0.0% (0)	2.0% (1)	4.0% (2)
The School Health Policy4/1/2017	11.8% (6)	5.9% (3)	82.4% (42)	7.5% (4)	3.8% (2)	88.7% (47)
The Female Genital Mutilation/ Cutting Policy:	9.6% (5)	17.3% (9)	73.1% (38)	9.3% (5)	11.1% (6)	79.6% (43)
The Protection Against Domestic Violence Act, 2015	16.7% (9)	13.0% (7)	70.4% (38)	12.1% (7)	19.0% (11)	69.0% (40)
The Sexual Offences Act, 2006	13.5% (7)	11.5% (6)	75.0% (39)	7.5% (4)	7.5% (4)	84.9% (45)
The Prohibition Against Female Genital Mutilation, 2011	11.8% (6)	7.8% (4)	80.4% (41)	16.7% (9)	11.1% (6)	72.2% (39)
The Counter-Trafficking in Persons Act 2006:	6.4% (3)	8.5% (4)	85.1% (40)	3.9% (2)	11.8% (6)	84.3% (43)
The HIV Prevention and Control Act, 2006:	10.2% (5)	2.0% (1)	87.8% (43)	7.3% (4)	9.1% (5)	83.6% (46)

Avenues where young people learnt about SRH and GBV laws and policies

The avenues where young people learnt about the SRH and GBV laws and policies are displayed in Figure 19.

As shown in Figure 19, majority of the adolescent boys aware of any of the SRHR and GBV laws and policies reported that they had learnt about them from radio (92%) followed by school (89%). Among AGYW most reported learning about the laws from radio (80%) and from school (77%). Other avenues noted were: public places, meetings, workshops, from friends and social workers among other forums, reading books, magazines and newspapers, social media and through community outreach activities.

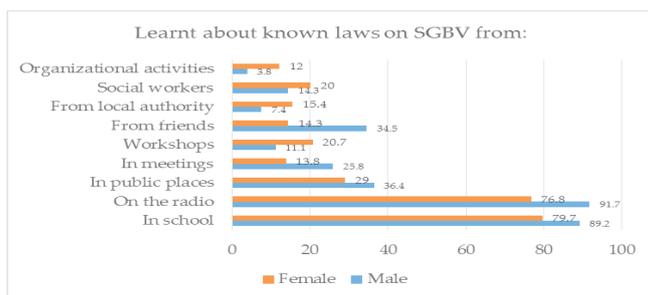


Figure 19: Forums from where young people learnt about known laws on SGBV.

3.2.8 Linkages between sexual and reproductive health and land and property rights in Homa Bay and Kisumu Counties

Land and property ownership

Majority of the young people (males: 84%, females: 74%) interviewed reported that their family members owned property. Nearly all reported land ownership (males: 98%, females: 97%), houses (males; 86%, females; 91%), livestock (males; 87%, females; 83%) and businesses (males; 42%, females; 57%) as shown in Table 17 below. Others reported they or their families owned bicycles, motorcycles and vehicles and other valuable property.

If family owns a property:	Male		Female	
	N	%	N	%
Land	285	97.6	242	97.2
House	184	86.0	187	91.2
Livestock	133	86.9	109	82.6
Business	36	42.4	52	57.1

Table 17: Proportion reporting own or family ownership of property

Majority of the young people owning property reported that they or their family members were in control of the property (males; 93%, females; 89%).

Over two thirds (68% of males and 63% of the females) had their own or family property registered under their names or a family member's names. About 17% of men and 19% of the AGYW did not have their or family property registered under their or family name which make them vulnerable to loss of the said property.

More males compared to females had property registered under their names. Among all the young people interviewed and owning a property, 81% of the men reported to control the use of the property compared to 71% of their female counterparts. Thus, slightly more males compared to females were in control of their own or family property. More females did not have control over the use of the property owned by them or their family members (males; 19%, females; 29%).

Results show that majority of the young men knew where they or their family members could access land registration services (53%). This was however not the case for young girls among whom over two thirds (63%) did not know where to access land registration services.

Also notable was that majority of the young people interviewed reported that themselves and their families did not have a will (males; 79%, females; 82%). Additionally, the majority (63% of males and 75% of females) reported not knowing the steps in land and property succession.

Avenues for accessing justice for violations of their property rights

The majority of respondents (72% of males and 70% of females) know the avenues available for AGYW to access justice for violations of their property rights.

The three most common avenues identified by male respondents were: chiefs (94%), police (90%), and courts (71%). Female respondents identified: chiefs (90%), police (85%) and courts (51%). It is notable that in all three instances, fewer females than males reported knowing the availability of these channels.

Other avenues reported were: religious groups and family, court users committees (CUCs), elders, land department, and civil society organizations such as FIDA and KELIN.

Avenues known:	Male		Female	
	N	%	n	%
Court Users Committees (CUCs)	25	37.9	11	15.5
Courts	70	71.4	49	50.5
Chief	178	94.2	170	89.9
Religious group	19	28.8	21	24.7
Family members	26	38.8	20	26.0
Police	153	90.0	138	85.2

Table 18: Avenues for seeking justice reported by respondents

The survey further investigated incidences of abandonment and disinheritance. Of all those interviewed, about 13% of the young men and 17% of the women reported ever being abandoned. About 12% of the young men compared to 14% of the young women interviewed reported that they had or their family members ever been disinherited.

For those who had ever been disinherited or abandoned, 43% of the young men and 51% of the young women reported that their issue was eventually addressed and resolved by chiefs (males -32%, females- 39%) and courts (18% of males and 23% of females). Other avenues that helped resolve the issues were interventions by family members and police as shown in Table 19 below.

Issue addressed by:	Male		Female	
	N	%	N	%
Court Users Committee (CUCs)	2	9.1	4	12.9
Courts	4	18.2	3	9.6
Chief	7	31.8	12	38.7
Family members	3	13.7	7	22.6
Police	2	9.1	4	12.9

Table 19: Proportion reporting avenues for resolving injustices experienced

The survey also asked respondents about the outcome of the issues reported for arbitration. Nearly half (48% of males and 50% of females) reported that their property was returned to them. About 33% of males and 31% of females reported waiting for the outcome with optimism.

The baseline survey asked the respondents about incidence of land and property violations in their communities. Results show that over two thirds of the respondents 37% of males and 40% of females perceive the incidences as either high or very high as illustrated in Table 20 below.

Rate of the prevalence of land and property rights violations in the community:	Male		Female	
	N	%	N	%
Very High	42	11.4	46	11.7
High	94	25.5	108	27.6
Low	126	34.2	122	31.1
Very Low	52	14.1	45	11.5
Not Sure	54	14.7	71	18.1
Total	368	100.0	392	100.0

Table 20: Proportion reporting incidence of land and property rights violations

Avenues for accessing land and property rights justice by AGYW and boys

Qualitative study finds show that orphaned and vulnerable AGYW and boys access land and property rights justice from a range of individuals and institutions. Among these include, teachers, religious leaders, cultural elders, CBOs and orphanages, provincial administration especially the chiefs, FIDA, hospitals and the police. Other avenues mentioned include prosecutors, Kenya Lands Alliance, *Kituo cha Sheria*, Ministry of Lands, Children’s Department, Nyanza Reproductive Health, Plan International and KELIN. These groups were similarly identified to promote access to SRHR justice in the communities.

“...they report to the FIDA, issued a letter from there and they take it back to the chief to judge the case.” FGD Participant, Young Girls, Mwangaza Kisumu.

“At the community level, young OVC can access justice through elders, and teachers. The teachers can be very helpful.” Key Informant Interview, Lawyer, Homa Bay.

Factors enhancing access to SRHR justice

Findings from the qualitative assessment established some factors that enhance access to SRHR justice. These include ease of access to the individuals and/or institutions such as the peer educators, community health workers, elders, teachers, religious leaders, chiefs. This is particularly critical because of the perceived confidentiality and lack or minimal financial costs involved in reporting to these avenues. Respondents also felt it was easier to deal with them as they understand the language and the cultural context for supporting the survivors.

Capacity building of the people and institutions involved in supporting OVCs access justice was also highlighted as a key enabler for seeking SRHR by OVCs. This was particularly emphasized for the police, paralegals, and service providers making it easier for the OVCs to seek friendly services and assistance. Having a gender desk at the police station was perceived as a key enhancer to reporting of SRHR injustices.

" Yes, it is. You find some...I had told you of officers trained. Now they are different from the other officers. So, if someone comes and files a case like that one, they are handed over to [name of a person] or to madam [name of a person] so that they can be talked to [and to make them] feel they have someone to talk to."
Key Informant Interviews, Police Officer, Ahero Kisumu.

"Sexual Offences Act 2007 is part of the training for police officers. Additionally, reporting to the police is free that is the p3 forms are provided freely for survivors of SGBV. The CID also support witness protection by using pseudo names"
Key Informant Interviews, CID, Nyabende Kisumu.

Creating awareness in the community about where to seek SRHR justice and range of services and nature of assistance provided at these centers was also identified in the qualitative assessments as a key enhancer to seeking justice by OVCs. Existence of guidance and counselling in schools, presence of sexuality education programs including "Abstinence Be Faithful" in schools were identified as key enhancers to seeking SRH justice. These programs not only create awareness about rights but also build the OVC skills to stand up for their rights and seek justice whenever their rights are violated.

The Kenyan constitution and existing legal framework for seeking justice was also identified as key factor that enhances access to justice for OVCs. The various police instruments that define and provide frameworks for addressing injustices by adolescent enable ease of administration of justice.

"Law of Succession talks about children of the deceased."
Key Informant Interview, Judicial Officer Homa Bay.

"Most of the time when the police are informed and investigate (70%) maybe not be property but the files have to be taken to the DPP in the 7/10 you can find 5 have been reasonably done well. The odds are that ¾ of them will be prosecuted."
Key Informant Interview, Lawyer, Homa Bay.

Barriers to access to Sexual and reproductive health rights services, information and justice for young people in Homa Bay and Kisumu Counties

Barriers to access to information and services, information and justice

The qualitative assessment investigated some of the barriers to accessing SRH justice by AGYW and boys. Among those identified were: confusion, embarrassment, psychological trauma and low self-esteem of the survivor, fear of the perpetrator, disbelief from the adults, perceived lack of confidentiality of those reported to, threats and power of the perpetrators, costs of reporting including travel costs and actual costs of accessing required services, length of time it takes to receive justice, corruption, failure and frustration by the authorities to pursue justice to the end, ignorance on where to first go to or what to do when reporting.

“I think some of them get traumatized and they don’t want to talk about it at all. Some in fact get threatened even by the suspect. They are told that if you report, you are done so they can’t say [anything] they just keep quiet. [For] the girl, that pregnancy grows and they don’t want to report it. For some, it is the fear like shame and they don’t want to tell their mothers ‘I did such and that.’” **Key Informant interview, Police Officer, Ahero- Kisumu.**

“I would say it is costly like court is usually expensive. Costs, fear, bribery.” **FGD participant, Young Boys, Kendu Bay, Homa Bay County.**

“Fear- If you have fear after telling people your information you might think that they will start talking about you after you leave. So, there are issues of confidentiality. Discrimination and stigma [and] distance from the facility to home. Sometime we consider the type of people we face when addressing your issue/problem. You might go to a person to tell them your problem then after telling them the answer she gives you hurts and you regret it. Lack of money some services need money.” **FGD participant, Young Girls, Homa Bay Town.**

“Older OVC are more likely to seek justice. Failure by teachers to report such cases of school related SGBV becomes a crime. There is a disconnect between occurrence of the event and reporting to the police.” **Key Informant Interview, Lawyer, Homa Bay Town.**

“Victim will feel lonely with his colleagues and experience low Self-esteem, one will not express herself where people are” **FGD Participant, Young Boys, Karachuonyo Homa Bay.**

“Each day the cases are reported some are dismissed because of collusion or lack of evidence.” **Key Informant Interview, Deputy Luo Council of Elders.**

There are also cultural barriers and myths that affect access to justice by OVC. The qualitative findings show that fear of embarrassing family and the clan are particularly common in cases of incest. Fear of cultural reprisals, curses from elders if they go against the clan wishes, banishment from the community are real for OVCs.

Fear of family conflicts and clan breakups especially for cases taken to the courts, or on reporting to other agencies affect reporting and follow up of violations of OVCs. For some in the community, religious and cultural beliefs that bathing in Lake Simbi cleanses and cures one of any violations, offers comfort for those who may fear reporting.

“Like people believe water in Lake Simbi can cure.” **FGD Participant, Young Boys, Karachuonyo, Homa Bay.**

There are structural challenges in the formal legal system. Issues of land are dealt with in the environment and land court (ELC) but the issue should be filed and the plea taken to the registry. This is costly and takes a lot of time and money and requires knowledge of the system.

Fear of shoddy investigations, ignorance about the courts and formal justice system, formal language required in court proceedings including fear of cross examination and coming to contact with the perpetrators of the injustices instills fear in OVC to report the violations of their rights.

“Land registry do not offer pro-bono services; the judge can appoint and direct an advocate for the OVCs but there is a big gap between the OVC knowing their rights and taking the issue to court for direction and assistance... Anyone with money can access justice but this is not the same for the OVC.” **Key Informant Interview, Lawyer, Homa Bay Town.**

“Another barrier is shoddy investigation carried out. They don't do proper investigation hence lack of evidences to support the case, we can set up a department that can do that.” FGD Participant, Young Boys, Karachuonyo, Homa Bay.

Recommendation for addressing the barriers to access to SRH services, information justice

The qualitative findings established that to overcome these barriers, concerted efforts among all stakeholder is necessary in:

- a) Creating awareness about existing avenues, provisions, spaces and channels available for reporting and seeking justice by OVCs;
- b) Training OVCs on SRH land and property rights and linking them with appropriate support individuals and groups in the community for example the chiefs, paralegals, councils of elders;
- c) Providing safe spaces/shelter such as CBO offices, orphanages, schools in the community;
- d) Providing legal aid to the OVCs;
- e) Establishing emergency call-in centers for survivors;
- f) Carrying out SRH rights awareness through local FM stations and enter-educate approaches, community meetings and barazas.

“Setting up emergency call numbers set digitally so that when someone has to access the emergency they just call, it is fast” FGD Participant, Young Boys, Kendu Bay, Homa Bay.

“There is need for simplification of the laws/directive to draft the laws in clear terms/layman's language. However, many people do not even read the laws. -So can create awareness through road shows, civil societies, local radio stations.”

Key Informant Interview, Lawyer Homa Bay Town.

- a) Sensitization about land and property rights for OVCs;
- b) Conducting court open days within communities to demystify court proceedings and encourage seeking justice within systems;
- c) Produce illustrative information education and communication materials on roles of key stakeholders, and channels of communications;
- d) Sensitize communities about existing laws and policy guidelines on SRH and land and property rights, law enforcement.

“Advocacy for change of laws/FIDA/KELLIN, Amendments to the children's Act e.g. reminding head teachers to report cases to the police. Get advocates for OVC offenders/watching brief/advocate for the victim. Initially there was no right of such an advocate to cross examine victims. However, there is a new dispensation such as change in the rights of the advocates watching brief for OVCs. Article 50 now allows the advocates holding brief to cross-examine witnesses and give submission. The court depends on evidence so if none is provided then the court cannot render justice. Criminal cases depend on evidence that is overwhelming. ...there is need for Laws on enforcement to ensure chiefs/public health workers/head teachers report a crime.” Key Informant Interview, Lawyer, Homa Bay Town.

The land office should disseminate information; land officers should come (to the community) and cooperate and make work easier through training. Materials for training forums be simplified for easy use by elders. Laws and policies should have simplified language for the orphans boys and girls to be able to understand” Key Informant Interview, Luo Council of Elders.

4.0 Conclusions and Recommendations

SRH issues affecting young people in Homa Bay and Kisumu Counties mentioned include: - challenges of managing menstruation and personal hygiene, lack of sanitary towels affecting school attendance for the young girls; low levels of knowledge on contraceptive, unprotected early sexual activities, unplanned pregnancies, unsafe abortions and increased risks of STI and HIV infections, school drop-outs leading to early marriages, sexual abuse including rape and defilement by guardians, lack of information and guidance on sex, sexuality, growing up and sexual reproductive health rights. Other challenges include lack of skill for managing peer pressure, drug abuse and trafficking, poor performance resulting in class repetitions, idleness and hopelessness, psychological trauma and attitude associated with death of parents and weakened family support.

Young people have varied sources of information on SRH. School teacher, family members, friends and peers are the most important source of information. Findings show that most young people have access to mobile phones. This presents an avenue for reaching them with SRHR information. Over half of the respondents reported getting information on SRH from other sources including the media. Majority of respondents reported attending SHR lessons while in school. Majority of the males and females interviewed reported that these lessons are important and should be continued as avenues of providing information on SRH to young people. Given that so far SRH lessons in schools by the Ministry of Education are provided within the realm of life skills, efforts should be made to ensure provision of comprehensive sexuality education.

Results show high levels of early and unprotected sexual activities which begin early with multiple partners. Most of the young people reporting to be sexually active confirmed discussing contraception with their sexual partners before sexual intercourse. Generally young people's attitudes and perception regarding condoms and condom use generally point to favorable perceptions particularly in preventing pregnancy. Most of the respondents reporting to be sexually active indicated using a method to delay pregnancy. The most common source for the contraceptive methods frequently used by young people interviewed, was the government health facilities, shops and pharmacy. On the other hand, over a third of the study respondents did not know what safe days were for the girls which calls for awareness creation on the same.

Quantitative results indicate mixed results on perception of SRH aspects such as sexual activities and relationships. Results show that over half of adolescent girls and boys and young men and women were in sexual relationships. While adolescent boys and young men to be reported in relationships with someone younger or the same age as them, majority of AGYW were in a relationship with someone older than them indicating possibility of transgenerational relationships. The study findings show high approval of premarital sex by the young people. Findings also show perception of approval of non-consensual sex that needs to be addressed programmatically. A significant proportion of respondents in the study report exchanging sex for economic reasons and favors including to access basic needs.

Knowledge of STI is high although notable is that more than half of the respondent did not know HIV as an STI. Together with the results on low knowledge of signs and symptoms of STIs, it is possible that many young people may not know they have an STI and when to seek treatment. Reports of STI recurrence is a reflection of high risk unprotected sexual activities requiring appropriate preventive interventions on awareness creation and correct and consistent condom use.

Perception of risk of HIV/STI infection is somewhat high with over two thirds of respondents in the study reporting being worried of contracting HIV or other sexually transmitted diseases from their sexual partners. Despite this the lack of perceived risk of HIV infection by a third of the sexually young people calls for sensitization of young people on risks of unprotected sex and consequent HIV and STI prevention methods. Quantitative and qualitative results indicate low uptake of SRH services and information by young people. Results from the qualitative study show that young people seek medical treatment for illness when it is too late and prefer private clinics and pharmacies for their SRH information and service needs.

Most of the study respondents acknowledged awareness of how they can protect themselves against STIs including HIV. However, knowledge Pre – Exposure prophylaxis (PrEP) and Post - Exposure Prophylaxis (PEP) was extremely low. The proportion reporting to know that condoms can prevent HIV was also low. Although most respondents could identify signs and symptoms of STIs, more females than males reported not knowing any signs of STI infection in men with an equal proportion of females and males not knowing any signs and symptoms of sexually transmitted infection among women.

Nearly all respondents in the study had heard about HIV although results suggest that more needs to be done in providing more comprehensive information on HIV prevention. More emphasis also needs to be placed on the awareness creation and promotion of Pre–exposure Prophylaxis (PrEP) in HIV prevention.

This study set to assess the current levels of access to sexual health and reproductive justice for orphaned and vulnerable girls in Kisumu and Homa Bay Counties. Young people in the study know where to seek for SRHR information and services although service uptake is generally low. Government facilities are preferred for treatment of STIs. Findings show that a lower proportion of males and females interviewed had ever visited a health facility or doctor for services or information on contraception, pregnancy, abortions or sexually transmitted diseases 12 months to the study period. Other services sought were termination of pregnancies and gynecological examination. Choice of health facility visited was influenced a variety of factors such as distance, affordability, youth friendliness, accessibility and privacy and confidentiality.

Most of the young people had heard about sexual and gender based violence and could illustrate the different forms of SGBV but high tolerance of the same among them is observed. Less than half of all respondents reported that issues around SGBV are commonly discussed in the community although young people in the study pointed out that they are not involved in events or activities aimed at addressing SGBV issues in the community. The most commonly known points of reporting SGBV cases were chiefs, police, family members, and teachers. About 7% of the men and 13% of the young women confirmed having experienced some form of sexual and gender based violence.

Overall, results point to low levels of awareness of laws on sexually reproductive health and sexual and gender based violence. On land and property rights majority of the young people interviewed reported that themselves or their family members owned property and were in control of it. A small but significant proportion of respondents reported themselves or their family members having been disinherited.

Some of the factors identified as enabling access to SRHR justice in the community include ease of access to individuals and institutions, assurance of protection against perpetrators, friendliness of supporting individuals, ease of communication in language, assurance of confidentiality, and minimal or no costs for reporting and follow-up.

Some of the barriers to accessing SRH justice by orphaned and vulnerable girls include; psychological trauma confusion, embarrassment, and low self-esteem of the survivor, fear of the perpetrator, disbelief from the adults, perceived lack of confidentiality to those reported to, threats and power of the perpetrators, costs of reporting including distance costs and costs of accessing required services, length of time it takes to receive justice, corruption, failure and frustration by the responding individuals and authorities to pursue justice to the end, ignorance on where to first go to or what to do when reporting.

Recommendations

In supporting the design and development of interventions, KELIN should consider the following:

1) Working with the County Ministry of Education departments, teachers, peers and parents in the project catchment schools to create awareness about SRHR among young people and create linkages to services and justice;

- 2) Work with local FM stations such as Radio Victoria and Ramogi FM, Lagnet theater and Wazito football club to develop enter-educate approaches, to increase awareness about SRHR justice and linkage to services awareness among young people;
- 3) Work with Lagnet theatre to develop innovative social media platforms such as WhatsApp, SMS and 24 hour hotlines in providing SRHR information and linkage the services for orphaned and vulnerable adolescent;
- 4) Work closely with County reproductive health coordinators and County AIDS/STI coordinators to create awareness among adolescents and young people about the availability of PEP ad PrEP at project catchment health facilities;
- 5) Work with Impact Africa team to produce and disseminate age appropriate information education and communication materials for orphaned and vulnerable adolescents;
- 6) Promote meaningful participation of orphaned and vulnerable adolescents girls in the in the selected CBOs in the design, development and implementation of interventions targeting them;
- 7) Together with county health management teams, CUCs, KMET, health facilities, CBOs local administrators and Council of Luo Elders to provide linkages and referrals for SRHR services and justices through among others approaches community outreach and fee waivers for services to enhance health service and information uptake;
- 8) Work with paralegals, CUCs, provincial administration, lands department and the judiciary to create awareness about SRHR, land and property rights and laws and the link between SRHR and land and property rights;

- 9) Work with elders and chiefs to increase access to justice for adolescents and young people;
- 10) Work with judges, magistrates, and lawyers in the two counties to conduct court open days within communities to demystify court proceedings and encourage seeking justice within systems;
- 11) Work with judges, magistrates, lawyers, CBOs and paralegal teams in the two counties to train OVCs on SRH land and property rights and linking them with appropriate support individuals and groups in the community for example the chiefs, paralegals, councils of elders;
- 12) Work with local MCAs, chiefs, CUCs, CBOs and paralegal teams in the two counties to create awareness about existing laws and policies on SRHR and avenues, provisions, spaces and channels available for reporting and seeking justice by OVCs;
- 13) Work with lawyers in the two counties to provide legal aid to the OVCs safe spaces/shelter such as CBO offices, orphanages, schools in the community including establishing emergency call-in centers for survivors;
- 14) Train entry points for reporting rights violations (police, health care providers, chiefs, religious leaders, teachers, elders, widows) on how to handle young people especially in provision of protection, privacy and confidential youth friendly services for the survivors;
- 15) Hold mixed group community dialogue in the community to address the cultural issues affecting access to SRHR justice for AGYW gender inequalities: Discrimination against girls on the basis of education and issues of property, wife inheritance involving minors, tolerance of Sexual and gender based violence, tolerance of intergenerational sex, and breakdown of traditional sex education.
- 16) Enhance the socio-economic capacity of the AGYW and their families through facilitating them to start income generating activities, empowerment including training on entrepreneurial skills and vocational building approaches for young people like training in carpentry, masonry and life skill trainings;
- 17) Work with partners and County Governments to domesticate and support the implementation of national policies on orphaned and vulnerable adolescents at the county levels;
- 18) Form partnerships with stakeholders at community and county levels to lobby and advocate for the rights of orphaned and vulnerable adolescents; and
- 19) Engage the DREAMS Innovation Challenge participating CBOs to generate a database orphaned and vulnerable adolescents.



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