

**FACTORS INFLUENCING ACCESS TO SEXUAL REPRODUCTIVE HEALTH
SERVICES: A CASE OF THE UNIVERSITY OF NAIROBI MAIN CAMPUS
UNDERGRADUATE STUDENTS INSTITUTE OF ANTHROPOLOGY AND AFRICAN
STUDIES UNIT IN KENYA**

BY

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DECLARATION

This research project report is my original work and has not been presented to any other University or institution of higher learning for degree or any other award.

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DEDICATION

The study is dedicated to my husband Evans Oketch for his encouragement and support. I also dedicate this research project to my two sons Tedd Omung'a Oketch and Gavin Ang'asa Oketch for always giving me time to work on this research proposal. Finally, I will dedicate this information to my siblings brothers and sisters; Malack, Naomi, Miriam, Truphena, Risper and Noah for them to take charge of their own sexual lives. May God bless you.

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ABBREVIATIONS AND ACRONYMS

AIDs:	Acquired Immune Deficiency Syndrome
DFID:	Department for International Development (DFID),
DRH:	Division of Reproductive Health
HIV:	Human Immunodeficiency Virus
ICPD:	International Conference on Population and Development
IDIS:	Institute of Diplomacy and International Studies
IEC:	Information, Education and Counselling
IPFPA:	International Planned Parenthood Federation
KAP:	Knowledge, Attitudes and Practices
KDHS:	Kenya Demographic and Health Survey
KEPH:	Kenya Essential Package of Health
KNBS:	Kenya National Bureau of Statistics
KSPA:	Kenya Service Provision Assessment
MDG:	Millennium Development Goals
MOH:	Ministry of Health
NPPSD:	National Population Policy for Sustainable Development
RH:	Reproductive Health
STIs:	Sexually Transmitted Diseases
SRH:	Sexual Reproductive Health
SRHR:	Sexual Reproductive Health Rights

UON: University Of Nairobi

IAGAS: Institute Of Anthropology And African Studies (IAGAS)

ABSTRACT

The purpose of this study was to assess factors influencing accessibility to Reproductive Health services by the undergraduate student of the University of Nairobi Main Campus, IAGAS unit. Previous studies highlight numerous issues caused by inaccessibility and underutilization of Sexual Reproductive Health (SRH) services such as: high levels of teenage pregnancies who are at risk of HIV infection, unsafe abortions, Sexually Transmitted Diseases (STI)s, unintended pregnancies and premature sex. This study was guided by the following objectives: to find out how health system factors influence access to Sexual Reproductive Health, to institute how knowledge factors influence access to Sexual Reproductive Health Services, to establish how social factors influence access to Sexual Reproductive Health Services and to establish how economic factors influence access to Sexual Reproductive Health Services by the undergraduate university students. Descriptive survey design research methods was used in this research. It was used to collect data in order to answer questions touching on current status of SRH access amongst undergraduate students. A sample of 198 respondents was selected using simple random sampling technique. Research instruments included use of structured questionnaires. The data collected was analyzed using statistical package for social sciences (SPSS) and Excel spread sheet. The data output is presented in form of tables and description. The research findings show that several factors as health facility, knowledge, social and economic factors have been found to be interacting with the access of sexual reproductive health services by undergraduate students. On the extent to which health system factors affect access to sexual reproductive health services, the study found out that most of the students were undecided to state if there is adequate information from IEC materials at the health facility, there is lack of distinctive and functional department to provide youth friendly SRH services and some were not able to access the health facilities. The study also found that there was inadequate information from the health provider and ineffective youth friendly services. Regression analysis showed that the interaction between health system factors and access to sexual reproductive health services was negative with $\beta = -0.257$ at significant level 0.326. Knowledge factors were found to affect access of SRH services. Knowledge factors positively affect access to sexual reproductive health services with $\beta = 0.826$ at significant level 0.045. While, social factors influence access of sexual reproductive health service which is positively related to access to sexual reproductive health services with $\beta = 0.498$ at significant level 0.069. Some of the suggested platforms through which information on SRH services should be conveyed, included through internet/social media, TV and radio in that order of preference hence internet and social media was highly preferred. On the other end, economic factors influence access of sexual reproductive health services negatively with $\beta = -0.038$ at significant level 0.905. Based on the findings, the study recommended that; the government through learning institution should put in place an effective legal infrastructure and policies to remove barriers to the access to health care in learning institutions. Institutions should identify young people's reproductive health needs as a priority and equip the health care and education system to address the youth's specific sexual reproductive health needs. The study concludes that access to sexual reproductive health services is influenced by health system factors which have a negative influence, knowledge factors which have a positive influence, social factors which have a positive influence and economic factors which have a negative influence.

CHAPTER ONE

INTRODUCTION

1.1 Background of The Study

Young people in Kenya are at risk from a broad range of health problems. Sexual and reproductive health behaviors are among the main causes of death, disability and disease among young people. They are at particular risk for unwanted pregnancy and pregnancy related complications, STIs and HIV/AIDS. Other significant problems include: physical and psychological trauma resulting from sexual abuse, gender-based violence and other forms of physical violence and accidents. The youth are vulnerable to these problems because they often venture into sex unprepared; have sex with multiple partners; engage in alcohol and drug abuse that impairs judgment; have limited awareness of STI prevention; lack skills to negotiate safer sex; and have poor health-seeking behavior.

In this case Youths are defined as individuals aged between 15 to 24 years, constitute 18% of the world's population, of which nearly 80% live in developing countries (World Population Bureau, 2009). Kenya's constitution defines youth as all individuals in the republic who have attained the age of 18 years but have not attained the age of 35 (GOK, 2010). The UN on the other hand defines youth as persons between the age of 15 and 24. Due to varying age groups, in this study we are going to profile youth as those aged between 17-25 as the university going students. Among the critical health problems young people face are those associated with sexuality and reproductive health. For example, the total fertility rate increases from age 15 and peaks at age 24 before it slowly starts declining. Adolescents are up to three times more likely to experience

pregnancy related complications than older women. The overall HIV prevalence among youth aged 15-24 years was 3.8%. However, prevalence varies from 2.5% - 12% among young women of that age and 0.41% to 2.6% among young men of the same age. By 24 years, women were 5.2 times more likely to be infected with HIV than young men of the same age (Youth Fact sheet, 2010).

Despite increased investment in the sector, utilization of health services by young people remains low as only 12% of health facilities provide youth friendly services that would enable them to make informed choices and decisions regarding their health and general well-being. There are also major regional and age disparities in access to services. Sadly though is the fact that young people consider health a low to medium priority. The role of family is crucial in the development of young people. Parents influence over their children is highest when they are younger and that influence reduces as they grow older and is replaced by media and peers. This is confirmed by the fact that media (television, radio, and the internet) is still the most prominent source of information on sexual & reproductive health (24%). Most young people however (an average of 33% of 7-19 year olds), have no source of sexual and reproductive health information. 7-10 year olds trust their parents but unfortunately parents are not giving the relevant information to this age group. Extensive studies confirm the assertion that a father is particularly important and show direct correlations between a father's absence in a child's life with poverty, maternal and child health, incarceration, crime, teen pregnancy, child abuse, drug and alcohol abuse, education, and childhood obesity, critical health problems. Among young people face however, are those associated with sexuality and reproductive health such as early and unprotected sexual activity. These have a significant bearing on both their current and future health status. High fertility levels as well as high teenage pregnancy rates have serious negative consequences. Early

childbearing disrupts the pursuit of education and limits future opportunities for socio-economic growth.

According to Kenya Demographic health Survey (KDHS), 2010, 11% of young women and 22% of young men aged 15 to 24 had their first sexual intercourse before the age of 15. By the age of 18, 47% of young women and 58% of young men had had their first sexual intercourse. The trend in 2009 is an Improvement from 2007 where 16.4% of young women and 33.7% of young men had had sex before the age of 15 as illustrated. The 1994 International Conference for Population and Development (ICPD) set the stage for putting adolescent and youth sexual and reproductive health (SRH) on the international agenda. During the conference it was recognized that reproductive health needs of young people had largely been ignored by existing health, education and other social programs. According to the consumer insight 2009, The most prominent sources of information on sexual & reproductive health are media (24%), religious institutions and leaders (16%), followed by peers and friends (8%) and health institutions (8%). However this varies among different age groups. Most young people (an average of 33%) have no source of sexual and reproductive health information. Interestingly, 7-10 year olds trust their parents as a source of sexual & reproductive health information but unfortunately parents are not giving the relevant information to this age group. The most trusted source of information for 11-14 year olds is school and media while for 15 to 17 year olds is media and health institutions. For 18 to 19 year olds the most trusted source is media, health institutions and peers/friends. The conference adopted a plan of action which has formed the basis for programs addressing the SRH needs of adolescents globally (ICPD, 1994). Five years later (ICPD + 5) made a further call for governments to ensure that adolescents have access to user friendly services that effectively

address their SRH needs including reproductive health information, education and counselling and health promotion activities, while encouraging their active participation.

In aligning the reproductive health agenda as deliberated at ICPD, 1994, the Kenyan government came up with a National Reproductive Health Strategy (NRHS 1997-2010). The strategy identified RH priority areas as: family planning and unmet needs; safe motherhood and child survival initiatives; promotion of adolescent and youth health; gender and reproductive health rights; management of STIs/HIV/AIDs; management of infertility among other reproductive health issues. Implementation plans were subsequently developed to improve reproductive health needs in the country. From the trends and according to KDHS, (2009), Kenyan women continue to experience a high unmet need for family planning. For example, 27% of 15-34 year olds have unmet need for spacing and limiting family planning methods. The unmet need for spacing children declines with age while that of limiting increases with age.

Ministry of Health in Kenya formally approved the country's first National Reproductive Health Policy (NRHP, 2003) to provide a framework for equitable, efficient and effective delivery of quality reproductive health services to the population especially those considered vulnerable such as the youth. The policy focuses on: safe motherhood, maternal and neonatal health, family planning, and adolescent/youth sexual and reproductive health and gender issues with the aim of giving guide to planning, standardization, implementation, and monitoring and evaluation of reproductive health care provided by various stakeholders. Despite the efforts, inequity to accessibility and general utilization of reproductive health services by the adolescents and youths is a worrying concern, especially in the developing countries. A review conducted 10 years later

(ICPD + 15) showed that teenage births were still a major concern, especially in sub-Saharan Africa where rates of more than 120 births per 1000 women aged 15–19 years are recorded and young people continue to be at risk for HIV infection, especially adolescent girls (UNFPA and PRB, 2009; Ringheim K et al., 2010; Khan S, Mishra VK, 2008).

In Kenya, a review by the Ministry of Public Health and Sanitation (MOPHS) 2010, and Ministry of Medical Services (MOMS) through a study on reproductive health communication (MOPHS & MOMS,(2012) revealed that health care services given to youths in schools focuses more on physical environment and sanitation, nutritional status, immunization with little attention given to reproductive health needs. According to the report 2009, *Best Practices in Reproductive Health in Kenya*, Kenya recognizes its need to identify existing best practices in RH and has made that a national priority. A deliberate effort should be made to refocus attention on the challenges and critical programmatic needs in the area of RH and to apply the best practices that have been identified. Currently, information on targeted and coherent programmes that have and have not worked is lacking, which has resulted in costly duplication of efforts and the implementation of ineffective programmes. Current, best-available evidence from relevant and valid research on the effects of different forms of health care is crucial for decisions about the management and care of individual patients and the delivery of health services, particularly in settings where resources are limited.

1.2 Statement of the problem

Low accessibility to RH services creates a universal concern since unintended pregnancies, unsafe abortions, and sexually transmitted infections (STIs) have been shown to contribute to high morbidity and mortality rates, especially in developing countries (Izugbara, 2010; Leon,

2002; Pathak,2002). For instance, Infant mortality rates are 1.8 times higher for infants of unmarried mothers than for married mothers (Matthews &MacDorman, 2000). Unmarried mothers are less likely to obtain prenatal care and more likely to have a low birth-weight baby. Researchers find that these negative effects persist even when they take into account factors, such as parental education, that often distinguish single-parent from two-parent families (U.S. Department of Health and Human Services, 1995 September. Globally, approximately 16 million adolescents become pregnant every year, of which three million undergo unsafe abortions (Ziraba, 2009). Adolescents are more likely to die from the causes related to pregnancy and childbirth compared to reproductive-aged women (Simoes, 2011; Mayor, 2004; Atuyambe , Mirembe, 2008). Likewise, the stigmatization of premarital sexual relations among young women deters them from seeking information about RH, engaging in safer sex and fulfilling their RH needs (Basculides, Laraque, 2004). Those disparities of access to RH care affect not only the individuals but also their families, society and health systems as a whole at both national and global levels (Kaljee, Green et al., 2007; Singh, 2010). Therefore, the inequity of access to RH services by the youth is an issue of high priority. According to the WDR (2007) nearly 60% of girls in developing countries become mothers before the age of 25. Boys make their transition a little later. This difference largely reflects gender differences in the age of marriage. However, many young men and women are not well prepared for parenthood or marriage and they therefore lack knowledge of good health practices and available maternal and child health services (WDR (2007). Preparing youth for the transition to family formation so that they can plan child bearing, have a safe pregnancy and raise healthy children has a lasting impact on the economy and demographic trends in a country.

Although the availability of RH services has been promoted globally, the disparities of access to RH care still remain among youths, especially those living in resource-limited areas ((Adinma, 2011); Hazarika, 2010). Premarital sexual intercourse is common and appears to be on the rise in all regions of the world. Young people everywhere reach puberty earlier and marry later than in the past. As a result, youth are sexually mature for a longer period of time prior to marriage. Among male youth, studies suggest that 24 to 75 percent of Asian men have had sex by age 18; 44 to 66 percent of Latin American men by age 16; and 45 to 73 percent of sub-Saharan African men by age 17. The University of Nairobi has in place Health services where they provide HIV and Aids preventive, care and treatment services for students, staff and staff dependants. They also provide treatment for sexually transmitted infections and other reproductive health services. This includes: contraceptive services especially condom use education and distribution. Condom use education is provided during HIV sensitization programs in all campuses. Condoms are also available in all the campuses. In consultative discussions with The Women Students Welfare Association WOSWA, there is still a gap noted in provision of SRH services especially in main campus located in the town Centre. This study seeks to critically look at the factors influencing access to sexual reproductive health services to contribute towards health implementation focus within the University undergraduate students in the University of Nairobi.

1.3 Purpose of the study

The purpose of this study was to investigate the factors influencing access to sexual reproductive health services among undergraduate students youth population in the University of Nairobi, main campus, IAGAS unit.

1.4 Objectives of the study

- i. To assess how health system factors influence access to Sexual Reproductive Health Services by the undergraduate university students.
- ii. To assess how knowledge factors influence access to Sexual Reproductive Health Services among the undergraduate university students
- iii. To establish how social factors influence access to Sexual Reproductive Health Services among the undergraduate university students.
- iv. To establish how economic factors influence access to Sexual Reproductive Health Services by the undergraduate university students.

1.5 Research questions

- i. How do the health system factors influence access to Sexual Reproductive Health Services by the undergraduate university students?
- ii. In which way do knowledge factors influence access of Sexual Reproductive Health Services among the undergraduate university students?
- iii. How do social factors influence access of Sexual Reproductive Health Services among undergraduate university students ?
- iv. How do economic factors influence access of to Sexual Reproductive Health Services by the undergraduate university students?

1.6 Significance of the study

This study finding may be significant since it will add knowledge to the earlier studies carried out on utilization of reproductive health services among youth in colleges. It will give an in-depth analysis on the factors that influence access to and utilization of reproductive health

services in institutions of higher learning. This might prompt further researches. The study is of significance to the University of Nairobi, main campus in that they may benefit by having prior knowledge on how challenges related to reproductive health services influence the performance of students and hence the need for addressing the underlying causes of the challenges.

The findings are expected to benefit policy makers to inform decision making in forming/implementing SRH policies targeting the youth population and allocating resources, other researchers in forming opinions and picking up SRH gaps amongst the youth population, Non-Governmental organizations' in allocation of resources and advocating for human rights, university students in accessing SRH services and add to the available documented knowledge for reference purposes. It's expected that it may also benefit other key stakeholders as community Based organizations, private sector in the Sexual reproductive health sector to promote and market these services in a non-discrimination manner to promote sexual reproductive health rights.

1.7 Limitations of the study

The study encountered the following limitations: Some students were not open and willing to discuss issues associated with Sexual reproductive health services because of the stigma and taboos associated with the topic of study. This was mitigated by assuring the respondents that this research was purely for academic purposes and confidentiality was assured. The cost of conducting the research was anticipated to be high since it involved travelling to the campuses of study. This however was mitigated by maximizing the available time and having a good budget and working within the budget.

1.8 Delimitations of the study

The study focused strictly on the University of Nairobi main campus, within Nairobi County with special attention on the undergraduate students youth, Institute Of Anthropology And African Studies (IAGAS) unit.

1.9 Basic Assumptions of the Study

The study targeted undergraduate university students from IAGAS unit studying at the university of Nairobi main campus. The study made an assumption that university students do not access Sexual Reproductive Health (SRH) services on need and want basis. This study also assumed that the information given by the students will be true and given in good faith without any biasness.

1.10 Definition of significant terms used in the study

According to this study, the following significant terms have the following meaning:

Economic factors: These are costs related to SRH services for the student ability to access them at any particular need basis which affects usage of the youth friendly reproductive health services

Factors influencing Health: These are a range of personal, social, economic and environmental factors which determine the health status of individuals or populations.

Health facility factors: The physical facility; private and public where the students can access SRH services.

Knowledge factors: The know-how factors to change way of thinking and information to make an informed decision of choice and control voluntarily.

Social factors: These are facts and experiences that influence students' personality, attitudes and lifestyle

Sexual reproductive health: Addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control

Youth: These are students attending undergraduate studies at the University and are between childhood and adulthood (maturity), consists of persons aged between 17-25 years

1.11 Organization of the study

This project report consists of five chapters. Chapter One describes the background of the study, statement of the problem, purpose and objectives of the study, research questions, assumptions, significance, limitations, delimitations of the study and definition of the significant terms. Chapter Two focuses on literature review organised on thematic objective areas, Theoretical framework and Conceptual framework. It has been organized according to the objectives of the study, theoretical framework and conceptual framework at the end. Chapter Three presents research methodology used in this study. It includes; research design, target population, sampling procedures and sample size, data collection instruments, validity of study instruments, reliability of study instruments and data analysis as well as ethical consideration and operationalization of the study variables. Chapter Four gives the results of the data analysis, the presentation in tables

and the interpretation. Chapter Five gives the summary of the research findings, discussion on the findings, conclusions made and recommendations made on each of the research variables.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature related to the factors influencing access to sexual reproductive health services amongst university undergraduate students youth. This section places emphasis on the numerous researches carried out and how such knowledge can be a guiding tool in analysing factors influencing access to SRH services amongst the university undergraduate various university youth. The literature is reviewed critically through identifying the gaps and also employing the lessons to inform the body of knowledge how various factors; Health system factors, knowledge factors, social and economic factors that are likely to influence the access to Reproductive Health services among undergraduate University students youth at the University of Nairobi. A theoretical and conceptual framework has also been represented and the literature gaps identified.

2.2 Health system factors and access to Sexual Reproductive Health services among undergraduate University students

Globally, equitable access to health care has been articulated as a basic human right. Reproductive health services have a special role in attaining MDG 5 for the improvement of maternal health, including maternal and newborn health, family planning, prevention of unsafe abortion, control of sexually transmitted infections, and promotion of sexual health. HIV control and gender are crosscutting issues to be addressed, also captured in the MDGs. Strengthening sexual and reproductive health services for adolescents and young people should involve them in determining their needs as these vary between countries and regions.

In Russia, the federation government has identified young people's reproductive health needs as a priority, however health care and education systems are not yet properly equipped to address the youth's specific reproductive health systems (WHO, 2010). The youth aged 15-18 year olds in Russia are served by pediatricians but health reports show that these young people who had a long relationship with pediatricians are often embarrassed to discuss difficult issues such as contraception or sexually transmitted infections (STIs) and may also worry about breaches of confidentiality (WHO, 2010).

Studies from the USA and UK have found similar needs to improve youth services and male-friendliness as well as integration of HIV services, learning from lessons integrating services for family planning and sexually transmitted diseases (Pearson S, 2003). Health Sector reform in Mongolia has resulted in innovative youth friendly services engaging urban youth. They reduced maternal mortality and increased contraceptive use, but sexually transmitted infections and rising rates of adolescent pregnancy remain a challenge (Hill PS et al 2006). Many countries in Africa are taking steps to improve youth reproductive health issues as a follow up to ICPD (1994). There are such initiatives as removing legal obstacles so that young people can access needed services, for example, under South African law, anyone 14 years or older has the right to receive contraception (UNFPA, 2003).

Following the ICPD (1994), the Kenyan government and development partners have come up with numerous policies, guidelines and strategies in order to make reproductive health services available, accessible, acceptable and affordable to young people. First, Adolescent Reproductive Health and Development (ARH&D) policy in was developed in 2003. The policy underscores the relationship between the nation's development and the health of its youth and identifies the significant role that can be played by young people in enhancing their own health. The policy

addresses various adolescent reproductive health issues and challenges including SRHR; harmful practices, including early marriage, female genital cutting and gender-based violence; drug and substance abuse; socio-economic factors; and the special needs of adolescents and young people with disabilities.

The *National School Health Policy (2009)* developed jointly by the Ministry of Public Health and Sanitation and the Ministry of Education, defines a comprehensive school health program that is meant to enable government to address the needs of learners, teachers and their families. The document covers a wide-range of health issues, including SRH, and life skills key in supporting young people's health. The policy recognizes the need to inform students on SRH and provide them with necessary skills to avert unwanted pregnancies, disease or sexual violence. The National School Health Policy approaches teen pregnancy from a human-rights angle and calls for the provision of counseling to a pregnant girl and her parents to ensure her well-being. The National School Health Policy also recognizes that girls have a right to education during and after pregnancy.

Despite the various policies and guidelines that have been put in place to ensure proper RH for adolescents in Kenya, numerous challenges continue to be faced. Unmet need for FP continues to be a problem among adolescents. According to the 2008/09 KDHS, two-thirds of sexually active adolescents were not using a method of FP at the time the survey was conducted. The stigma that unmarried adolescents experience when they are seen at RH and HIV service centers is a great barrier to the use of RH services. A disconnect exists between policies and action. Kenya's RH indicators remain poor and a myriad of SRH challenges continue to be faced, some of which include a high rate of unintended pregnancies and unsafe abortions. These challenges give rise to high morbidity and mortality especially among adolescents and other vulnerable populations.

2.3 Knowledge factors and access to Sexual Reproductive health services among undergraduate University students

Most family planning and reproductive health programs designed to serve young people have neglected the special needs of married adolescents, a particularly disadvantaged group. Lack of availability of services is commonly noted as the most important barrier, but lack of access to reproductive health knowledge was also associated with lack of self-confidence among young people to discuss such issues. In Sri Lanka, focus group sessions found that the most common problems for 17–19 year-olds were psychological distresses, masturbation, and menstrual cycle problems (Agampodi et al, 2008).

A study in Cambodia showed that the barriers to youth access to reproductive health services included lack of confidentiality, shyness, poor relations with health staff, illiteracy and low prioritization by parents for reproductive health services (Adra, 2007).

Studies of the attitudes of health professionals to adolescent SRH problems concerning provision of services in Kenya, Zambia, Swaziland' and Uganda confirmed reported experiences of young people. There was disapproval of adolescent sexual activity, including masturbation, contraception, and abortion, although those with more education had more youth-friendly attitudes (Kippet al., 2007, Warenius et al., 2006 and Mngadi et al., 2008). Young people rated expected factors as most important in youth-friendly services: confidentiality, privacy, short waiting time, low cost, and friendliness to both young men and young women (Erulkar et al, 2005 and Mmari et al, 2003). Least important characteristics included youth-only service, youth involvement, and young staff.

According to a report by Kenya National commission on Human Rights (2012) inquiring into violations of SRH rights in Kenya youth lack easy access to quality and friendly health care, including STI services, safe abortion services, antenatal care and skilled attendance during delivery, which result in higher rates of maternal and perinatal mortality. Other specific reproductive health problems experienced by young people include sexual violence and abuse including coerced sex, defilement and rape which increase their risk to STIs including HIV. The enquiry found out that University students who get pregnant are expected to vacate their halls of residence and seek alternative accommodation. Date rape is also common in male halls of residence in various campuses of Nairobi University. Abortion is also a problem as fetuses are collected from the dustbins. Most girls do not seek safe abortion services including post abortion care citing fear of being known to have aborted. In addition, young girls are unsuspectingly lured into sexual activities making them highly vulnerable to rape, STIs, pregnancy, drugs and at times arrest. At times, girls are exposed to various forms of sexual harassment in return for favours such as money, grades, internships or pure blackmail. It was noted that, the sexual reproductive health challenges facing adolescents and youth in Kenya today are due to lack of sex education and information, poor guidance and counselling services, unavailability of youth friendly sexual reproductive health services such as contraceptives among others. Many university students suffer in silence and ignorance of their rights and do not consider family planning as a priority issue (KNCHR, 2012).

2.4 Social factors and access to Sexual Reproductive Health Services among undergraduate University students

Globally, young women face extraordinary barriers in accessing sexual and reproductive health (SRH) services, particularly when it comes to accessing safe abortion services. They are doubly

stigmatized— both for being sexually active and for seeking an abortion. Yet, they are also stigmatized if they decide to keep their pregnancy. It's a no win situation (Chelsea, IPPFA).

Age is a demographic factor that affects utilization of health services. Reports from KDHS 2008/09 revealed an increased uptake of family planning services among age 20-24 years as compared to 10-19 year old youth. The youth hardly perceive the seriousness of sickness or health need and this is a major impediment to the youth in accessing and utilizing health services. A study by Senderowitz, et al (2003) on rapid assessment reproductive health services concluded that youth are unwilling to seek care due to the national laws and policies restricting care based on age and/or marital status, poor understanding of their changing bodies and insufficient awareness of risks associated with early sexual debut, STI/HIV and pregnancy.

On the other end, some taboos have been successfully addressed, such as improving traditional youth education to avoid pregnancy and prevent HIV/AIDS in Ghana. Work by the Planned Parenthood Association supported by the Department for International Development (DFID), reached almost 30 000 young people and the number of young people using contraception increased from 27% to 80%. In Zambia, DFID support to the AIDS Alliance has helped support sexual and reproductive health sessions with 80 000 young people; a community member said, “More boys and girls recognize their rights to refuse sex, enjoy their feelings without intercourse or insist on using a condom” (International Planned Parenthood Federation 2006). The NRHS 1997 to 2010 laid the guidelines for the execution of the reproductive health program. However, implementation was hampered by inadequate funding, among other challenges, leading to declines in the quality of health service delivery and worsening health indicators. In addition, the 2010-2012 Reproductive Health Communication Strategy identifies the provision of adequate

information and universal access to RH services as a priority for young people for the purpose of improving their RH.

2.5 Economic factors and access to sexual Reproductive Health Services among undergraduate University students

The economic costs of health care seeking include not only payment for treatment but also loss of productive or school/college time for the student, and the travelling expenses. This means that persons of low socio-economic status can have difficulty in affording the costs associated with access of healthcare making utilization unlikely unless they are provided with subsidized costs (Taylor, 2003). Poverty has led some university/college youth to engage in pre-marital sex in exchange for gift or economic support further exposing them to RH risks. User fee charged at the health facilities may hinder the youth from utilizing youth friendly services (MOH, 2005; NCAPD et al, 2005). Lack of political will has led to a corresponding lack of financial commitment to sexual reproductive health to both international donors and national governments thus further complicating access for the youths who may not have funds for the services (Global Fund, PEPFAR, World Bank's MAP). Enabling characteristics (family and community resources)-Family income or economic status, location of residence, access to health care facilities and availability of persons for assistance are key factors in health seeking behaviour. The school going youth is largely dependent on parents/guardian and the infrastructure within their schools or residence. Need characteristics explores perceived need for health services, and expected benefit from treatments. Health care system includes health policy, resources and organization which refers to how health care system manages itsresources and consumer satisfaction determine individual's use of health services.

U.S. funding preferences for abstinence-until-marriage programs have also undermined comprehensive approaches. The current U.S. guidance on PEPFAR programs limits condom programming to youth 15 and over. In none of the three countries was this seen as a common sense restriction that addressed the needs of youth. Almost every youth program manager tries to promote only abstinence, reality often dictated a less stringent approach to condom promotion. In the Dominican Republic, the U.S. guidance sharply contrasts with the government's recent action to revise the age of reproduction from 15 to 10 due to the high number of pregnancies and STIs occurring in this age group. However, because of U.S. funding majorly provide condoms to these girls if they admit being sexually active; otherwise they only teach abstinence. This affects resource allocation towards the youth.

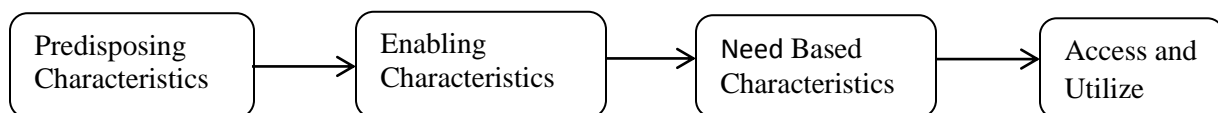
In Ethiopia for instance, programs explain that their youth clubs have to be divided based on donors—in some groups they can promote condom use, but in the U.S.-funded groups they cannot. The director discussed the issues that this raises, as they are challenged by the youth in the PEPFAR-funded groups, who say “why don't you teach us about condoms? It is our right.” Chapter 4 of UN on Youth & Health Issues shows that most parts of the world, young people consider health a low to medium priority. A recent review of expectations of young Arabs indicates that while economic issues such as job opportunities are important to 45 per cent of 15- to 20-year-olds, health care is a top priority for only 4 per cent of them. Health ranks below education, the environment, wealth and income distribution, and political participation. There are some young people, however, for whom health is articulated as an issue. Estimates indicate that more than half the world's population is below the age of 25—the largest youth generation in history and nearly one-third is between the ages of 10 and 24. Their numbers are still growing,

particularly in sub-Saharan Africa. About 83 per cent of all adolescents currently live in developing countries with Africa holding the largest proportion. In Kenya specifically, the high fertility and declining mortality that are typical of the region have yielded a youthful population. Over 40 per cent of Kenyans are younger than 15 years and only about 4 per cent are aged 65 years and above according to the 1999 census data. This means that over half of Kenya's population of about 31 million is aged below 24 years, with the larger proportion being adolescents. Indeed, more than one-quarter of the country's population consists of young people aged 10 to 24 years. Unfortunately, pervasive social, economic and health problems mean that circumstances for Africa's and Kenya's adolescents are often especially difficult even though these young people comprise form a formidable force that can no longer be ignored. Thus, Africa, Kenya included must rise to the massive challenge of providing its adolescents with opportunities for a safe, healthy and economically productive future.

2.6 Theoretical Framework

The study employed Andersen' Phase one Model of Health Service Utilization (Andersen R, Newman JF, 2005) to investigate reproductive health service utilization among college students within Nairobi University.

Andersen's Behavioral Model of Health Services Utilization (adapted from Wolinsky, 1988b)



This behavioral model provides a systems perspective to investigate a range of individual, environmental and provider related variables associated with decisions to seek health care. It proposes that the use of health care services is a function of three categories of factors;

Predisposing characteristics which mainly explains the association of demographic factors such as age, sex and education level and consumption of health services.

Enabling characteristics (family and community resources)-Family income or economic status, location of residence, access to health care facilities and availability of persons for assistance are key factors in health seeking behavior. The college youth is largely dependent on parents/guardian and the infrastructure within their schools or residence. Need characteristics explores perceived need for health services, and expected benefit from treatments.

2.7 Conceptual Framework

The following is a conceptual framework useful in understanding the relationship between the dependent and independent variables in this study. The conceptual framework that has guided this study is constructed from four independent variables; health system factors, knowledge factors, social factors and economic factors attributed to health systems and structures, societal and individual factors. Individual personality of different players and their respective levels of commitment as moderating variables for the independent and dependent variable affect access to SRH services among the undergraduate students youth among University students, IAGAS unit.

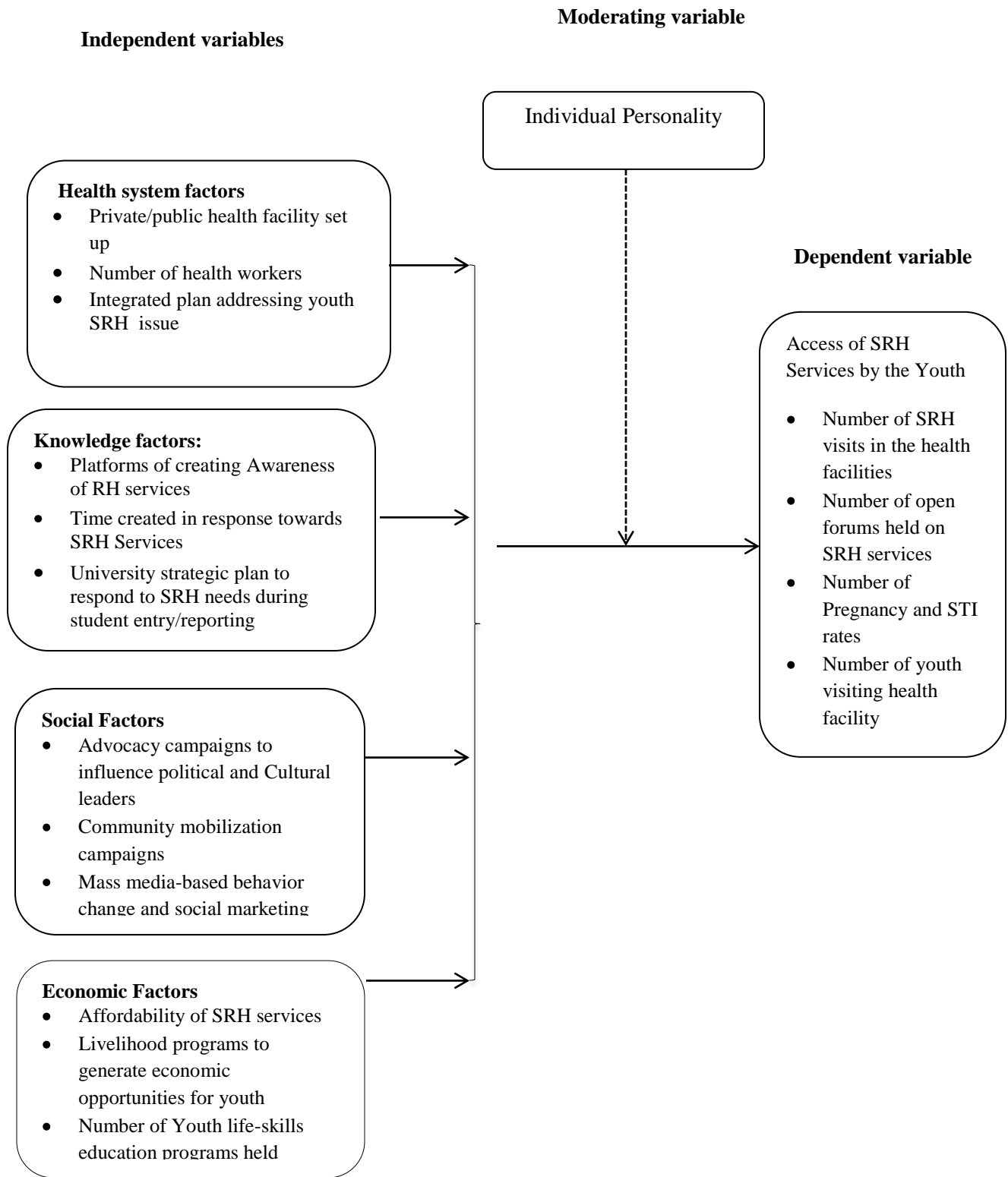


Figure 1: Conceptual Framework

2.8 Knowledge gap

A systematic review of interventions to increase young people's use of health services in developing countries has shown that a combination of interventions, including health service provider training, facility improvement initiatives and community-wide health education can lead to increased service uptake. The need for careful monitoring, evaluation and operations research was also highlighted in this review. Health care provider training on youth-friendly services (YFS) that are linked to other service components such as education in schools and the community, significantly increases service use especially among younger males (15-19 yrs).

A study conducted by One World UK to assess facilities providing Youth-Friendly Services(YFS) found out that gaps existed in provision of YFS and that few facilities qualified to be called youth friendly as they did not meet universally acceptable standards for youth friendly services and such were run by Non-Governmental Organizations(NGOs) and the Universities. There was inadequate staffing, lack of clear policies and guidelines on YFS provision and inadequate Information Education Communication (IEC) materials (Osanyin, 2009).

Study in Zambia on vulnerability and sexual and reproductive health among Zambian secondary school students concluded that boys and girls lacked adequate information about human reproduction and STIs including HIV (Warenius et al., 2007). A study done by Motuma (2012) on youth-friendly services (YFS) utilization and factors in Harar, Ethiopia concluded that most youth had positive attitude towards YFS but had poor knowledge on the services.

In the National Health Sector Strategic Plan II 2005–2010 (NHSSP II), adolescent SRH has been recognised as a priority within the Kenya Essential Package of Health (KEPH) [21]. Within the KEPH the Ministry of Health commits itself to providing services that are specific to this age group including reproductive health counselling, contraceptives and HIV/AIDS related services. This is to be achieved through the establishment of youth-friendly SRH health services within existing health facilities.

According to the NHSSP II (2005–2010), the government intended to increase the number of facilities providing youth-friendly services from five in 2004 to 60 in the year 2010 [21]. In spite of this commitment, there is still some scepticism among planners, policy makers and development partners with regards to allocating resources to SRH services targeting young people. One of the reasons for this reluctance to allocate resources could be that stakeholders are not fully convinced about the model of service provision. In addition to this, there is limited documentation on the state of SRH services for young people in Kenya. The national guideline for provision of youth friendly services in Kenya document further articulates reproductive health issues such as providing information and services which are available, accessible, affordable and acceptable and made available (MOH, 2005). These services are geared towards meeting unmet reproductive needs of the youth. Family Health Options Kenya (FHOP) is an organization partnering with other organizations such as International Planned Parenthood Foundation, Family Health International, DANIDA among others with a strategic objective of strengthening commitment on support for sexual and reproductive health and rights and needs of adolescents/young people. To achieve this strategic area, Family Health Options Kenya uses various strategies, provision of youth friendly integrated services, sexuality education, peer education, advocacy and empowerment of young people through outreach activities. Integrated outreach activities include VCT/SRH mobile and Moonlights provides an avenue for the young people to access the services with reduced barriers (FHOP, 2013).

The University of Nairobi has in place Health services where they provide HIV and Aids preventive, care and treatment services for students, staff and staff dependants. They also provide treatment for sexually transmitted infections and other reproductive health services. This includes: contraceptive services especially condom use education and distribution. In following up closely with The Women Students Welfare Association WOSWA, there is still a gap noted in provision of SRH services especially in main campus located in the town Centre. They advocate this through holding events such as; reproductive health week to promote these type of services, an event carried out on a yearly basis. During reproductive

health week, a few organisations as; Non-Governmental and other organizations (USAID Aphia II, Population Services International (PSI), Marie Stopes Kenya, I Choose Life (ICL), G- Pange, GlaxoSmithKline (GSK), Bayer Healthcare, Eco Bank, Standard Group organizations’) once in a while come on board support them with creating awareness and provision of SRH services.

Consultative information showed that few young people receive adequate preparation for their sexual lives at the university. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs) including HIV. Questions which remain is that are these Sexual Reproductive Health services accessible amongst the university undergraduate youth and what are the factors influencing accessibility?

Family Health International (FHI), 2014 carried out a study with UON on: Providing integrated sexual and reproductive health services at Kikuyu Campus, University of Nairobi. The research showed that that there has been an increase in awareness of RH services and CCAs at the UON over the year between the two surveys. Most respondents knew of the newly opened RH unit though awareness of specific services was not very high. The results demonstrate that there is still a need for greater promotion of the reproductive health unit and also the specific services that the unit provides.

2.9 Summary of Chapter

Literature revealed that despite the initiatives put in place towards improving SRHs for the youth, barriers still exist which affect the utilization of services by the youth. Studies across the health systems point to the ways the services are given and the youth unfriendliness of the facilities. This is evidenced in factors such as service delivery hours, cost of services, lack of confidentiality and facility organization. Others are individual factors such as lack of knowledge and attitude. Literature also revealed that there is concerted effort by many countries to reach the youth with reproductive health services and though little has been achieved, a lot more need to be done to reach a good threshold to rid the youth from reproductive health problems. Kenya is

among the countries a lot of effort is going on in the area of reproductive health service delivery but little evidenced is shown for the youth in the university.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter includes study design, variables, area, sampling criteria and study instruments used in the study, data collection, data analysis and interpretation and lastly ethical considerations for the study.

3.2 Research Design

Descriptive survey research methodologies was used in this study. According to the office of Human Research Protections (OHRP), descriptive survey provides information about the naturally occurring health status, behavior, attitudes or other characteristics of a particular group. Descriptive studies are also conducted to demonstrate associations or relationships between things in the world around you. This research design is best for this study since this research aims at clarifying relationships among the study variables and draw explanatory interpretations. The researcher used structured questionnaire methods in collecting data since it can produce a lot of data in a short time at a low cost. The questionnaires was self-administered to ensure a high return rate. The research used a quantitative method of data analysis in order to establish and describe the degree of relationship between the independent and dependent variables.

3.3 Target Population

The study sought to examine the factors influencing access to sexual reproductive health services for undergraduate students youth in the University of Nairobi main campus, IAGAS unit. The population of the study was 407 undergraduate students in the University of Nairobi, data was received from the university Administration student database (Attached APPENDIX V). Focus

population as defined by Frederick (2010) is a universal set of study of all members of real or hypothetical set of people, events, objects to which an investigator wishes to generalize the result. The accessible population is the population in research to which researchers can apply their conclusions (Thorn Hill, 2009). The study population will comprise the university youth studying undergraduate degree course at the time of study.

3.4 Sample size and sampling procedures

Sampling is done to some elements of a population so that conclusions about the entire population can be drawn. The ultimate test of a sample design is how well it represents the characteristics of the population it purposes (Thorn hill, 2009). The study sample size was determined by using the following formulae as used by Krejcie and Morgan (1970).

$$S = \frac{X^2 NP(1-p)}{d^2(N-1) + X^2 P(1-P)}$$

Where;

S = Required sample size

X^2 = The table value of chi-square for 1 degree of freedom at the desired confidence level (3.841)

N= the population size (407)

P = The population proportion (assumed to be 0.50)

d = the degree of accuracy (margin error) expressed as a proportion

thus;

$$S = \frac{3.842^2 (407)(0.5)(1-0.5)}{0.05^2 (407-1) + 3.842^2 (407)(1-407)} = 198$$

The sample size was 198 respondents

Simple random sampling procedure was used to ensure that the sample adequately represents the target population of the targeted respondents in this study. The respondents were randomly selected from that list for the sample. Thereafter, I conducted student administered questionnaires for this study.

3.5 Research Instruments

Data collection methods are a very key component of any research since the methods used determine the validity and reliability of the research findings. The investigator relied on both primary and secondary data. According to Kothari, 2004, primary data are those that are collected afresh and for the first time, and thus happen to be original in character. Secondary data on the other hand, are those which have already been collected by someone else and which have already been passed through the statistical process.

This study utilized a questionnaire to collect primary data from the sample size selected. The questionnaire designed for this study comprised of two sections. The first part included personal details of the respondents that may hinder access to sexual reproductive health services of the respondents. The second part has factors affecting access to SRH services among the undergraduate youth population. Kothari (2004) observes that questionnaires have the advantage of being cost effective, free from bias of the interviewer, gives the respondents adequate time to give well thought out answers, convenient in reaching out respondents who are not easily approachable and large samples can be made use of thus the results can be made more dependable and reliable. The focus of the study is to know the factors influencing accessibility of RH services among the youth.

3.5.1 Piloting of the Questionnaire

The researcher carried out a pilot study to pretest and validate the questionnaire. This pilot study involved 20 undergraduate students of the University of Nairobi main campus Institute of Diplomacy and International Studies (IDIS) unit. Various research authors (Sekaran, 2008; Mugenda, 2008) recommend pilot study as a critical pretest for establishing the reliability and validity of the instruments for data collection. Isaac (2005) states that a sample size of between 10 and 30 responds for a pilot study is adequate for any study. A total of 20 undergraduate students from IDIS unit were picked randomly and a questionnaire was issued. The respondents in the pilot study were not be included in the main study. The questionnaires consisted of 2 sections. The first section relates to personal details of the respondents, the second section had factors influencing access to SRH services; health facility factors, knowledge factors, social factors and economic factors.

3.5.2 Validity of the research instrument

Validity is the accuracy and meaningfulness of inferences, which was based on the research results. It is the degree to which results obtained from the analysis actually represent the phenomenon under study, Mugenda and Mugenda (2003). Validity of the instrument was used to measure the degree to which the items represented specific areas covered by the study. Validity of the instrument was determined by experts in the field of research who looked at the measuring technique and coverage of specific areas (objectives) covered by the study. The questionnaire was given to professionals in the field of research to critique it and to give suggestion on the necessary areas to change in order to establish the validity of the instrument. The corrections on the identified questions were then incorporated in the instrument to ensure validity of the

research instruments. Validity was ascertained by checking whether the questions were measuring what they were supposed to measure such as the: clarity of the wording and whether the respondents were interpreting all the questions in a similar way, Orodho (2005). Validity was therefore established by the researcher by revealing areas causing confusion and ambiguity and this led to reshaping of the questions to be more understandable by the respondents and to gather uniform responses across various respondents.

3.5.3 Reliability of Research Instrument

Reliability refers to the measure of the degree to which research instruments yield consistent results (Mugenda and Mugenda, 2003). Reliability also refers to the stability, accuracy and precision of measurement. In order to achieve this, the researcher administered the instruments in person in order to assess their clarity. To assess the reliability of the research instruments, the researcher employed split-half technique whereby the questionnaires were administered to two groups; odds and evens and the results compared. This measures the extent to which all parts of the test contribute equally to what is being measured. This was done by comparing the results of one half of a test with the results from the other half. The two halves of the test provided similar results with a high correlation ($r = 0.646$) which suggested that the test had internal reliability. This ensured the reliability of the research instruments as the two results were compared to measure the consistency of the scores obtained.

3.6 Data Collection Methods

A cover letter from the University of Nairobi and research permit was taken along to enable the administering of the research instrument. The respondents were assured of confidentiality of their names and responses were not handled by any other person but rather to be used purely for academic purposes. Each research instrument was coded and only the researcher had the

knowledge on which student responded. Self-administered drop and pick questionnaires were distributed among sampled undergraduate student youth. This made it easier to get adequate and accurate information necessary for the research. The questionnaire had both open and close-ended questions. The close ended questions provided more structured responses to facilitate tangible recommendations. The open-ended questions provided additional information that had not been captured in the close-ended questions. Secondary data sources was employed with previous documents or materials to supplement the data received from questionnaires.

3.7 Data Analysis and Interpretation

Data collected through using the research instruments was coded first to enable analysis to be done. Descriptive and inferential statistics was used to analyze data from which answers to the research questions were found. Descriptive statistics according to Mann (2011) consists of methods of organizing, displaying, and describing data by using tables, graphs and summary measures. On the other hand, Inferential statistics use a random sample of data taken from a population to describe and make inferences about the population. Inferential statistics are valuable when it is not convenient or possible to examine each member of an entire population. In this study, both quantitative and qualitative analysis was be used. Descriptive statistical tools was used to analyze quantitative data whereby software Statistical Package for Social Science (SPSS) was used to generate tabulations, percentages and measures of central tendency and regression model was used to analyze quantitative data. Tables were used to present responses and facilitate comparison. Qualitative data was analyzed using narrative statements based on the relevant thematic areas and the findings given in prose form.

3.8 Ethical Considerations

Ethics is defined as norms for conduct that distinguishes between acceptable and unacceptable behavior. The researcher observed the following ethical procedures: The researcher indicated that data was collected through questionnaires and would be purely for research purpose. The researcher was honest in reporting data, results, methods and procedures. The confidentiality of the student and personal information was assured. Respondents did not receive any incentives to participate in this study and no participant was forced to answer questions they did not wish to answer. Confidentiality was maintained throughout the study. The researcher sought informed consent from the participants before administering questionnaire for the data collection. The researcher was objective during the administration of the questionnaire; data analysis and data interpretation to avoid or minimize bias or self-deception. Respect for intellectual property was guaranteed by finding proper acknowledgement or credit for all contributions to this study and would not engage in plagiarism.

3.9 Operationalization of Variables

Table 3.1: Operational definition of variables of independent, moderating and dependent variables of factors influencing access to sexual reproductive health services

Type of variable	Variable	Indicators	Measure	Scale of measurement	Tools of analysis
Dependent variable	Access of SRH Services by the Youth	<ul style="list-style-type: none"> - Number of SRH visits in the health facilities - Number of open forums held on SRH services - Number of Pregnancy and STI rates - Number of youth visiting health facility 	Effective SRH services access and positive response of different levels of parties involved	Nominal scale of measurement	Descriptive and inferential statistics
Independent variable	Health system factors	<ul style="list-style-type: none"> - Private/public health facility set up to offer youth friendly - Number of health workers offering SRH services - Integrated plan addressing youth SRH issue 	<ul style="list-style-type: none"> - Extent of availability, efficiency and effectiveness of infrastructure and IEC materials offering youth services - Extent of effectiveness of health workers and leadership in handling SRH services 	Ordinal scale of measurement	Descriptive and inferential statistics

Independent variable	Knowledge factors	<ul style="list-style-type: none"> - Platforms of creating Awareness of RH services - Time created in response towards SRH Services - University strategic plan to respond to SRH needs during student entry/reporting 	Extend to which higher institutions of learning adopt the concept	ordinal scale of measurement	Descriptive and inferential statistics
Independent variable	Social Factors	<ul style="list-style-type: none"> - Advocacy campaigns to influence political and Cultural leaders - Community mobilization campaigns - Mass media-based behavior change and social marketing 	<ul style="list-style-type: none"> - Open promotion of SRH services in the community - Creating awareness and promotion of SRH services in the communities 	Ordinal scale of measurement	Descriptive and inferential statistics
Independent Variable	Economic factor	<ul style="list-style-type: none"> - Affordability cost of SRH services - Enabling family environment to discuss matters on SRH services 	<ul style="list-style-type: none"> - Cost of SRH services - Enabling family and community - Forums to access premarital information 	Ordinal scale of measurement	Descriptive and inferential statistics
Moderating variable		<ul style="list-style-type: none"> - Individual personality 	Level of engagement of the respective stakeholders	Ordinal scale of measurement	Descriptive and inferential statistics

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter contains results and interpretation of the major research findings. It focuses on questionnaire return rate, demographic characteristics of respondents, analysis and interpretation of findings. The data analyzed both qualitatively and quantitatively by use of descriptive and inferential statistics, has been arranged according to the objectives of the research and the sample groups the summarized using tables and graphs for ease of interpretation.

4.2 Response Rate

The researcher self-administered 198 questionnaires to the undergraduate youth students, IAGAS department in the University of Nairobi Main Campus. The study was conducted whereby the researcher visited the IAGAS unit of student respondents in the University. The respondents were first of all called to confirm their availability in order to administer the questionnaires. Information was obtained from 160 respondents; hence the return rate was 81% percent.

4.3 Background information on respondents

This section had question that enabled the researcher to obtain background information of the students who participated in the research. The variables looked at include age, residence and the number of years they have been at the campus. The demographic information of the respondents were meant to give strength to the research findings.

4.3.1 Distribution of the respondents by Gender

Access to SRH services can influence gender dynamics. In most cases ladies as their biological make up may suffer than their male counter parts. This is mainly due to poor gender tasks that tends to overburden women and skewed mode of reproduction. The study required the respondents to indicate their gender by ticking on the spaces provided in the questionnaire. The gender disparity as far as SRH services access is concerned could be explained by various factors. For instance, most ladies reported that they had visited health facility for health check-ups.

Table 4.1: Distribution of the Respondents by Gender

Gender of the Respondents Gender	Frequency	Percentages (%)
Male	78	48.75
Female	82	51.25
Total	160	100.00

From Table 4.1, 78 (48.75%) of the respondents were male while 82 (51.25%) of the respondents were female. It can however be concluded that majority of the members of IAGAS undergraduate population are female. The findings show that the undergraduate students youth studied had both male and female members who were well represented in the study. This findings implies that women's role in SRH access has changed since more women were found to be seeking access of the services.

4.3.2 Distribution of the respondents by Age

Age distribution can influence access to Sexual Reproductive health services. The study required the respondents to indicate their age by ticking on the spaces provided in the questionnaire.

Table 4.2: Distribution of the respondents by Age

Age distribution	Frequency	Percent
18-24years	137	85.6
Over 25 years	23	14.4
Total	160	100.0

Results from Table 4.2 indicates that majority of the population are aged 18-24 years comprising of 137 (85.6%) of the respondents. None of the students were below 18 years old. The students aged over 25 years accounted for 23 (14.4%). The age distribution concerned could be explained by various factors. For instance, most undergraduate students youth are aged 24 years and below and a few are above 25 years old.

4.3.3 Distribution of the respondents by Residence

The researcher sought to find out place of residence of the students. The results are shown in the table below.

Table 4.3: Students' residence

Residence	Frequency	Percent
University hostel	70	43.8
Rental	43	26.8
Home	47	29.3
Total	160	100.0

Table 4.3 indicates that most 70 (43.8%)of the respondents who were students lived in the university hostels. Those who commuted from home were 43(29.3%) and the rest 47 (26.8%)

rented outside the university. This implies that most of the undergraduate students reside at the university hostels where SRH services should be intensified.

4.3.4 Distribution of students by the years they have been at the University

The researcher also sought to find out the distribution of respondents by the year they have studied at the university. The results are as shown in table 4.4 below.

Table 4.4: Distribution of students by the years they have been at the university

Duration at university	Frequency	Percent
0-1years	35	21.8
2-3 years	86	53.7
3-4 years	39	24.5
Total	160	100.0

As indicated by Table 4.4, it is evident that most 86 (53.7%) of the respondents had stayed at the university for between two and three years. Those who stayed at the university for less than one year accounted for 35 (21.8%) while those who stayed at the university for more than 3 years accounted for 39 (24.5%). This implies that most of the undergraduate stay longer on their own at the university which should be directly linked to informed choice of their sexual lifestyle.

4.4 Extend to which health system factors influence access of sexual reproductive health services

In this section, the research sought to find out the extent to which health system factors affect access to sexual reproductive health services.

4.4.1 Health Facility Accessibility by the respondents

The researcher sought to examine geographical accessibility of the health facilities by distance which applies to IAGAS undergraduate students youth allowing them to be linked to SRH services. Accessibility of the health facilities plays a big role in seeking for sexual reproductive health services. It is in this light that the researcher found it important to establish the influence of accessibility of the health facilities in seeking of sexual reproductive health services.

Table 4.5: Accessibility of the health facilities

Health facility is accessible	Frequency	Percent	Cumulative percent
Strongly Disagree	12	7.3	7.3
Disagree	43	26.8	34.1
Somehow agree	43	26.8	61.0
Agree	35	22.0	82.9
Strongly agree	27	17.1	100.0
Total	160	100.0	

Table 4.5 indicates that 62 (39.1%) agreed that the health facility is accessible while 43 (61%) somehow agreed or disagreed that health facility is accessible.

4.4.2 Youth Friendly Services in accessibility of SRH services by the respondents

The researcher sought to find out how ineffective youth friendly services affect the access the sexual reproductive health services. This measure entails attributes that attract adolescents to the health care facilities and provide comfortable and appropriate setting for the youth students. This too will include procedures to ensure privacy, confidentiality and acceptance.

Table 4.6: Ineffective youth friendly services

Ineffective youth friendly services	Frequency	Percent	Cumulative percent
Strongly Disagree	51	31.7	31.7
Disagree	55	34.1	65.9
Somehow agree	23	14.6	80.5
Agree	27	17.1	97.6
Strongly agree	4	2.4	100.0
Total	160	100.0	

Table 4.6 above indicates that majority of the respondents 55 students out of 160 (65.9%) disagreed that there is ineffective youth friendly services while 31 students out of 160 (19.5%) agreed that facilities offer ineffective youth friendly services .

4.4.3 Adequate information from Information Education & Communication (IEC) materials available at the health facility

Adequacy of information from Information education and communication (IEC) materials plays a critical role in the access to reproductive health services. This should include all relevant information of variety of services offered at the health care facility i.e. brochures, fliers, booklets. It is to this view that the researcher sought to find out how this influenced the access to reproductive health services at the campus.

Table 4.7: Adequacy of information from information education and communication (IEC) materials at the health facility

Inadequate information from information education & communication materials at the health facility	Frequency	Percent	Cumulative percent
Strongly Disagree	8	4.9	4.9
Disagree	39	24.4	29.3
Somehow agree	35	22.0	51.2
Agree	43	26.8	78.0
Strongly agree	35	22.0	100.0
Total	160	100.0	

The results from table 4.7 shows that 82 students (51.2%) were undecided or disagreed that there is inadequate information from information education and communication materials at the health facility. Only 78 (48.8%) indicated that information from information education and communication materials at the health facility was inadequate.

4.4.4 Adequate information from the health provider

The researcher sought to find out attitude and behaviours of health care providers that can hinder access to sexual reproductive services by the youth population at the facility level.

Table 4.8: Adequate information from the health provider

Inadequate information from the health provider	Frequency	Percent	Cumulative percent
Strongly Disagree	4	2.4	2.4
Disagree	43	26.8	29.3
Somehow agree	86	53.7	82.9
Agree	12	7.3	90.2
Strongly agree	16	9.8	100.0
Total	160	100.0	

On the adequacy of information from the health provider, 28 respondents (17.1%) felt that there was inadequate information from the health provider while 47 respondents (29.2%) felt otherwise and 86 respondents (53.7%) were unsure.

4.4.5 Distinctive and functional department to provide youth friendly SRH services at the health facility

A functional department in an health care facility is key in facilitation access to sexual reproductive health services. The researcher sought to find out if this has been included in the health facility planning services approach to handle variety of issues of SRH.

Table 4.9: Distinctive and functional department to provide youth friendly SRH services

There is lack of distinctive and functional department to provide youth friendly SRH	Frequency	Percent	Cumulative percent
Strongly Disagree	27	17.1	17.1
Disagree	39	24.4	41.5
Somehow agree	8	4.9	46.3
Agree	51	31.7	78.0
Strongly agree	35	22.0	100.0
Total	160	100.0	

Table 4.9 above revealed that 86 respondents (53.7%) felt that there is lack of distinctive and functional department to provide youth friendly SRH services and 66 respondents (41.5%) disagreed while 4.9% were undecided.

Suggestions to improve the health facility in provision of SRH services

The researcher sought to get views from the respondents on what can be done to improve the health facility.

Table 4.10: Suggested improvement to the health facility

Suggestion	Frequency	Percent
Adequate information	37	23.1
Easy accessibility to health facility	29	18.1
Increase number of doctors and nurses	18	11.3
Youth friendly services	20	12.5
Improve on time taken to offer services	20	12.5
More facilities	16	10.0
Others	20	12.5
Total	160	100.0

Majority (23.1%) suggested that there should be adequate information, 18.1% suggested that there should be easy access to health facility, 12.5% suggested youth friendly services same to improved time taken to offer services. 11.3% suggested that the number of doctors and nurses need to be increased.

Summary of the responses on Health system factors

The following statement were presented to respondents in order to measure their extent of agreement. The results obtained are as indicated in Table 4.11.

Table 4.11: Health system factors influencing access of sexual reproductive health services

Statements	Mean	Std. Dev
Inadequate information from IEC materials at the health facility	3.366	1.220
Lack of distinctive and functional department to provide youth friendly SRH services	3.171	1.465
The health facility you visit is accessible	3.146	1.216
Inadequate information from the health provider	2.951	0.921
Ineffective youth friendly services	2.244	1.157

The table indicates that the respondents somehow agreed that there is inadequate information from IEC materials at the health facility (Mean=3.366, SD=1.22), there is lack of distinctive and functional department to provide youth friendly SRH services (Mean=3.171, SD=1.465) and also somehow agreed that the health facilities are accessible (Mean=3.146, SD=1.216). It was also disagreed that; there was inadequate information from the health provider and ineffective youth friendly services with means of 2.951 and Mean=2.244 respectively.

4.5 Extent to which knowledge factors affect access of sexual reproductive health services

In this section the researcher sought to find the extent to which knowledge factors affects access of sexual access of sexual reproductive health services. This measured the level of utilization of the services by the University youth.

4.5.1 Youth friendly SRH activities in health facilities to support access and utilization

The research wanted to find out which actions and activities take place to promote utilization of SRH services. The results are as shown below.

Table 4.12: Youth friendly SRH activities in health facilities to support access and utilization

Lack of youth friendly SRH activities in health facilities to support access and utilization	Frequency	Percent	Cumulative percent
Strongly Disagree	4	2.4	2.4
Disagree	35	22.0	24.4
Somehow agree	66	41.5	65.9
Agree	51	31.7	97.6
Strongly agree	4	2.4	100.0
Total	160	100.0	

Results shown in Table 12 indicated that majority 55 (34.1%) agreed that there was lack of youth friendly SRH activities in health facilities to support access and utilization compared to 39 (24.4%) who disagreed. 66 (41.5%) were undecided.

4.5.2 Available information on Sexual Reproductive Health services in the University administration support e.g. orientation program

The University administration can be key drivers in creating a conducive environment in access of sexual reproductive health services to the university student youth. The researcher wanted to find out which steps and effort made so far including induction of the undergraduate students joining the university in making an informed decision on access of SRH services. The following table shows the results:

Table 4.13: Available information on sexual reproductive health services

Available information on sexual reproductive health services	Frequency	Percent	Cumulative percent
Strongly Disagree	23	14.6	14.6
Disagree	62	39.0	53.7
Somehow agree	43	26.8	80.5
Agree	16	9.8	90.2
Strongly agree	16	9.8	100.0
Total	160	100.0	

The research found out that few respondents 32 (19.6%) indicated that information on sexual reproductive health was available compared to 85 (53.6%) who disagreed on availability of SRH services. The remaining 43 (26.8%) somehow agreed.

4.5.3 Availability of SRH services to students including prenatal and postnatal care services, VCT, STI, Family Planning

The research sought to find out availability of different SRH services to students including prenatal and postnatal services, VCT, STI and family planning.

Table 4.14: Availability of SRH services to students including prenatal and postnatal services, VCT, STI, family planning

All SRH services to students including prenatal and postnatal services, VCT, STI, family planning	Frequency	Percent	Cumulative percent
Strongly Disagree	43	26.8	26.8
Disagree	51	31.7	58.5
Somehow agree	31	19.5	78.0
Agree	35	22.0	100.0
Total	160	100.0	

Table 4.14 revealed that majority of the respondents 94 (58.5%) disagreed that the services were not available compared to 35 (22%) who stated that the services are available.

Summary of the responses on Knowledge factors

The respondents were asked to indicate their level of agreement with statements related to knowledge factors affecting access to sexual reproductive health services. The responses from strongly agree to strongly disagree are as shown in table 4.15 below.

Table 4.15: Knowledge factors affecting access of sexual reproductive health services

Statements	Mean	Std. Dev
Lack of youth friendly SRH activities in health facilities to support access and utilization	3.098	0.86
Available information on SRH services in the University administration support e.g. orientation program	2.610	1.159
Are all SRH services available for the students including; pre-natal and post-natal services, VCT, STI, Family planning	2.366	1.113

The results shows that the respondents (Mean = 3.098, SD=0.86) moderately agreed that there was lack of youth friendly SRH activities in health facilities to support access and utilization. The findings indicates that the respondents agreement is uniform because the standard deviation is close to the mean. The results also indicates that the respondents disagreed that there was available information on SRH service in the university administration support and that all SRH services are available for the students including pre-natal and post-natal service, VCT, STI, family planning with mean of 2.610 and 2.366 respectively.

4.6 Extend to which social factors influence access of sexual reproductive health services

4.6.1 Advocacy campaigns to influence political and Cultural leaders to discuss issues affecting access of SRH services

This includes believes, cultural practices, taboos, stereotypes which hinder access of SRH services. The researcher sought to establish discrimination made up of negative social attitudes and cultural assumptions hampering access to SRH services.

Table 4.16: advocacy campaigns issues affecting access of SRH services

Advocacy campaigns to influence political and cultural leaders to discuss issues of SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	94	58.5	58.5
Disagree	20	12.2	70.7
Somehow agree	23	14.6	85.4
Agree	23	14.6	100.0
Total	160	100.0	

Results in table 4.16 indicates that 113 (70.7%) of the respondents indicated that it is not a taboo to discuss issues of SRH services as compared to 23 (14.6%) who believed that it is a taboo to discuss issues of SRH services. The rest 23 (14.6%) were undecided.

4.6.2 Community based campaigns on access and availability of SRH services

The researcher is concerned on the sensitization workshops/forums held in creating awareness of SRH services amongst the undergraduate students.

Table 4.17: Community Based campaigns on access and availability of SRH services

There are Community based campaigns on access and availability of SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	27	17.1	17.1
Disagree	66	41.5	58.5
Somehow agree	35	22.0	80.5
Agree	20	12.2	92.7
Strongly agree	12	7.3	100.0
Total	160	100.0	

Table 4.17 indicates that majority 93 (58.5%) of the respondents indicated that few forums/workshops were held compared to 31 (19.5%) who indicated that there were many forums and workshops held.

4.6.3 Access of information on SRH services through media

The researcher is concerned on campaigns of youth friendly services in reaching young people. This will include; social marketing, mass media and feedback platform thereafter.

Table 4.18: Access of information on SRH services through the media

Is information on sexual SRH services access from media services easier	Frequency	Percent	Cumulative percent
Strongly Disagree	23	14.6	14.6
Disagree	16	9.8	24.4
Somehow agree	16	9.8	34.1
Agree	15	19.5	53.7
Strongly agree	74	46.3	100.0
Total	160	100.0	

The results in table 4.18 indicated that majority 89 (65.8%) indicated that it was easier to access information on SRH services through the media compared to 39 (24.4%) who disagreed.

4.6.4 Access and Availability of materials on SRH services

The researcher sought to find out the youth undergraduate students community environment that supports access of SRH services. This will also include availability of the materials in various learning departments and resource centers.

Table 4.19: Access and availability of materials on SRH services

Can access materials talking about SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	23	14.6	14.6
Disagree	51	31.7	46.3
Somehow agree	35	22.0	68.3
Agree	39	24.4	92.7
Strongly agree	12	7.3	100.0
Total	160	100.0	

On whether the youth can be able to access materials talking about SRH services, the results indicated that only 51 (31.7%) were able to access the materials on SRH services while 46.3% were not able. The remaining 35 (22%) somehow agreed hence undecided.

Other platforms/ways the youth would prefer getting SRH information from

Table 4.20: Platforms/ways preferred to convey information of SRH services

Platforms	Frequency	Percent
Internet/social media	63	39.4
Forums/workshops	30	18.8
TV/Radio	24	15.0
Printed media(poster/pamphlets/magazines)	39	24.4
Others	4	2.5
Total	160	100.0

Responded when requested to suggest platforms through which information on SRH services should be conveyed, majority of the respondents (63%) indicated through internet/social media for instance Facebook, twitter among others to be preferred. Surprisingly only 15% preferred TV and radio.

Summary of the responses on social factors influencing access to SRH services

The study sought to find out the extent to which social factors influence access of sexual reproductive health service. Basing on the statements given, the results are as shown in Table 4.21 below

Table 4.21: Social factors that influence access of sexual reproductive health services

Statements	Mean	Std. Dev
Is information on SRH services access from media services easier?	3.732	1.500
Can you access materials talking about SRH services available?	2.780	1.194
There are many forums/workshops held to share and discuss access and available SRH services	2.512	1.143
It's a taboo/cultural to discuss issues of SRH services	1.854	1.152

The results shows that the respondents moderately agreed (mean=3.732,SD=1.500) that information on SRH services access from media services is easier. A mean of 2.78 (SD=1.194) indicated that the respondents are not able to access of materials talking about SRH services which are not available. A mean of 2.512 (SD=1.143) indicated that there are no many forums and workshops held to share and discuss access and availability of SRH service. While a mean of 1.854 (SD=1.152) indicated that they strongly disagreed that it is a taboo/cultural to discuss issues of SRH services.

4.7 Economic factors influencing access of sexual reproductive health services

The researcher also sought out to discover how economic factors influence access of sexual reproductive health services. This will detail right of equal access appropriately across health facilities. The results are as shown in tables below:

4.7.1 Financial resources influencing access to SRH services

Since most undergraduate students youth are studying and not working, the researcher wanted to know how it directly affects their access to SRH services.

Table 4.22: Financial resources to provide SRH services

Unavailable financial resources to provide SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	31	19.5	19.5
Disagree	70	43.9	63.4
Somehow agree	31	19.5	82.9
Agree	12	7.3	90.2
Strongly agree	16	9.8	100.0
Total	160	100.0	

Table 4.22 depicts that 27 (17.1%) indicated that there was unavailability of financial resources to provide SRH compared to 101 (63.4) who indicated that there was enough financial resources to provide the services.

4.7.2 Affordability of SRH services

The researcher pursued to understand if the services are affordable for those who are able/have tried to access the services in the health facilities

Table 4.23: Affordability cost of SRH services

SRH services are affordable	Frequency	Percent	Cumulative percent
Strongly Disagree	27	17.1	17.1
Disagree	78	48.8	65.9

Somehow agree	31	19.5	85.4
Agree	20	12.2	97.6
Strongly agree	4	2.4	100.0
Total	160	100.0	

On the affordability of SRH services, majority 105 (65.9%) of the respondents indicated that it was not affordable while only 23 (14.6%) said it was affordable.

4.7.3 Enabling family environment to discuss matters on SRH services

The researcher sought to establish an enabling environment to share and discuss matters pertaining to SRH services.

Table 4.24: Enabling environment for family member to discuss with SRH services

There is enabling environment for family member to discuss with SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	51	31.7	31.7
Disagree	27	17.1	48.8
Somehow agree	43	26.8	75.6
Agree	31	19.5	95.1
Strongly agree	8	4.9	100.0
Total	160	100.0	

Results in Table 4.24 indicates that only 10 (24.4%) agreed that there was enabling environment for family members to discuss with SRH services as compared to 48.8% who disagreed on enabling family environment to discuss on SRH services.

4.7.4 Availability of community platforms to discuss access of SRH services

The home community environment plays a big role in creating awareness and availing SRH services at strategic points where the undergraduate student youth can walk in and seek help and advice on matters of SRH services. The researcher wanted to explore the community environment of the youth more so those who are staying out of the university hostels.

Table 4.25: Availability of community platform to discuss SRH services

Available community platform to discuss SRH services	Frequency	Percent	Cumulative percent
Strongly Disagree	16	9.8	9.8
Disagree	82	51.2	61.0
Somehow agree	20	12.2	73.2
Agree	20	12.2	85.4
Strongly agree	23	14.6	100.0
Total	160	100.0	

Table 4.25 shows that there was no available community to discuss SRH services as indicated by the 98 (61%) of the respondents. Only 43 (26.8%) of the respondents agreed that there was availability of community platform to discuss SRH services.

4.7.5 Lack of access to SRH services widens gap of Poverty levels

Majority of the world population composes of the youth population who have specific health and development needs. Health needs include access to SRH services. Inequity costs of seeking sexual reproductive health services can directly be linked to vulnerable groups who includes the youth. The researcher wanted to find out if poverty is directly linked to prioritizing spending rates of the undergraduate students.

Table 4.26: Access to SRH services and poverty level

Lack of access to SRH service widens gap of poverty levels	Frequency	Percent	Cumulative percent
Strongly Disagree	20	12.2	12.2
Disagree	8	4.9	17.1
Somehow agree	20	12.2	29.3
Agree	35	22.0	51.2
Strongly agree	78	48.8	100.0
Total	160	100.0	

The study revealed that majority (70.8%) of the respondents agreed that lack of access to SRH services widens gap of poverty levels as compared 27 (17.1%) who disagreed. 20 (12.5) of the respondents were undecided.

Summary of responses of economic factors influencing access of SRH services

The summary results of the findings are shown in Table 4.27 below:

Table 4.27: Economic factors influencing access of sexual reproductive health services

Statements	Mean	Std. Dev
Lack of access to SRH services widens gap of Poverty levels	3.902	1.393
Available community platform to discuss SRH services	2.707	1.250
Enabling environment for family member to discuss n with SRH services	2.488	1.267
Unavailable financial resources to provide SRH services	2.439	1.184
SRH services are affordable	2.341	0.990

The results indicates that the respondents agreed there was lack of access to SRH services which widens gap of poverty levels (Mean=8.902, SD=1.393). The respondents disagreed that there was enabling environment for family members to discuss with SRH services, unavailable financial resources to provide SRH services and SRH services are affordable with means 2.488(SD=1.267), 2.439(SD=1.184), 2.341(SD=0.99) respectively. The respondents moderately agreed that there was available community platform to discuss SRH services with mean 2.707 (SD=1.250).

4.8 Regression analysis on the factors influencing access of sexual reproductive health service (Model)

Regression analysis is a statistical process that aims to establish the degree of relationship between variables. It basically helps one to understand how a typical value of the dependent variable if any one of the independent variables changes. In this case, access of sexual reproduction health service as the dependent variable and independent variables included health system factors, knowledge factors, social factors and economic factors. The results of multiple regression analysis were presented and interpreted in the table 4.11 below. The table reveals that access of sexual reproductive services and the variables affecting it are significantly correlated with the coefficient $R= 0.646$ with the coefficient of determination $R^2= 0.417$ at a significant level of $p=0.001$. The results shows that the access of sexual reproductive health services by the students can be explained by the changes in the health system factors, knowledge factors, social factors and economic factors. In addition it gives the summarized ANOVA (analysis of variance) table and F statistic, which reveals the value of F (6.439) is significant at the 0.001 level which is less than 0.05. This indicates that all or at least one of independent variables (health facilities

factors, knowledge factors, social factors and economic factors) is a significant predictor of the dependent variable (access of sexual reproductive health services).

Table 4.28: Regression model- Adoption of e-commerce as dependent variable

Model Summary						
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.646 ^a	.417	.352	.97845		
ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	24.657	4	6.164	6.439	.001 ^b
	Residual	34.465	36	.957		
	Total	59.122	40			
Coefficients ^a						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.429	1.131		.379	.707
	Health System factors	-.257	.257	-.137	-.997	.326
	Knowledge factors	.826	.398	.381	2.077	.045
	Social factors	.498	.266	.329	1.877	.069
	Economic factors	-.038	.312	-.022	-.120	.905
a. Dependent Variable: Access to SRH services						
b. Predictors: (Constant), Economic factors, Health System, Social factors, Knowledge						

The evaluation of the regression equation to estimate the contribution of each independent variables in the study to the access of sexual reproductive health services the dependent variable. Looking at the coefficients table, the coefficient for the constant is the value of Y-intercept. These value calculates the possible access to health service facilities. The equation from this output is in the form of :

$$Y = 0.429 - 0.257x_1 + 0.826x_2 + 0.498x_3 - 0.038x_4$$

Where,

Y represents Access to Sexual Reproductive Health services;

X₁ is Health system factors;

X₂ is Knowledge factors;

X₃ is Social factors and;

X₄ is Economical factors

$$Y = 0.429 - 0.257x_1 + 0.826x_2 + 0.498x_3 - 0.038x_4$$

The relative importance of association of each independent variable was different. This was evaluated and interpreted by the coefficients of correlation (β). Health system factors negatively influence the access to sexual reproductive health services with $\beta = -0.257$ at significant level 0.326. This indicates that the value of Y (access to sexual reproductive health services) will change if x₁ changes by 1 unit. That is 0.257, so if knowledge and skills goes up by 1 unit, access to sexual reproductive health services is predicted to go down by 0.257.

Knowledge factors positively affect access to sexual reproductive health services with $\beta = 0.826$ at significant level 0.045. This indicates that the value of Y (access to sexual reproductive health

services) will change if x_2 changes by 1 unit. That is 0.826, so if knowledge factors goes up by 1, access to sexual reproductive health services is predicted to go up by 0.826.

Social factors are positively related to access to sexual reproductive health services with $\beta = 0.498$ at significant level 0.069. This means that the value of Y (access to sexual reproductive health services) will change if x_3 changes by 1 unit. That is 0.498, so if social factors goes up by 1, access to sexual reproductive health services is predicted to go up by 0.498.

Economic factors are negatively correlated to the access to sexual reproductive health services with $\beta = -0.038$ at significant level 0.905. This indicates that the value of Y (access to sexual reproductive health services) will change if x_4 changes by 1 unit. That is -0.038, so if economic factors goes up by 1, access to sexual reproductive health services is predicted to go down by -0.038.

CHAPTER FIVE
SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND
RECOMMENDATIONS

5.1 Introduction

The main purpose of this study was to establish the factors that influence access of sexual reproductive health services by students in the institute of anthropology and African studies unit in the university of Nairobi. In the preceding chapter, effort was made to analyze and report the results of the collected data. This chapter is divided into three sections. In the first section the summary of the findings are given, in the second section conclusions and implications of the findings are given and in the third section, suggestions for further research are made.

5.2 Summary of the study findings

Data was collected from a sample of 160 undergraduate youth students, IAGAS department in the University of Nairobi Main Campus. The study was conducted whereby the researcher visited the IAGAS class of student respondents in the University. The respondents age, residence and the number of years they have been at the campus was presented. Most of the respondents were female (51.25%) while male were 48.75%. The findings implies that women's role in SRH access has changed since more women were found to be seeking access of the service. Age distribution can influence access to Sexual Reproductive health services. The study required the respondents to indicate their age. The age distribution is concerned could be explained by various factors. For instance, most undergraduate students youth are aged 24 years and below and a few are above 25 years old. Results indicated that majority of the population are aged 18-24 years comprising of 85.6% of the respondents. None of the students were below 18 years old. The students who Those aged over 25 years accounted for 14.4%. Most (43.8%) of the

respondents lived in the university hostels. Those who commuted from home were 29.3% and the rest (26.8%) rented outside the university. The study sought to find out the distribution of respondents by the year they have been at the campus. It was found out that most (53.7%) of the respondents had stayed at the university for between two and three years. Those who stayed at the university for less than one year accounted for 21.8% while those who stayed at the university for more than 3 years accounted for 24.5%.

5.2.1 Extend to which health system factors influence access of sexual reproductive health services

To find out the extent to which health system factors affect access to sexual reproductive health services. The respondents were required to state their agreement with the given statements. It was found out that respondents were undecided to stated if there is adequate information from IEC materials at the health facility (Mean=3.366, SD=1.22), there is lack of distinctive and functional department to provide youth friendly SRH services (Mean=3.171, SD=1.465) and also somehow agreed that the health facilities are accessible (Mean=3.146, SD=1.216). It was also disagreed that; there was inadequate information from the health provider and ineffective youth friendly services with means of 2.951 and Mean=2.244 respectively.

Suggestions of the respondents on improving the health facility in provision of SRH services

On the suggestion to improve the health facility in provision of SRH, majority (23.1%) suggested that there should be adequate information, 18.1% suggested that there should be easy access to health facility, 12.5% suggested youth friendly services same to improved time taken to offer services. 11.3% suggested that the number of doctors and nurses need to be increased.

5.2.2 Extent to which knowledge factors influence access of sexual reproductive health services

On the extent to which knowledge factors affects access of sexual access of sexual reproductive health services, it was found out that the respondents (Mean = 3.098, SD=0.86) moderately agreed that there was lack of youth friendly SRH activities in health facilities to support access and utilization. The findings indicates that the respondents agreement is uniform because the standard deviation is close to the mean. The results also indicates that the respondents disagreed that there was available information on SRH service in the university administration support and that all SRH services are available for the students including pre-natal and post-natal service, VCT, STI, family planning with mean of 2.610 and 2.366 respectively.

5.2.3 Extend to which social factors influence access of sexual reproductive health services

The study sought to find out the extent to which social factors influence access of sexual reproductive health service. The results shows that the respondents moderately agreed (mean=3.732,SD=1.500) that information on SRH services access from media services is easier. A mean of 2.78 (SD=1.194) indicated that the respondents are not able to access of materials talking about SRH services which are not available. A mean of 2.512 (SD=1.143) indicated that there are no many forums and workshops held to share and discuss access and availability of SRH service. While a mean of 1.854 (SD=1.152) indicated that they strongly disagreed that it is a taboo/cultural to discuss issues of SRH services.

Other respondents platforms/ways suggested by the youth which they would prefer getting SRH information from

Responded when requested to suggest platforms through which information on SRH services should be conveyed, majority of the respondents (39.4%) indicated through internet/social media

for instance Facebook, twitter among others to be preferred. Surprisingly only 15% preferred TV and radio.

5.2.4 Economic factors influencing access of sexual reproductive health services

To discover how economic factors influence access of sexual reproductive health services it was found out that, the respondents agreed there was lack of access to SRH services which widens gap of poverty levels (Mean=8.902, SD=1.393). The respondents disagreed that there was enabling environment for family members to discuss with SRH services, unavailable financial resources to provide SRH services and SRH services are affordable with means 2.488(SD=1.267), 2.439(SD=1.184), 2.341(SD=0.99) respectively. The respondents moderately agreed that there was available community platform to discuss SRH services with mean 2.707 (SD=1.250).

5.3 Discussion of the findings

This section of the report discusses in detail the findings and compares them with literature reviewed in chapter two.

5.3.1 Extend to which health system factors influence access of sexual reproductive health services

Equitable access to health care has been articulated as a basic human right and attainment of the MGD 5 for the improvement of maternal health, including maternal and new born health, family planning, prevention of unsafe abortion, control of sexual transmitted infection and promotion of sexual health. According to WHO(2010) health care and education systems are not yet properly equipped to address the youth's specific reproductive health system. This study found out that there was adequate information from IEC materials at the health facility which most of the

students were not aware of. It was also discovered that there is lack of distinctive and functional department to provide youth friendly SRH services and that the health facilities are only accessible to a few students. There is need for the policy to be put in place to inform students on SRH and provide them with necessary skills. The study found out that there was adequate information from the health provider and ineffective youth friendly services.

Suggestions to improve the health facility in provision of SRH services

To improve the health facility in provision of SRH, there should be adequate information, easy access to health facility, improved on time taken to offer services and increase the number of doctors and nurses need to be increased. This concurred with UNFPA (2003) that there are such initiative as removing legal obstacles so that young people can access needed services, for example anyone 14 years or older has the right to receive contraception.

5.3.2 Extent to which knowledge factors influence access of sexual reproductive health services

The study found out that some of the students felt that there was lack of youth friendly SRH activities in health facilities to support access and utilization. This is in agreement with a report by KNCHR (2012) inquiry that Kenyan youth lack access to quality and friendly health care. It was also found out that there was inadequate information on SRH service in the university administration support and that all SRH services are available for the students including pre-natal and post-natal service, VCT, STI, family planning.

5.3.3 Extent to which social factors influence access of sexual reproductive health services

The study shows that some of the students found it difficult to access information on SRH services from media services due to various reasons known to themselves. This concurs with

study by Senderowitz et al (2003) which concluded that youths are unwilling to seek care due the national laws and policies restricting care based on age and/or marital status, poor understanding of their changing bodies and insufficient awareness of risks associated with early sexual debut, STI/HIV and pregnancy. The study also indicated that students are not able to access materials talking about SRH services which are not available and that there should be many forums and workshops held to share and discuss access and availability of SRH service. The 2010-2012 Reproductive Health Communication Strategy identifies the provision of adequate information and universal access to RH services as a priority for young people for the purpose of improving their RH. Student did not believe it as taboo/against cultural beliefs to discuss issues of SRH services.

5.3.4 Economic factors influencing access of sexual reproductive health services

Lack of access to SRH services is determined by the wide gap of poverty levels. This is in line with a study by Taylor (2003)with stated that persons of low socio-economic status can have difficulty in affording the costs associated with access of healthcare. There is unfavorable environment for family members to discuss with SRH services. Enabling characteristics such family income or economic status, location of residence are key factors in seeking health care facilities. Hence the study found out that there was in adequate financial resources to provide SRH services and SRH services are not affordable. Some of the respondents were not aware of any available community platform to discuss SRH services.

5.4 Conclusion

In conclusion the studied factors have been found to be interacting with the access of sexual reproductive health services by undergraduate students. On the extent to which health system factors affect access to sexual reproductive health services. The study found out that most of the

students were undecided to state if there is adequate information from IEC materials at the health facility, there is lack of distinctive and functional department to provide youth friendly SRH services and some were not able to access the health facilities. The study also found that was inadequate information from the health provider and ineffective youth friendly services. Regression analysis showed that the interaction between health system factors and access to sexual reproductive health services was negative with $\beta = -0.257$ at significant level 0.326.

On the suggestion to improve the health facility in provision of SRH, it was suggested that there should be adequate information, there should be easy access to health facility, provide youth friendly services and improved time taken to offer services. Also the number of doctors and nurses need to be increased.

On the extent to which knowledge factors affects access of sexual access of sexual reproductive health services, the results indicated that some students lack youth friendly SRH activities in health facilities to support access and utilization. The findings indicates that the respondents agreement is uniform because the standard deviation is close to the mean. The results also indicates that there was inadequate information on SRH service in the university administration support and that all SRH services are not available for the students including pre-natal and post-natal service, VCT, STI, family planning. Regression analysis found out that knowledge factors positively affect access to sexual reproductive health services with $\beta = 0.826$ at significant level 0.045.

To find out the extent to which social factors influence access of sexual reproductive health service. The results shows that the respondents moderately agreed that information on SRH services access from media services is easier. The result found out that there are barriers to access of materials talking about SRH services which are also not available. It was also found

out that there are no many forums and workshops held to share and discuss access and availability of SRH service. There was a strong disagreement on that it is a taboo/cultural to discuss issues of SRH services. Regression model showed social factors is positively related to access to sexual reproductive health services with $\beta = 0.498$ at significant level 0.069.

Some of the suggested platforms through which information on SRH services should be conveyed, included through internet/social media for instance Facebook, twitter, TV and radio in that order of preference hence internet and social media was highly preferred.

To discover how economic factors influence access of sexual reproductive health services it was found out that there was lack of access to SRH services which widens gap of poverty levels. There was enabling environment for family members to discuss with SRH services, unavailable financial resources to provide SRH services and SRH services are affordable. Few of the students were of the view that there was available community platform to discuss SRH services. The regression analysis showed that economic factors are negatively correlated to the access to sexual reproductive health services with $\beta = -0.038$ at significant level 0.905.

5.5 Recommendations

This study makes the following recommendations.

Access to health care plays a major role in attaining MDG 5 for the improvement of maternal health, including maternal and newborn health, family planning, prevention of unsafe abortion, control of sexually transmitted infection among others. It is in this regard that the government through learning institution should put in place an effective legal infrastructure and policies to remove barriers to the access to health care in learning institutions.

Institutions of higher learning should identify young people's reproductive health needs as a priority and equip the health care and education system to address the youth's specific sexual reproductive health needs.

Scholars should come up with a theory or model that explain the interaction between other factors such as behavioural and institutional factors that can lead to the access of sexual reproductive health services. Come up with the model for the prediction of behavioural intention and attitude towards the access of reproductive health services. Should also look at the other factors that influence the youth's decision to on how and when to access sexual reproductive health services.

In relation to the changing dynamics with openly sexual content from the media, focus should be on how to reach out to young women and on how to behave in relation to sexual activities, contraceptive choice and use and what their role is in decision making with their partners. This study recommends on-going sexual reproductive health education and counselling services for young women and men.

Many young people have problems accessing sexual and reproductive health information. It is, therefore, prudent that new alternatives for youth centered sexuality education. One such alternative is social media; Facebook, twitter in that internet and mobile technologies are increasingly being recognized as important communication channels for reaching young people.

5.6 Suggestion for further studies

This study focused more on the students the consumers of sexual reproductive health services not on the provider. There is need to conduct further study on sexual reproductive health services provider's barriers that influences the provision of sexual reproductive health services.

A study on the role of faith based organizations on access to sexual reproductive health facilities should be carried out.

The study should be replicated in the other learning institutions to see if the results are consistent. This study was limited to University of Nairobi. The findings are not generalizable, and there may be some regional differences from the respondents. Such potential differences should be explored in other higher learning institutions in the country.

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APPENDIX I: LETTER OF TRANSMITTAL

P.O Box 40653-00100

NAIROBI, Kenya

July, 2015

Dear Madam/Sir,

RE: REQUEST FOR DATA COLLECTION

I am a postgraduate student pursuing a Masters in Project Planning and Management. I am required to submit as part of my research work assessment, a project on “**FACTORS INFLUENCING ACCESS OF SEXUAL REPRODUCTIVE HEALTH SERVICES: A CASE STUDY OF THE UNIVERSITY OF NAIROBI, MAIN CAMPUS UNDERGRADUATE STUDENTS INSTITUTE OF ANTHROPOLOGY AND AFRICAN STUDIES**” To achieve this, you have been selected to participate in the study. I kindly request you to fill the attached questionnaire to generate data required for this study. This information will be used purely for academic purposes and will be treated in confidence and will not be used for publicity. Neither your name nor the name of your institution will be mentioned in the report.

Your assistance and cooperation will be highly appreciated. Thank you in advance.

Yours faithfully,

Lydia Manoti

The University of Nairobi.

APPENDIX II: QUESTIONNAIRE

Please indicate the extent to which you know that each of the listed background information which affects access and utilization of sexual reproductive health services by the undergraduate students in the department of Institute of Anthropology, Gender and African Students (IAGAS) by ranking the factors on a five-point scale. (Tick as appropriate)

SECTION 1: BACKGROUND INFORMATION

- 1.** Please indicate your gender
 - a. Male
 - b. Female

- 2.** How old are you? Kindly indicate your age bracket.
 - a. 17 years and below
 - b. 18-24 years
 - c. Over 25 years

- 3.** Please indicate your residence area
 - a. University hostel
 - b. Rental
 - c. Home
 - d. Other

4. For how long have you been at the University?

a. 0-1 years

b. 2 to 3 years

c. 3 to 4 years

SECTION 2: EXTEND TO WHICH HEALTH SYTEM FACTORS INFLUENCE ACCESS OF SEXUAL REPRODUCTIVE HEALTH SERVICES

5. Please indicate the extent to which you agree/ disagree that each of the listed health system negatively affects access and utilization of sexual reproductive health services by the undergraduate students in the department of Institute of Anthropology, Gender and African Students (IAGAS) by ranking the factors on a five-point scale. (Tick as appropriate)

	Strongly disagree (1)	Disagree (2)	Somehow agree (3)	Agree (4)	Strongly agree (5)
The health facility you visit is accessible					
Ineffective youth friendly services					
Inadequate information from IEC materials at the health facility					
Inadequate information from the health provider					

Lack of distinctive and functional department to provide youth friendly SRH services					
--	--	--	--	--	--

6. What improvements would you suggest to the health facility following last visit?.....

SECTION 3: EXTENT TO WHICH KNOWLEDGE FACTORS INFLUENCE ACCESS OF SEXUAL REPRODUCTIVE HEALTH SERVICES

7. Please indicate the extent to which you agree/ disagree that each of the listed knowledge factors negatively affects access and utilization of sexual reproductive health services by the undergraduate students in the department of Institute of Anthropology, Gender and African Students (IAGAS) by ranking the factors on a five-point scale. (Tick as appropriate)

	Strongly disagree (1)	Disagree (2)	Somehow agree (3)	Agree (4)	Strongly agree (5)
Lack of youth friendly SRH activities in health facilities to support access and utilization					
Available information on					

SRH services in the University administration support e.g. orientation program					
Are all SRH services available for the students including; pre-natal and post-natal services, VCT, STI, Family planning					
Others (specify)					

SECTION 4: EXTEND TO WHICH SOCIAL FACTORS INFLUENCE ACCESS OF SEXUAL REPRODUCTIVE HEALTH SERVICES

8. Please indicate the extent to which you agree/ disagree that each of the listed social factors negatively affects access and utilization of sexual reproductive health services by the undergraduate students in the department of Institute of Anthropology, Gender and African Students (IAGAS) by ranking the factors on a five-point scale. (Tick as appropriate)

	Strongly disagree (1)	Disagree (2)	Somehow agree (3)	Agree (4)	Strongly agree (5)
It's a taboo/cultural to discuss issues of SRH					

services					
There are many forums/workshops held to share and discuss access and available SRH services					
Is information on SRH services access from media services easier?					
Can you access materials talking about SRH services available?					

9. Which other platforms do you prefer getting this SRH information from?.....
.....
.....

SECTION 5: THIS SECTION COVERS ECONOMIC FACTORS INFLUENCING ACCESS OF SEXUAL REPRODUCTIVE HEALTH SERVICES

10. Please indicate the extent to which you agree/ disagree that each of the listed economic factors affects access and utilization of sexual reproductive health services by the undergraduate students in the department of Institute of Anthropology, Gender and African Students (IAGAS) by ranking the factors on a five-point scale. (Tick as appropriate)

	Strongly disagree (1)	Disagree (2)	Somehow agree (3)	Agree (4)	Strongly agree (5)
Unavailable financial resources to provide SRH services					
SRH services are affordable					
Enabling environment for family member to discuss n with SRH services					
Available community platform to discuss SRH services					
Lack of access to SRH services widens gap of Poverty levels					

APPENDIX III: LETTER FROM THE INSTITUTION



UNIVERSITY OF NAIROBI
COLLEGE OF EDUCATION AND EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
DEPARTMENT OF EXTRA-MURAL STUDIES
NAIROBI EXTRA-MURAL CENTRE

Your Ref:

Main Campus
Gandhi Wing, Ground Floor
P.O. Box 30197
NAIROBI

Our Ref:

Telephone: 318262 Ext. 120

3rd August, 2015

REF: UON/CEES//NEMC/22/179

TO WHOM IT MAY CONCERN

RE: LYDIA MAKENDO MANOTI - REG NO- L50/82472/2012

This is to confirm that the above named is a student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra- Mural Studies pursuing a Master of Arts in Project Planning and Management.

She is proceeding for research entitled "**factors influencing access sexual reproductive health services**". A case of the University of Nairobi Main Campus Undergraduate Students Institute of Anthropology and African Studies (IAGAS) unit.

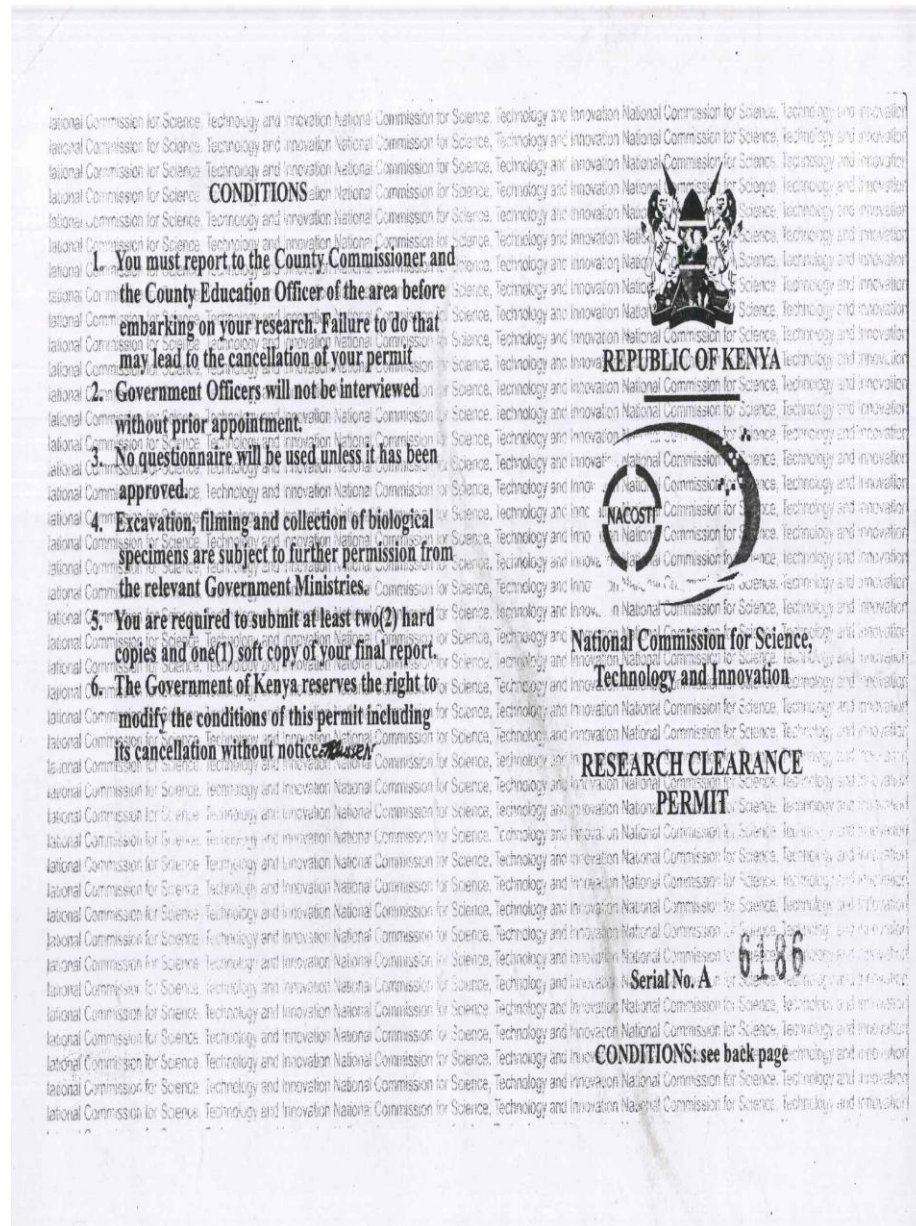
Any assistance given to her will be appreciated.

Caren Awilly

CAREN AWILLY
CENTRE ORGANIZER
NAIROBI EXTRA MURAL CENTRE



APPENDIX IV: RESEARCH CLEARANCE PERMIT AND LETTER OF AUTHORIZATION

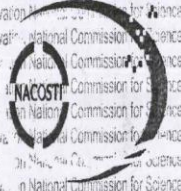


CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.



REPUBLIC OF KENYA



National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 6186

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:

MS. LYDIA MAKENDO MANOTI
of THE UNIVERSITY OF NAIROBI, 0-100

Nairobi, has been permitted to conduct
research in Nairobi County

on the topic: FACTORS INFLUENCING
ACCESS OF SEXUAL REPRODUCTIVE
HEALTH SERVICES: A CASE OF THE
UNIVERSITY OF NAIROBI MAIN CAMPUS
UNDERGRADUATE STUDENTS INSTITUTE
OF ANTHROPOLOGY AND AFRICAN
STUDIES (IAGAS) UNIT

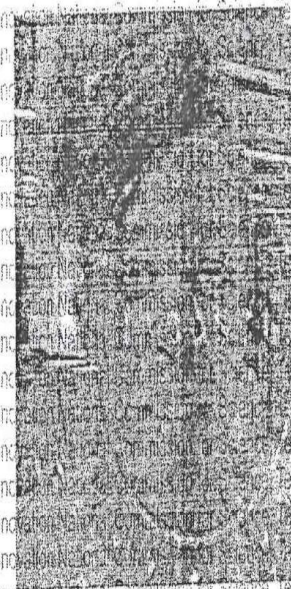
for the period ending:
4th December, 2015



.....
Applicant's
Signature

Permit No: NACOSTI/P/15/6046/7452

Date Of Issue: 17th August, 2015

Fee Received: Ksh 1,000




.....
Director General
National Commission for Science,
Technology & Innovation



**NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION**

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

17th August, 2015

NACOSTI/P/15/6046/7452

Lydia Makendo Manoti
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Factors influencing access of sexual reproductive health services: A case of the University of Nairobi Main Campus undergraduate students Institute of Anthropology and African Studies (IAGAS) Unit,*" I am pleased to inform you that you have been authorized to undertake research in Nairobi County for a period ending **4th December, 2015.**

You are advised to report to **the Vice Chancellor, University of Nairobi, the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

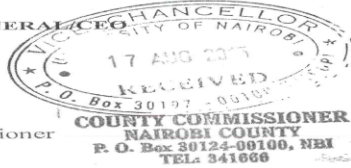
On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

S.AID HUSSEIN
FOR: DIRECTOR-GENERAL/CEO

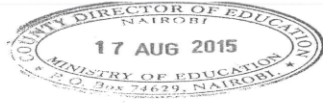
Copy to:

The Vice Chancellor
University of Nairobi.

The County Commissioner
Nairobi County.



The County Director of Education
Nairobi County.



APPENDIX V: STUDENTS DATABASE

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES STUDENT POPULATION

S/NO	UNIT	DIPLOMA	BACHELORS	PGD	MASTERS	Ph.D	TOTAL
1	School of Business	0	8,000	0	4,300	450	12750
2	Faculty of Arts	384	7,479	102	1,800	60	9825
3	School of Economics	0	4,327	0	450	22	4799
4	School of Law	0	2,900	0	400	40	3340
5	School of Journalism	0	348	0	300	20	668
6	IDIS	87	482	4	182	10	765
7	IAGAS	0	407	0	69	13	489
8	IDS	0	0	0	21	9	30
9	PSRI	0	0	0	18	14	32
10	CASELAP	0	0	0	93	38	131
11	CTI	0	0	0	23	0	23
12	AWSC	0	0	0	0	1	1
	TOTAL	0	23,943	106	7,656	677	