

**DETERMINANTS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH
SERVICES AMONG FEMALE ADOLESCENT REFUGEES IN NAIROBI CITY
COUNTY**

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DECLARATION

I, the undersigned do hereby declare that this research project is my original work and has not been presented for any academic degree in any other university.

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I confirm that the candidate, under my supervision, carried out the work reported in this research project and has been submitted for examination for the degree of Master of Arts in Gender and Development Studies of the University of Nairobi with my approval as the university supervisor.

Signature: _____ Date: _____

Dr. Dalmas O. Omia

DEDICATION

To my dearest Catherine, Elijah and Geraldine- thank you for giving me the greatest gift, education, and for spurring me on at every stage of it. To God, without whom I am nothing.

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ABSTRACT

This is a cross-sectional qualitative study on the determinants of access to sexual and reproductive health services among female adolescent refugees living in Nairobi City County. Specifically, the study set out to establish the socio-economic and facility based determinants of access to sexual and reproductive health services among female refugees aged between 10 and 19 years. This is because sexual and reproductive health (SRH) is a significant aspect of adolescents' growth but remains difficult to access among adolescents who have been displaced by emergency and conflict situations and are not located in a specific camp or geographic area but are spread across urban areas.

The disruption of family structures and adult role models that adolescents usually look to and the protective social norms, structures, and community groups through conflict and natural disasters makes access to SRH services particularly difficult for adolescents. Populations, who often end up living in displaced situations for a long time, in camps, rural or urban settings, face acute health challenges with women and adolescent girls, particularly, being vulnerable to being excluded, marginalized and exploited and at a higher risk of GBV. In Sub-Saharan Africa, efforts to attain quality sexual and reproductive health are constrained by inadequate access to and inequitable distribution of quality SRH services consequently contributing to poor utilization of SRHS among adolescents.

The socio-economic determinants under study were: Parental support and control; Peer influence; Socio-cultural norms; Religious beliefs; Media and popular culture; Financial status. The facility-based determinants studied were: Availability, accessibility, acceptability and, equality. The study used the Social Exclusion Theory to explore how female refugee adolescents are excluded from accessing SRH services due to their age and their migrant status as refugees.

The study utilised in-depth interviews, focus group discussions and key informants. Purposive sampling was used to select the 30 participants of the in-depth interviews who were spread around different areas of Nairobi. The FGD participants were a subset of the participants of the in-depth interviews for two separate discussions. Four key informants were purposively sampled on the basis of their knowledge of adolescent refugee sexual and reproductive health matters.

The results revealed a low access of SRH services among adolescent refugees. A majority of the study subjects accessed information from school, however this information was limited in scope and content. For most of the respondents, parents and guardians provided them with the initial information on SRH. However, this information was mostly limited to menstruation and menstruation hygiene. Though parents and guardians were the ones providing the initial source of information on SRH matters for most of them, the most preferred source of information were friends and social media. The adolescents shared that they were afraid or shy to bring up sexuality topics with their teachers and relied on the discretion of the teacher on what SRH topic they were to be taught.

A total of 27% of the female adolescents had ever been to a medical facility to access SRH services. Most of those who had been to a medical facility were there for HIV testing and counselling and the rest to access services before and after child birth. Only 16% had access to information on contraceptives.

The main barriers of access to SRH services were shyness and fear, cultural norms, imagined cost of access to SRH services and judgemental attitudes of service providers. Though most of study participants had never accessed SRH services from a health facility, they reported thinking that the services would be too expensive for them and thus did not attempt to visit any.

The study recommends interventions to enhance the knowledge of SRH issues especially to the out-of-school adolescent refugees who would not be able to access the information from a school. There is also the need to broaden the SRH issues taught in school beyond abstinence to also include contraceptives and other STIs other than HIV. There is also the need to build the capacity of teachers, parents and guardians so that they might be able to speak freely about SRH matters.

ABBREVIATIONS AND ACRONYMS

CSE	Comprehensive Sex Education
DFID	Department for International Development
FGDs	Focus Group Discussions
GBV	Gender Based Violence
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
KIIs	Key Informant Interviews
KNH	Kenyatta National Hospital
MoH	Ministry of Health
NCCK	National Council of Churches Kenya
RAS	Refugee Affairs Secretariat
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children’s Fund
UoN	University of Nairobi
USA	United States of America
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Adolescence is a period accompanied by biological, physical, behavioural, psychosocial and cognitive changes and due to this, they have particular sexual and reproductive health (SRH) needs (Kalyanpur et al., 2018; UNFPA & Save the Children USA, 2009). It is defined as the period between 10 and 19 years of age and is a time of transition between childhood and adulthood (Population Division of the Department of Economic and Social Affairs, 2012). In this transition period, adolescents usually profit from the guidance of adult who they trust and look up to, social norms and structures, and community groups, which are often disrupted when people are displaced (Kerner et al., 2012). Kerner et al. (2012) continue to state that when these community and social structures are broken down, adolescents are left without access to SRH information and services during a time when they are vulnerable.

UNHCR estimates that globally, there were approximately 68.5 million forcibly displaced people by the end of 2017 with 52 percent of these being children (UNHCR, 2018). These populations, who often end up living in displaced situations for a long time, in camps, rural or urban settings, face acute health challenges with women and adolescent girls, particularly, being vulnerable to being excluded, marginalized and exploited and at a higher risk of GBV (World Health Organisation, 2015). In the past decade, there has been an increased challenge in assisting populations that have been forcefully displaced living in urban areas especially with most of them living in informal settlements and slum areas together with rural-urban migrants and other marginalized (Guterres & Spiegel, 2012).

Approximately 80% of refugees are hosted in developing countries (mostly in SSA and Asia) and primarily by neighbouring countries with a majority of them living in urban areas in anticipation

of good living conditions and services (Guterres & Spiegel, 2012). However, in most host countries, refugees are not always welcomed into urban areas and usually end up living in informal settlements in and around cities where they compete for services with other immigrants and the autochthonous urban poor (Amara & Aljunid, 2014). They are isolated from their host communities who mistake them for foreigners who are well-off or for economic migrants who have come to compete for the few available jobs and other urban assets (Women's Refugee Commission, 2016). Refugees are often erroneously presumed as those bringing diseases, an increase in crime, and economic declines to their host cities. Refugees in these settings regularly face great inequalities in access to disposable income, support systems in the community and are often excluded from social protection systems and health insurance schemes (Spiegel, 2010). Access to health care and other services is not guaranteed for urban refugees in developing countries, and they are usually excluded from enjoying the same rights in accessing health care as the nationals of the host country. This is due to scarce resources, being spread over a wide geographical area, a lack of protection and barriers due to language and cultural differences (Amara & Aljunid, 2014).

Kenya is host to over four hundred and fifty refugees with a majority of these being encamped (United Nations High Commissioner for Refugees, 2018). As of February 2019, there were over seventy five thousand registered urban refugees and asylum seekers and of these 7.5 percent being females between 12 and 17 years (UNHCR, 2019). In humanitarian emergencies, the SRH of adolescents is largely unmet (UNFPA & Save the Children USA, 2009). Displaced adolescents have limited access to health care, especially care that protects their SRH including protection from STIs and contraception (Women's Refugee Commission, 2019). In such settings, female adolescents face additional risks such as being coerced into having sex, being forced into marriage

and child marriage for economic reasons, early childbearing, bearing on more adult roles and thereby engaging in risky behaviours, and the unavailability of adolescent SRH services (UNFPA, 2016).

Forcefully displaced adolescents may find themselves in an unfamiliar area that can be volatile, stress inducing, and/or unhealthy (Kalyanpur et al., 2018). Kalyanpur et al. (2018) continue to state that adolescents who live in crisis settings, and especially girls, are highly vulnerable to being coerced into sex, being exploited, and violence, and may engage in risky survival sex. Among displacement-affected populations, adolescent girls are an overlooked group and their SRH needs remain largely unmet (Ivanova et al., 2018). Consequently, their use and knowledge of SRH services in refugee settlement or urban areas remains low and access to the services remains a challenge.

The access and utilisation of SRH services available in a particular area is able to provide a state of physical, mental and emotional well-being, and not merely not being sick, in every area related to sexuality and reproduction (Shabani et al., 2018). Shabani et al. (2018) continue to state that access is related to the availability, quality and cost of services, as well as to the socio-economic structure and personal characteristics of the users.

Though adolescents have a right to SRH services that are offered impartially, accessible both physically and financially, acceptable to them, appropriate to their age and effective to the needs they present, evidence shows that in developing countries, they face systemic, socio-cultural and policy barriers to obtaining SRH information and services (Woog & Kågesten, 2017). These barriers to accessing health services tend to be greater in adolescents than in other age groups (WHO, 2019).

1.2 Research Problem

Knowledge and access to SRH care and education is important for adolescents in crisis and emergency situations. There is a dearth in the information available on adolescent SRH needs, perspectives and experiences even though it is generally agreed that the SRH needs of this group are of critical importance (Women's Refugee Consortium, 2014). Although globally, the research on the SRH of populations affected by conflict and disaster is coming more to the forefront, there is still a dearth of information on the needs and experiences of young refugees, of which adolescents are part, in humanitarian settings, who are likely to be at grave risk of negative SRH outcomes (Ivanova et al., 2018).

Harvard Center for Health and Human Rights (2017) estimates that over sixty percent of the world's 21.3 million refugees now live in urban areas, with over half of these being children. Adolescent refugees around the world, facing years of protracted displacement, are increasingly moving to cities in search of safety and opportunity (Donger et al., 2017). Traditionally, the global system of humanitarian response to refugees was built around the encampment model to simplifying service delivery to people in consolidated camps that were meant to be temporary and therefore research was based on refugees living in camps (Harvard FXB & UNHCR, 2017). Therefore, it is important to rethink these and a matching change in what researchers emphasise on.

The study sought to provide an in-depth understanding of the determinants of access to SRH services among female adolescent refugees in Nairobi and was guided by the following questions:

Overall question

What are the determinants of access to sexual and reproductive health services by female adolescent refugees in Nairobi City County?

Specific questions

1. What are the socio-economic determinants of access to sexual and reproductive health services by female adolescent refugees in Nairobi City County?
2. What are the facility-based determinants of access to sexual and reproductive health services by female adolescent refugees in Nairobi City County?

1.3 Objectives of the Study

1.3.1 Overall Objective:

To assess the determinants of access to sexual and reproductive health services among female adolescent refugees in Nairobi City County.

1.3.2 Specific Objectives:

1. To establish the socio-economic determinants of access to sexual and reproductive health services by female adolescent refugees in Nairobi
2. To establish facility-based determinants of access to sexual and reproductive health services by female adolescent refugees in Nairobi

1.4 Assumptions of the Study

The study was guided by the following assumptions:

1. There are socio-economic determinants to access of SRH services among female adolescent refugees with parental support and control being the major socio-economic determinant.
2. There are facility-based determinants to access to SRH services among female adolescent refugees with the attitude of the service providers being the major facility-based.

1.5 Justification of the Study

Sexuality, sexual and reproductive behaviour, and reproductive ill health have both biological and socio-cultural origins and therefore, the beliefs, values, and preferences of potential SRH service users, providers, and policy-makers are greatly conditioned by society and determine the acceptability and successful use of the interventions (Collumbien et al., 2012). This research may be important for providing insights into these human factors and assessing their practical implications for the management of SRH services therefore contributing to improving SRH services and programming towards female adolescent refugees.

Woog et al. (2017) state that more data is needed on the most marginalized or vulnerable groups of adolescents, including but not limited to refugees and other displaced people. While concluding their research, Ivanova et al. (2018) state that there exists a gap in the information on SRH on displaced populations and especially girls and women and that by targeting displaced adolescents is very key in aiding understanding of what adolescents in this particular population are facing. Reducing the dearth of information on SRH needs and experiences of adolescent girls affected by crisis provides the tools and information that is important for evidence-based programming (Ivanova et al., 2018). This research contributes to the body of knowledge regarding this vulnerable and often ignored group.

Though there has been research on urban refugees living in Kenya, there is hardly any research focused on the reproductive health of refugee adolescents living in urban areas. Most of the research on children and especially girls has been on access to education, protection needs and coping mechanisms. Nkam (2012) focuses on Socio-cultural determinants of pregnancy and the spread of sexually transmitted infections among adolescents. His research, however, focuses on adolescents living in Kakuma refugee camp in northern Kenya. Ivanova, et al. (2019) have

researched on the topic SRH knowledge, experiences and access to services among refugee adolescent girls but their research on refugees living in the Nakivale refugee settlement in Uganda. Ivanova et al. (2018) have done a similar research but have based their study on the whole of Africa. These studies have pointed out patterns and trends in adolescent knowledge and access to SRH care and services but do not have information on the female urban refugee and asylum seeker living in Kenyan urban areas.

1.6 Scope and Limitation of the Study

This study was conducted in Nairobi City County. The county is host to approximately seventy-five thousand refugees and approximately seven thousand of these are girls aged 12 to 19. Available UNHCR data does not disaggregate this data for ages 10-19. This study focused on the socio-economic and facility based determinants of access to SRH services among female adolescent refugees. The study used a cross-sectional design and based its arguments on the theory of social exclusion. The study participants were selected using purposive sampling.

While the study had key interest in access to SRH services among female adolescent refugees, it did not focus on quantitative aspects of access to SRH such as frequency of access of services and information and including a large sample size that is characteristic of a quantitative study. This would have been outside the scope of the study. The study used purposive sampling which would have left out hard-to-reach adolescents. However, the study aimed to reduce potential bias by including a variety of nationalities in the study sampled from different parts of the county. Limited financial resources confined the geographical scope of the study to a small sample size who were purposively sampled therefore, the results of this study cannot be generalised given the unique experiences of each individual with SRH issues.

A subset of the study participants did not speak in English and therefore, the interview questions were orally translated to them then their responses translated back into English which may have lacked to convey the exact, culturally-adapted message. The study was to include girls aged between 10 and 19 years. The study might have reporting bias in terms of age of participants because the reported age could not always be verified due to lack of valid documents for some of the cases.

The study included sensitive questions on sexual activity and contraception. There was the possibility of underreporting or giving culturally-appropriate answers by the participants. A few respondents indicated sexual activity and were open about contraceptive use. Though triangulation of data aided in correcting this drawback and ensured that the data was verified, the results might not reflect the real situation.

1.7 Definition of Terms

Refugee: In this study the term mean those who have been forcefully displaced from their countries and have come to Kenya include asylum seekers.

Adolescent: In the study it mean an individual aged 10-19 years.

Access: Knowledge of and ability to seek SRH information and services that are affordable, physically accessible, acceptable in quality and relevant and effective to the adolescents it is meant to serve.

Socio-Economic Determinants of health: The social structures, norms and economic systems that include the social environment, physical environment, health services, and structural and societal factors that contribute or hinder access to SRH services by adolescents.

SRH Services: information and counselling about sexuality, provision of contraceptives, prenatal and postnatal care and delivery, post-abortion care, prevention and treatment of STIs,

Facility-Based Determinants: The availability, accessibility and acceptability of health facilities to adolescents.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on access to SRH services among adolescents. The literature is reviewed along the following sub-areas: social-economic determinants of access to SRH services among displaced adolescent and; Facility-based determinants of access to SRH services. The chapter concludes with a discussion on the theoretical framework that guide this study and its relevance to the study.

2.2 Access to SRH Services among Adolescents

Sexual and reproductive health (SRH) is an important aspect of to the growth and development of adolescents and encompasses the complete physical, mental and social well-being in all aspects related to sexual and reproductive growth (Iqbal et al., 2017). Access to SRH is particularly difficult in emergency and conflict situations and possess a greater challenge when adolescents are not located in a specific camp or geographic area but are spread across urban areas (UNFPA, 2016). It is usually difficult to reach less advantaged populations like migrants, adolescents, and ethnic minorities with the health infrastructure that is already in place since there exists several barriers legally, socially and culturally that hinder them from accessing SRH services (Gausman & Malarcher, 2011). These crises exacerbate the deeply entrenched gender inequality and gender-based discrimination in many societies (UNFPA, 2016). Female adolescents are worst affected by these inequalities which makes them more vulnerable and at a higher risk. Crisis increases the vulnerability of women and girls to negative SRH outcomes like unwanted pregnancies, HIV and other STIs, maternal death and sexual violence (Ivanova, et al., 2019).

Pandey et al. (2019) state that, globally, adolescents face numerous challenges to access and utilization of SRH services which is largely associated with complex social, environmental,

cultural, economic, and psycho-social factors. Access to SRH services is not merely an issue of physical distance or geographical location, but one that involves other dimensions such as economic, administrative, cognitive and psychosocial (Measure Evaluation, 2019). Inequalities in access to resources often leads to a cycle of exclusion at the individual level which is evidenced by the disadvantaged people groups being more vulnerable to exposure, less likely to access health care, and having adverse health outcomes (Gausman & Malarcher, 2011). Adolescent access and utilisation of SRH services is related to the availability, quality and cost of services, as well as to the socio-economic structure and personal characteristics of the users (Shabani et al., 2018). This access to services that provide contraception, safe abortion, pregnancy care, and diagnosis and treatment of sexually transmitted infections is critical for adolescents (Shaw, 2009).

Globally, more than half of the refugee population are under the age of 18 and yet despite these numbers, there is no satisfactory prioritization of SRH challenges faced by the adolescents in humanitarian settings, and their SRH needs are often neglected (Ivanova, et al., 2019). There exists inequity of accessibility to and utilization of SRH services among adolescents that varies by cultural and socio-economic contexts (Zaw et al., 2012). As compared to the greater population and even that of male adolescents, adolescent girls are at greater risk of reproductive ill health due to power imbalances and traditional and cultural norms that reduces their agency over their own sexual and reproductive lives (UNFPA, 2008) (Pathfinder International, 2009).

Adolescents lack adequate access to suitable, age appropriate SRH information and services which contributes to unprotected sexual activities which lead to negative SRH outcomes (Mbeba, et al., 2012). Adolescents suffer unequally from negative SRH outcomes, such as early and unintended pregnancy, unsafe abortion, and STIs, including HIV/AIDS (Pathfinder International, 2009). Though a number of adolescents voluntarily get pregnant, a number of pregnancies occur due to

human rights violations such as child marriage, coerced sex or sexual abuse (MoH GoK, 2015). These pregnancies are as a result of the unmet need for contraception (Pandey et al., 2019). Pandey et al., (2019) estimate that 21 million girls between 15–19 years of age and two million girls under the age of 15 become pregnant each year. Pregnancy and childbirth at this age is high risk and may cause complications, which are the highest cause of death for adolescents aged 15-19 in developing countries (Pathfinder International, 2009).

Adolescents face adverse complications during pregnancy because they are not fully prepared both physiologically and biologically for pregnancy due to gynaecological immaturity and incomplete pelvic growth (MoH GoK, 2015). Those who are not gravely affected by the complications during pregnancy and delivery are usually at risk of experiencing protracted health consequences that include, include fistula and infertility (Pathfinder International, 2009). Among adolescents, infant mortality rates are almost double the ratio of that among women over age 20 (UNFPA, 2008). Regardless of whether an adolescent's pregnancy is voluntary or not, it increases the risk of maternal mortality and morbidities and the complications arising from unsafe abortion, protracted labour, delivery and post-natal period (MoH GoK, 2015).

In SSA, female adolescent girls are unequally affected by HIV with every 7 in 10 new infections in adolescents being among girls (IAWG, 2017). These high infection rates and risk of cervical cancer are attributed to high fertility rates, early age at birth of first child and high birth rates (UNFPA, 2008). In Kenya, adolescents represented about nine percent of people living with HIV and make up 13 percent of all HIV-related deaths while HIV testing rates are lowest among adolescents between 15-19 years (49.8%), with only 23.5 percent reporting awareness of their status (MoH GoK, 2015). In Sub-Saharan Africa, efforts to improve the status of SRH in the

population are often limited by low access to and unequal distribution of quality SRH services consequently contributing to inadequate utilization of SRHS among adolescents (Odo et al., 2018).

These disparities of access to SRH services have economic, social and health consequences that have a direct bearing on the individuals, their families, society and health systems in their entirety both nationally and globally (Pathfinder International, 2009; Zaw et al., 2012).

The access and use of SRH services by female refugee adolescents is hampered due to socio-cultural norms and taboos, judgemental attitude and negative perception by parents, the community and health practitioners towards adolescents seeking SRH services, the absence of confidentiality and privacy, and inhibiting service fees (Ayehu et al., 2016). Adolescents can theoretically access all health services through health facilities, however, policies that do not support adolescent sexual and reproductive independence and agency hamper their rights to gain access to these much needed services (Tanabe et al., 2013; Woog & Kågesten, 2017). Access and up take to SRH services is determined by both socio- economic factors and facility-based factors some of which include; few outlets that provide SRH information and services, health care professional bias, family, religious or societal beliefs and pressures around sexual initiation (Tanabe et al., 2013).

2.3 Socio-Economic Determinants of Access to SRH Services

2.3.1 Parental guidance and peer influence

The access to SRH service and patterns of sexual behaviour of adolescents is influenced by both parents and peers (Kamau, 2019). Adolescents have a lowered risk of negative SRH outcomes if they are living with both parents and they have a good relationship with them (Wamoyi et al., 2010). The parents and guardians to adolescents are usually the gatekeepers and are required to

give consent for adolescents to access services such as HIV testing and contraceptives (Woog & Kågesten, 2017).

Among adolescent girls, there exists gaps in the provision of services and parental control decrease their ability to gain access to age-appropriate information and services for their health and well-being, which is key for their sexual and reproductive development (UNFPA, 2016). This results to high prevalence of SRH problems among this age group (Odo et al., 2018). Since adolescent girls have limited social and economic power their parents and guardians are the main influences towards SRH decisions such as the age of first sex or early marriage (Pulerwitz, et al., 2019). Adolescents are also more likely to access SRH services if they have support from their parents and peers (Muhwezi, et al., 2015). For most adolescents, the belief that their peers are engaging in risky sexual behaviour acts as a motivator for them to do the same (Widman et al., 2016).

2.3.2 Socio-cultural Norms

The SRH practices and access to services by female refugees is greatly affected by socio-cultural factors. These practices and patterns of access have a direct bearing on the on the RH status of adolescents and also affects them later in life (MoH GoK, 2015). These socio-cultural factors include social norms that restrict access to SRH services through stigma and negative social pressure (Odo et al., 2018). When families and government policies support different social norms, communities often continue to enforce the traditional norms to the disadvantage of the adolescent (Pulerwitz, et al., 2019). Adolescents may fear and feel embarrassed from accessing SRH services if they think that they might be seen by adults from their communities or if their information is made known to other people (Shabani et al., 2018). Social pressure and cultural norms around early child-bearing and contraceptive use imposed by partners, family, religious communities, and

the larger society often limit a young person's desire and ability to access and utilize SRH services (Zaw et al., 2012).

2.3.3 Religious Beliefs

There exists a complicated association between the goals of progressing towards and achieving women's reproductive health and rights and the religious practices and beliefs adopted by a large number of the population in the world (UNFPA, 2015). Cense et al. (2018) state that in various cultures of the world, religion is a key factor in deciding how sexual norms and values are practiced. Religion plays a keep part in influencing decisions and behaviours towards accessing health including sexual and reproductive health.

Initially, it was believed that religion acted as a gatekeeper to protect adolescents from negative SRH outcomes like unplanned pregnancy but this view is continuously being debunked and shown to be inconsistent in many places around the world (Moreau et al., 2013). Evidence shows that adolescent who practiced their religion regularly were more likely to delay sexual debut but that those who were already sexually active were less likely to use contraception (Arousell & Carlbom, 2016). Numerous religious beliefs and values related to gender and sexuality obscure effort to improve SRH since they are at most times overtly or covertly opposed to the idea of sexual rights for all (Cense et al., 2018). Adolescents have been made to believe that by seeking SRH services and information shows that they are engaging in sexual activity and due to this religious beliefs and practices act as a barrier against adolescents seeking healthcare despite contraceptive needs and risky sexual behaviour (Hall et al., 2012).

Attitudes towards sexuality and reproductive health are aspects such as romantic relationships, sex, marriage, pregnancy, bearing of children, abortion and contraception are molded by dedication to a particular religion and also to its beliefs and practices (Hall, Moreau, & Trussell,

2012). Hall et al (2012) continues to argue that adolescents who participate actively in religious activities and have strong religious beliefs are usually at an increased risk of negative SRH outcomes since they do not receive CSE due to the taboos around it which also makes them less likely to use contraceptives even when they are sexually active.

2.3.4 Media and popular culture

Mass media and the popular culture tend to portray sex as fun and risk free. Exposure to sexual content through television, movies, music and magazines which is now more accessible than before, contributes to involvement of adolescents in sexual activities (Odo et al, 2018). Sexual content exposed to boys and girls during early adolescence determines their sexual behavior during middle and late adolescence (Shabani et al., 2018). Though these paint a bleak picture of media and its effects on SRH among adolescents, there has been an increase use of technology to pass on health information. According to Nigenda et al. (2016), the evidence shows that when rightly aligned with the needs of the population and the providers, the use of mobile and electronic health is able to strengthen SRH systems and expand access to health services in the population.

Young people are the largest consumer of mobile technology globally which is in part due to the declining costs of mobile phones and also increased reliance on mobile phones as essential commodities (Ippoliti & L'Engle, 2017). Electronic mass media is the prime source of reproductive health information since parents and teachers shy away from having discussions about SRH with teachers skipping over chapters that covered SRH (Nkam, 2012). In addition, the privacy and convenience afforded by mobile phones make them especially appealing to adolescents (Ippoliti & L'Engle, 2017).

These conventional non-formal SRH information sources like peers, mass media, may prove unreliable since there is a scope of subjective misinterpretations (Tanabe et al., 2013). However,

when directed to reliable sources mobile phones provide cost-effective, efficient, and a highly suitable communication channel for reaching and engaging youth around SRH issues especially those living in resource-poor settings (Ippoliti & L'Engle, 2017). They are also useful in reaching poor and marginalised populations by enabling them to access health services regardless of where they are located geographically.

2.3.5 Financial Status

There is an intimate relationship between the economic status and SRH with economic deprivation being both a cause and a consequence of poor SRH outcomes (Woog & Kågesten, 2017). Woog et al. (2017) continue to state that poverty is linked with school dropouts, early or child marriage, early childbearing, reduced prospects of labour force participation, and a lower ability to contribute to a household income. There is a direct correlation between the economic status of individuals and households and ill health particularly in SSA where the status of public health systems is mostly wanting (Bloom & Lucas, 1999). Female adolescents who come from the top three wealthiest quintiles have shown a reduction in pregnancy rates while those from the lower three of those who are economic deprived have shown a marked increase (M. Denno et al, 2015). Poverty has been associated with increased risk of negative SRH outcomes both directly and indirectly. For instance, lack of money for transport is an inhibitor to access of SRH services if the health facility is far from the place of residence. Poverty also acts as an indirect cause to negative SRH outcomes for instance when an adolescent misses out on school, they may miss out on CSE which has been shown to foster positive SRH behaviour.

2.4 Facility Based Determinants

The facility-based determinants of access to SRH services relate to the availability, accessibility, acceptability and equity of health services (WHO, 2012). Availability refers to whether the service

that an adolescent needs is present at the health facility they visit. These services include- accurate SRH information, a range of safe and affordable contraceptive methods, counselling, obstetric and ANC services as well as the prevention and management of STIs including HIV (UNFPA, 2014).

WHO (2019) classifies accessibility into three categories: physical, economic or affordability and information accessibility. Physical accessibility refers to availability of health services within a reasonable geographical area and with favourable opening hours, availability of a working appointment system and other features of a service facility that allow adolescents to be able to get the services they need. WHO (2019) continues to state that economic accessibility or affordability is a measure of whether an adolescent or her family is able to pay for services without financial hardship and takes into account not only the direct cost of the health services but also the indirect and opportunity costs. Lastly, information accessibility comprises of the right to pursue, obtain and convey information and ideas concerning SRH issues (WHO, 2019). Access to information should be done within the confines of having the right to have the personal health data of adolescents treated with confidentiality.

Though services may be both available and accessible, adolescents may still shy away from using them if they are not acceptable. For adolescents to access SRH services, they require confidentiality and privacy while at the health facility and non-judgmental attitudes from health care providers (Shaw, 2009). Non-acceptability of a service may be due to the long waiting times in areas where the adolescent may be recognized by someone they know. Adolescents might also fear that health workers reprimanded them, ask them very personal questions, put them through unpleasant procedures, and not maintain confidentiality (WHO, 2012). Additionally, adolescents are limited from accessing SRH information and services in health facilities by the health care providers' own moral and belief background determine when adolescents are old enough to access

SRH services (Paney et al., 2019). These practices among health practitioners often hinder access to SRH services (Shaw, 2009).

Equitability of how service is offered is also a determinant of access to SRH services. These are services that do not discriminate on the basis of economic status, marital status, or migrant status. Though there are requirements for a parent or guardian to be present for the provision of SRH services to adolescents, especially those aged 10-14, their rights include the consideration of their evolving capacities to consent to services, which is particularly key for adolescent refugees who may have been separated from their parents or guardians (Shaw, 2009).

Pandey et al. (2019) state that there is need to increase the capacity of health care workers to separate their own beliefs and socially approved moral background when working in adolescent SRH so as to be able to offer services free of judgement.

2.5 Theoretical Framework

This study was guided by the theory of social exclusion.

2.5.1 Theory of Social Exclusion

Rene Lenoir, who was Secretary of State for Social Action, is attributed with coining the term “Social Exclusion” in 1974 (De Haan, 1999). De Haan (1999) continues to state that Lenoir used the term to mean poor people, those who were living with a disability, suicidal people, the aged, abused children and substance abusers. DFID (2015) defines the concept of social exclusion as a process by which certain groups are systematically disadvantaged through discrimination because of their gender, ethnic background or race, migrant status, age, religion, sexual orientation, disability, HIV status or the area they live. It is multidimensional and includes material deprivation and also the deprivation caused by relations and processes (De Haan, 1999; Department of Economic and Social Affairs, 2016). Social Exclusion is also dynamic, in that it affects people in different ways and to various degrees over time (Khan et al., 2015). When a group of people are socially excluded they can be great differences between them and others and the society in that they can fail to participate socially, lack social protection, fail to integrate socially and lack power (Khan et al., 2015). It may lead to an absence of agency or ability to make significant decisions over one’s life (Department of Economic and Social Affairs, 2016). The discrimination faced by these groups occurs in public institutions and systems and also social institution of which health services and the household are part of (DFID, 2015).

Exclusion affecting people at different levels from the individual to the global are driven by unequal power relations that affect the economic, political, social and cultural dimensions of one’s life (Popa, et al., 2008). Popa et al. (2008) continues to state that this results in a cycle of exclusion characterised by unequal access to resources, capabilities and rights, which leads to health

inequalities. The applicability of the concept is not only limited to developed countries but also in lower-income developing countries. This is because the focus of the concept on relational features proves useful to examining processes that lead to poverty and a deprivation of capability which are similarly across various regions and countries that are at different levels of development (Department of Economic and Social Affairs, 2016). Additionally, while the concepts of poverty and social exclusion are intertwined they are nonetheless distinct and need not go hand in hand since not all groups that are socially excluded are at a disadvantage economically.

Social exclusion affects health both directly and indirectly. It affects it directly through its health system manifestation and indirectly through social and economic inequalities thus creating a vicious cycle (WHO, 2010). Social exclusion theory is a useful concept for exploring why certain population groups may be more at risk of poverty and associated health inequities (WHO, 2010). Wahome (2008) uses the concept to guide his research on access and utilization of RH services by adolescents in Nairobi City. Mwendu (2013) used this theory to research on challenges facing girls accessing sanitary towels in Kasikeu Division in Makueni County. Lastly, Mbugua (2014) used the theory to study empowerment of female immigrants in Nairobi County.

2.5.2 Relevance of the theory to the study

The theory of social exclusion can be used to study the socio-economic as well as facility-based determinants to access to SRH services among female adolescent refugees in Nairobi. The theory is relevant to the study since it highlights how female adolescents are socially excluded due to their age, gender and migrant status from accessing SRH services. It was useful in highlighting why adolescent refugees are at risk of health inequalities when accessing SRH services. Social exclusion involves many dimensions that determine social participation, social protection, social integration and power. These dimensions working together affect the socio-economic status of

female adolescent refugees and their ability to access SRH services. For example, by affecting the ability of a refugee adolescent’s parents to gain access to a job through discriminatory policies, the household and specifically the adolescent, may lack the necessary finances to be able to gain access to needed SRH services.

2.5 Conceptual Framework

The conceptual framework illustrates the relationship of the independent and dependent variables in this study. It shows the demographic characteristics and determinants to access of SRH services by female adolescent refugees in Nairobi.

Independent Variables

Dependent Variable

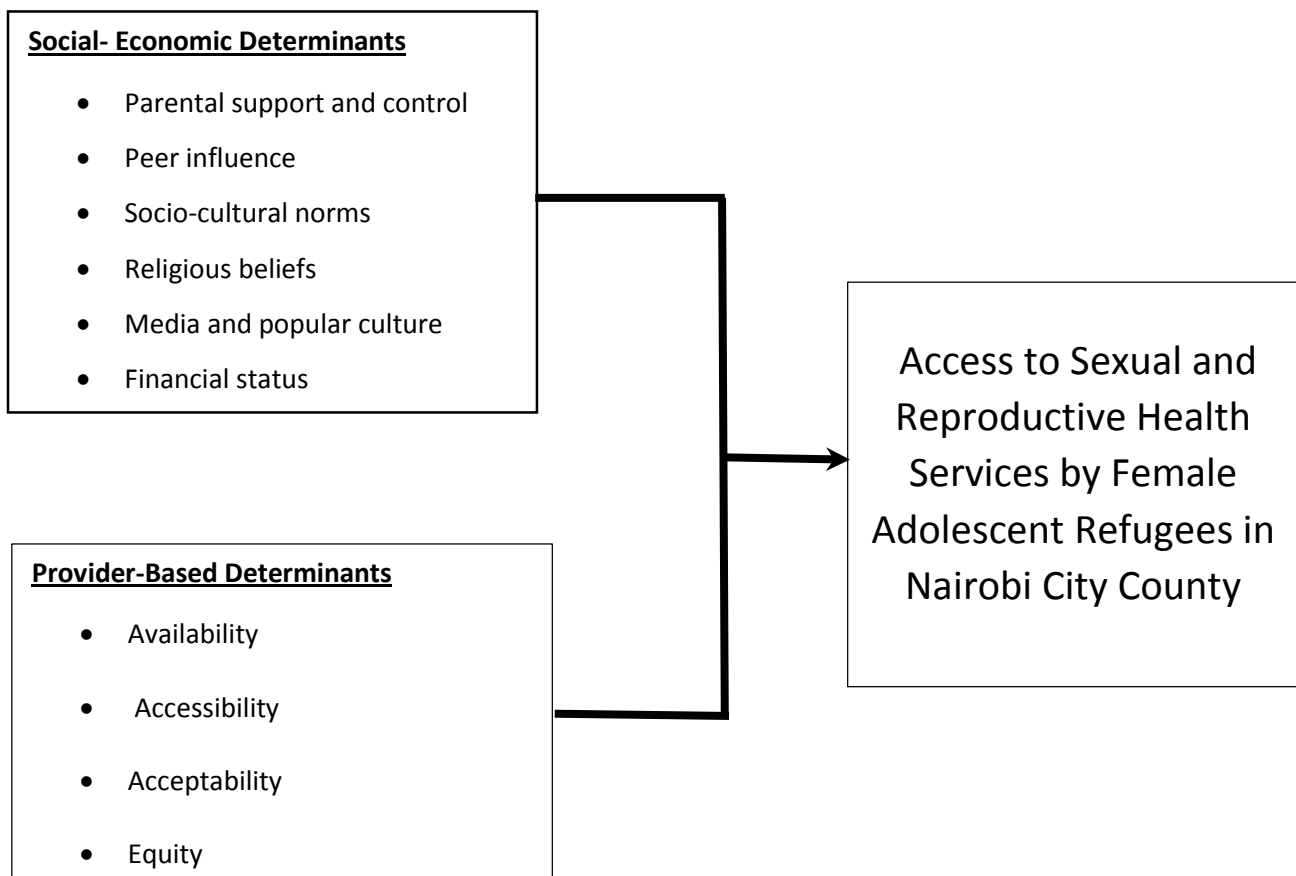


Figure 2.1: Conceptual Framework

(Source: Author)

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter describes the procedure that was used to carry out the study. The research site, research design, study population, sample population, sample procedure, data collection methods, data processing and analysis, ethical considerations, as well as the problems encountered in the study are presented.

3.2 Research Site

This study was carried out in Nairobi City County (Fig3.1). Nairobi was been chosen as the area of study since it hosts a majority of the urban refugees (UNHCR, 2019). The geographical coordinates of Nairobi are 1.2921° South and 36.8219° East, it has an elevation of 1795 metres above sea level and the total land area of the county is 696 square kilometres (GPS Coordinates, 2019). Nairobi is the capital city of Kenya and UNHCR and Refugee Affairs Secretariat (RAS) have offices in the city that cater for the urban refugees. There are a number of UNHCR implementing partners serving urban refugees.

The asylum seeking and refugee population is managed jointly by the government through RAS and also by UNHCR. Refugee work in Kenya is governed by the 2006 refugee Act and the 2009 Refugee Regulation as well as other international laws on refugees. A majority of refugees and asylum seekers in urban areas such as Nairobi, are engaged in the informal sector as casual laborers, small business holders and semi-skilled workers while a smaller percentage of them run medium sized enterprises or are employed in the formal sector (UNHCR, 2019). Due to the encampment policy, most refugees are required to live in the camps (Goitom, 2016). This has made refugee movement very limited. Goitom (2016) continues to state that the encampment policy has made life harder for refugees who are not abke to engage in informal employment as

easily as they could before. A majority of the refugees live in poverty due to economic exclusion and as a result are disadvantaged in many aspects of their life. All foreigners, including refugees, are required to have work permits to be able to work in the country. These work permits are expensive and rarely issued to refugees. Due to the harsh economic environment, some refugees end up in engaging in transactional sex, early marriages, and school drop which lead to negative SRH outcomes.

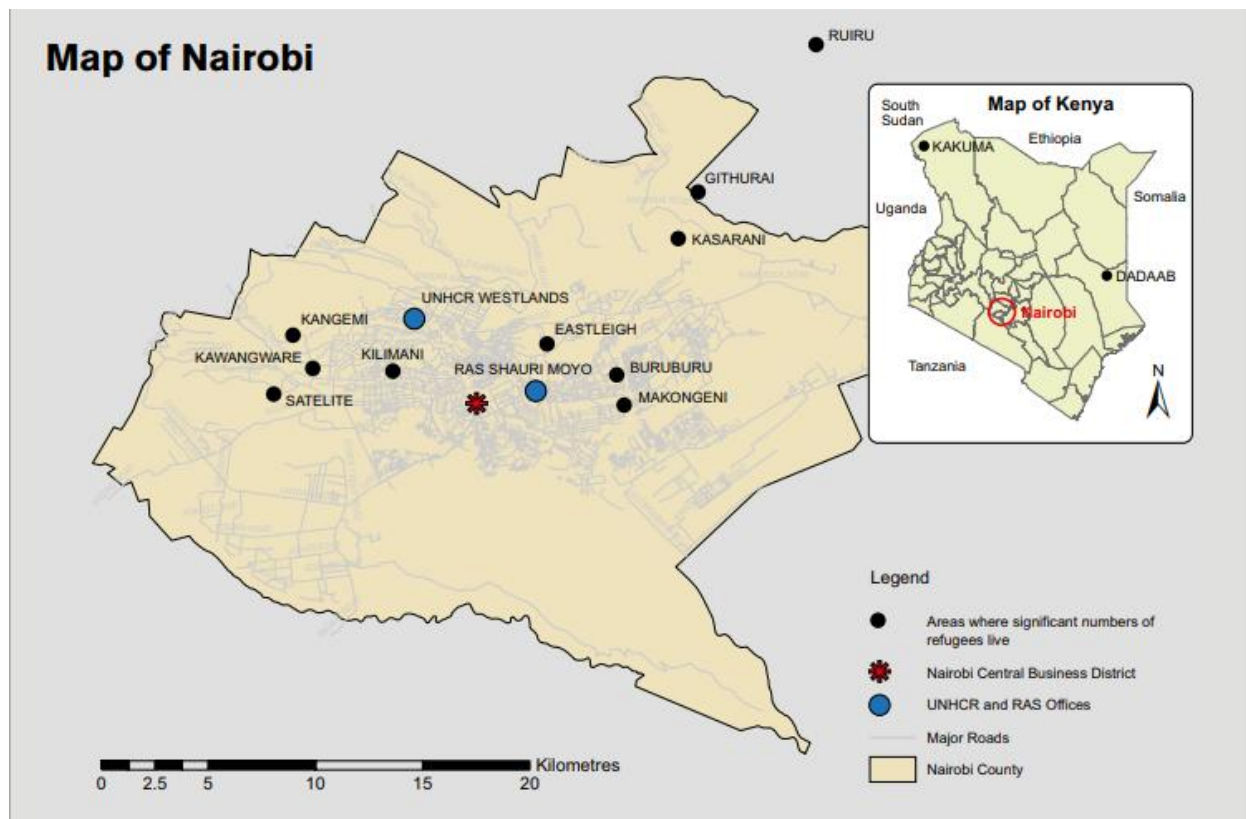


Figure 3.1: Map of Nairobi City County

(Inset Map of Kenya Showing position of Nairobi County) Source: (NRC; IHRC, 2017)

3.3 Research Design

This study employed a cross-sectional design. The design was appropriate for this study since it was to be carried out within a short period of time with the aim of capturing a ‘snapshot’ of

determinants of access to SRH services within which the study is carried out since they might change over time.

It employed qualitative approaches of data collection, specifically in-depth interviews, Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). Interview guides, FGD guides and KII guides were used as the tools to collect data. The instruments were piloted and necessary changes and adjustments were done before data was collected.

The study had three phases. The first phase involved in-depth interviews with thirty female adolescent refugees of different nationalities. The second phase involved two FGDs with adolescent females aged 10-19. The third phase involved four KIIs with members of the community who interact with refugees namely; a community health worker who works directly with refugees at Riruta Health Centre, one child protection officer from HIAS, one UNHCR child protection staff and a Community worker from HIAS.

3.4 Study Population and Unit of Analysis

As of February 2019, there were over seventy five thousand registered urban refugees and asylum seekers and of these 7.5 percent being females between 12 and 17 years (UNHCR, 2019). The study population included all female adolescent refugees who live in Nairobi City County. The respondents were drawn from seven countries which included: South Sudan, Somalia, Democratic Republic of Congo, Ethiopia, Burundi, Rwanda and Eritrea. The in-depth interviews involved thirty female adolescent refugees interviewed separately. The FGDs comprised of female adolescent girls purposively selected from participants in the in-depth interviews the grouped according. The KIIs were four individuals who have worked with adolescent refugees and have an understanding of their reproductive health issues and the urban refugee setting.

The unit of analysis was an individual female adolescent refugee aged 10-19 from various nationalities or ethnicities.

3.5 Sampling

A sample of 30 respondents was purposively selected for the in-depth interviews. This sample size was found to be convenient for a qualitative study for the purpose of getting the experiences of the participants rather than use the findings for generalisations. The study participants were drawn from seven different countries. There were ten respondents from South Sudan, Seven from Somalia, six from Democratic Republic of Congo, and one each from Eritrea, Burundi and Rwanda. The information from the in-depth interviews was triangulated with that from the FGDs. The participants of the FGDs were be purposively selected from among the participants of the in-depth interviews.

3.6 Data Collection Methods

3.6.1 In-depth Interviews

In-depth interviews were conducted with 30 participants aged between 10 and 19 years and were of seven different nationalities. An interview guide (APPENDIX IV) was used to capture socio-demographic characteristics of the respondents relevant to the study. The interview guide was also used to collect data on socio-economic and facility-based determinants of access to SRH services from the perspective of an individual female adolescent refugee. The interviews were conducted in a language that the respondent was comfortable using with the help of the research assistants.

3.6.1 Focus Group Discussions

Two separate FGDs were conducted using the discussion guide (APPENDIX III). The groups consisted of 6 individuals each. One FGD was conducted in Eastleigh and another in Kawangware.

Each had a mixture of participants from different nationalities purposively selected from the in-depth interviews.

3.6.3 Key Informant Interviews

Interviews were conducted with key informants who included a community health worker from who works directly with refugees at Riruta Health Centre, one child protection officer from HIAS, a UNHCR child protection staff and a Community worker from HIAS. The four were have extensive information on SRH and adolescent refugees. A KII guide (APPENDIX V) was used to guide the interview and capture both the socio-economic determinants and facility-based determinants of access to SRH services by female adolescent refugees.

3.6.3 Secondary Data

The study also relied on secondary sources of data obtained from articles from periodicals, peer-reviewed journal articles, books, reports and other relevant sources. Key to the research was secondary information from UNHCR, WHO, Women Refugee Commission and UNICEF reports with particular focus on SRH issues.

3.7 Data Processing and Analysis

The study was conducted the study was conducted in English, Swahili, Somali and Kinyamulenge by three field workers who were proficient in these languages. During the interviews, notes were taken and field assistants checked them to ensure the accuracy of the records. The interviews were written down and some were recorded with voice recorders and transcribed. The interview transcripts were translated to English where applicable. The data was coded using primary deductive coding. The researcher then reviewed all the data and generated a codebook and themes based on the literature. The researcher employed thematic content analysis for this research.

3.8 Ethical Considerations

The study received clearance from relevant bodies before the collection of data started. Approval from the Ministry of Education was given through the National Commission of Science, Technology and Innovation (NACOSTI). Before conducting the study, a clear explanation of the nature and purpose of the research was explained to the study participants. The minors filled an assent form (APPENDIX II) and their parents filled the informed consent form (APPENDIX I) after agreeing to participate in the study. The study participants were informed of their right to withdraw from the study at any point and those that chose to withdraw had their wishes respected. The interviews were conducted in a private setting without parents or caregivers being present.

The confidentiality of the participants' responses was assured and the researcher did not fill any identifiable markers like names in the data collection tools. The participants were informed on the purpose of the study and what would be done after their responses were collected. The study participants were informed that a copy of the report would be available at the Institute of Anthropology, Gender and African Studies library.

3.9 Problems encountered during the study

A subset of the study participants did not speak in English, therefore the interview guide questions were orally translated to them then their responses translated back into English which may have lacked to convey the exact and culturally adapted message. The field assistants were trained beforehand on what exactly the study was looking into and this helped reduce the message being lost in translation.

Some of the parents and guardians were sceptical about the study and thought that their children would learn "bad habits" like having sex at a very young age. Some guardians also pointed out that talking about sex was a taboo in their culture. The researcher and the assistants went over the

tool with them. The research assistants were very helpful since they knew the different cultures and how to communicate with the parents to alleviate their fears. The parents to young adolescents were informed that the questions to their children would mostly include sources of information on puberty and not on contraceptives.

Some respondents were shy to talk about SRH issues and were worried that their parents or guardians might get to know the responses they gave during the study. The respondents were assured of anonymity and the field assistants created an environment where participants could share their thoughts freely.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This section presents findings of the study. First, the demographic characteristics of the respondents is presented followed by sources of information on reproductive health. In the third section, the socio-economic determinant of access to SRH services are discussed. Lastly, the facility-based determinants of access to SRH services are discussed.

4.2 Demographic characteristics of the respondents

4.2.1 Age of respondents

The study interviewed thirty adolescent girls all between the age of 10 and 19 years. The distribution of the ages of the participants are shown on figure 4.1. below. The study had more of the older adolescents (aged 15-19 years) than the very young adolescents (aged 10-14 years) as shown on table 4.1 below. This is because parents/guardians of very young adolescents were apprehensive about the study and thought that their children would be exposed to things that were not of their age. For the 7 very young adolescents that took part in the study, care was taken not to ask them questions on contraception use and cervical screening and dwell more on access to information on Menstruation and menstruation hygiene and HIV/AIDs.

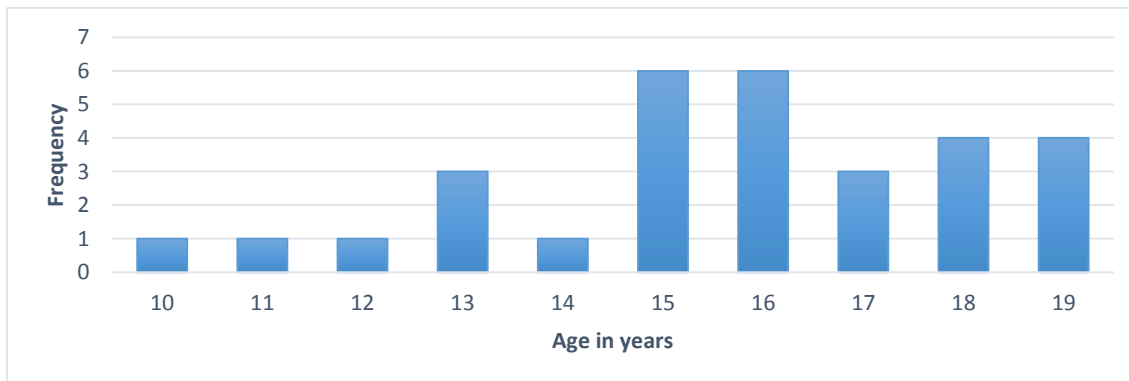


Figure 4.1: Distribution of age of respondents

Table 4.1: Distribution of age of respondents

Age	Frequency	Percentage
Very young adolescents	7	23%
Older adolescents	23	77%
Total	30	100

4.2.2 Education status

In the study, 57% of the respondents were in school while 43 percent were out of school as shown in table 4.2 below. Of those who were out of school, six had never been to school. The education level of the respondents is also shown. Cross tabulation of the education level attained versus information on various SRH aspects showed that respondents who were at a higher level of education had more information on certain SRH aspects than those at lower levels of education.

Table 4.2: Education status of respondents

Education status	Frequency	Percentage
In School	13	43
Out of school	17	57
Total	30	100
Education Level	Frequency	Percentage
None	6	20
Preschool	1	3
Literacy classes	1	3
Primary school	19	64
Secondary school	2	7
Tertiary	1	3
Total	30	100

4.2.4 Religion

Religion plays a key part in influencing decisions and behaviours towards accessing health. 33% of the respondents were protestants, 30% were Muslim, 23% were catholic, 7% were Orthodox and 7% were Seventh Day Adventist The distributions are shown on table 4.3 below.

Table 4.3: Religion and denomination of respondents

Religion	Frequency	Percentage
Catholic	7	23
Muslim	9	30
Orthodox	2	7
Protestant	10	33
Seventh Day Adventist	2	7
Total	30	100

4.2.5 Country of Origin

The participants were drawn from 7 nationalities. Refugees from South Sudan form the bulk of the majority followed by refugees from Somalia. The distribution of the nationalities is shown in table 4.4 below.

Table 4.4: Countries of origin of respondents

Country	Frequency	Percentage
South Sudan	10	33
Somalia	7	23
Democratic Republic of Congo	6	20
Ethiopia	4	13
Eritrea	1	3
Rwanda	1	3
Burundi	1	3
Total	30	100

4.3 Sources of information on SRH topics

The various sources on SRH and whether they are the main source or preferred source are shown on table 4.5 below. The findings showed that adolescents found it easier to get SRH information when they were in school since they would be taught than those who did not go to school. There is the life skills program taught in the school curriculum that incorporates aspects of SRH. However, teaching about SRH and especially matters sexuality is left to the discretion of the teacher and students will only get the information that the teacher is comfortable enough to share

(Pandey et al., 2019). 43% of the respondents stated that, parents and guardians provided them with the initial information on SRH. However, this information was mostly limited to menstruation and menstruation hygiene. Though parents and guardians were the ones providing the initial source of information on SRH matters for 43% of the respondents, the most preferred source of information were social media and internet at 47% and friends at 23%.

Table 4.5: Sources of SRH information

Source	Initial Source		Main Source		Preferred source	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
School	6	20	13	43	4	13
Parents/guardians	18	60	6	20	2	7
Friends	2	7	3	10	7	23
Radio/TV	1	3	0	0	0	0
Social Media/Internet	2	7	5	17	14	47
Non-governmental organisation	1	3	2	7	3	10
Clinic	0	0	1	3	1	3
Total	30	100	30	100	30	100

4.4 Socio-Cultural determinants of Access to SRH

4.4.1 Financial Status

The study findings show that 90% of the primary caregivers to the respondents were engaged in the informal sector as casual labourers and semi-skilled workers. Most of them worked in more than one job or switch to other businesses in different seasons. The average income made in these jobs is KShs. 200 per day. The jobs are not regular in nature and sometimes the parents/guardians do not make an income in a day. There is an intimate relationship between the economic status and SRH with economic deprivation being both a cause and a consequence of poor SRH outcomes (Woog & Kågesten, 2017). Some of the older adolescents work to supplement whatever income their parents/guardians earn or are themselves looking after younger siblings and other relatives.

The lack of long-term jobs and a steady income for the parents was stated as a reason for dropping out of school which goes hand in hand with the research by Woog and Kågesten (2017). Some of the older adolescents were themselves the primary guardians to their younger siblings and relatives and had to work so as to sustain their families and had no opportunity to go to work themselves. Respondents stated that even when they suspect that they have an RH issue, they delay the matter and hope it may go away on its own since they cannot afford to go to the hospital when there are others more pressing needs. The opportunity cost of having an income at the end of the day surpasses the need to seek SRH services or information. Migrants reported they would not visit any health care service unless the condition they were suffering from was very serious because of the money and time they needed to attend to health matter and that they would therefore postpone going to as long as they were still able to work (UNFPA, 2016).

“There was a time that I had an itch in my private parts that would not go away. I wanted to go to the hospital but I knew if I missed going to work, I would not have money at the end of the day to buy food for me and my younger siblings so I just ignored the issue and continued working” (19-year-old respondent).

“I was told that there was an NGO that was teaching people about sexual and reproductive health matters. However, if I went, I would miss out of work and they would replace me with someone else. I like my current job and it was not very easy to get it. I had to make a choice between having money to meet my bills or having information. I chose money because I cannot eat information.” (18-year-old respondent).

Even though finances are a determinant of whether an adolescent would seek SRH services or information 47% of the respondents stated that they would have wanted to get services from a health facility but imagined that the services would be very costly and they ended up not going. 17% of the respondents who were in dire need of SRH services or information but did not have the finances they needed, found other alternatives.

“Most of the adolescent refugees do not have National Health Insurance but need SRH services for example when they are pregnant. When they come to this health centre and have been asked to go for a scan that they cannot afford, our organization can give them a referral letter which states that the organization will pay for the service. They can go and present that letter to a government health facility that they have been referred to and they will get the service they need” (Key Informant).

“There was a time that I needed to go to the hospital because I was having heavy bleeding. I did not want to go to the big hospital in this area because I knew I could not afford it. I asked around of ways that I could get help and I was told that there was a doctor that gives free services to refugees in my area once a week. I went there and though there were many people waiting to see the doctor, I waited and was able to be seen” (15-year-old respondent).

Low financial status was linked to negative SRH outcomes. Lack of finances to meet basic needs was given as a reason for why some adolescents go into transactional sex and get pregnant. There was also a government directive for employers to ensure that all foreign employees have work permits to be able to work. This directive negatively impacted many refugees who were let go from their places of work since many could not afford paying for a work permit. These findings are congruent with the previous work of Popa et al (2008) since the unequal power relationships negatively affects economic status which leads to a cycle of exclusion characterised by unequal access to health resources which has negative impacts on the health of migrant families.

“Because of being refugees, some of us cannot get employed because we do not have identity cards and some people do not understand the refugee identification papers. Therefore, some girls opt to sleep with men who promise to give them money. Some of these men promise heaven on earth but just use the girls. If a girl becomes pregnant, the man chases her away” (FGD participant).

“Most girls from our community do not have a lot of information about sex or contraceptives. There are a lot of myths about sex and pregnancy that girls have when they are coming from our country. So when they come to Kenya and are not living with their parents, or a relative

who provides for them, they get boyfriends who promise them that they will provide them with everything that they need and that they will marry them. The girls have sex and think that they cannot get pregnant when they have sex for the first time and also do not know ways of preventing themselves from getting pregnant” (FGD Participant).

4.4.2 Parental Support and control

Parental support and control was the major socio-economic determinant of whether female adolescent refugees would access SRH services at 67%. Parents who were very controlling and strict do not allow their children to access SRH services while those who were free with their children support their children to access SRH information and services. This concurs with the UNFPA (2016) report that showed that parental control decreases the ability of adolescents to access age-appropriate information and services for their health and well-being.

“Staying indoors all day and not being allowed to move freely makes me not able to easily access SRH information and services. I do not go to school and I also do not have a mobile phone to be able to look up those things on the internet. My parents do not talk about those things to me. They tell me I will find out when I get married,” (15-year-old respondent).

The study findings showed that 60% of the respondents received initial information on SRH from their parents, guardians or older sibling if the parent was not around. This information was mostly on menstruation and menstrual hygiene. The information they received was very basic and most adolescents were not comfortable enough to ask more questions.

“My mother called me one day and told me that she was going to tell me about ‘women things’. She asked me if I had noticed some changes in my body and that I should expect more changes. She told me that I would start bleeding about once a month and that it was very normal. She said because of this, I had to keep myself very clean or else I would become infected. She told me to keep away from boys because some unwanted things would happen to me if I hang around boys very much” (14-year-old respondent).

“My mother is very traditional and I could never ask her questions about sex or pregnancy. I was afraid that she would think that I want to have sex and that would have gotten me into trouble. When I started getting my period is when she told me about menstruation. It was very brief and that was the only time she has ever told me about anything to do with sexual and reproductive health” (12-year-old respondent)

“My aunt is very free with me and I can ask her questions. My friends are usually very shocked to hear this because their parents or guardians do not talk to them as freely. When my friends have questions, they ask me to ask my aunt. Because of being able to speak freely about SRH issues I have been chosen as a peer counselor at my school. I can talk to my friends about sexuality, sex and STIs without being afraid” (16-year-old respondent).

10% of adolescents reported being the ones who initiated questions about sexual and reproductive health. This was because most parents and guardians shy away from talking about sexual and reproductive health matters with their children. Parents prefer that their children learn from external sources like teachers or other relatives like aunts.

“My mother sent me and my sister to my aunt to be told about sexual and reproductive health matters. She said that my aunt will be giving me a talk and that I should be very attentive. When we got to my aunt’s house, she waited until her children and husband were asleep to give us the talk. She was very secretive and told us that such womanly things are not to be talked about in the presence of men” (FGD participant).

“I learn about periods in school and when I went to ask my guardian a question, she told me that I should wait till the next day to ask my teacher. I was not able to approach the teacher so I just stayed with my question because I did not know who else to ask” (FGD participant).

When parents or guardians treat sexual and reproductive health matters with a lot of secrecy, adolescents also learn to treat it like a taboo topic. If parents and guardians were more free to talk about SRH matters, children get to learn the same and also be free to ask questions. Adolescents end up asking their peers who may have wrong information. The above findings are congruent

with the theory of social exclusion as expounded by Popa et al., (2008) since it leads to an absence of agency or ability to make significant decision over one's life.

4.4.3 Peer Influence

The study findings show that peers were the second most preferred source of SRH information at 23%. Due to age similarity and shared life experiences, adolescents intimated that they find it easy to ask their peers about SRH information.

“There was a time that I needed information on contraceptives and I was afraid to ask my family members because they do not know that I have a boyfriend. I asked my friend who also has a boyfriend and she told me of the one she uses” (FGD participant).

“In my experience, friends are not always right. One is better off asking a grown up or looking on the phone. My sister got pregnant because her friend told her that she would not get pregnant because it was her first time having sex. She was also told to shower but that also was not true. Her friend might have used the same tactics and they might have seemed to work because she was just lucky but my sister was not so lucky” (FGD participant).

Peer influence is not always positive. Some adolescents may be influenced to make bad decisions some of which have lasting effects. Peers do not always have the right information and they usually give information based on their previous experience which is most times very limited. This may lead to the wrong information passed on from adolescent to adolescent. These findings are congruent with the research by Tanabe et al (2013) who state that non-formal SRH information sources like peers, mass media, may prove unreliable since there is a scope of subjective misinterpretation.

4.4.4 Socio-Cultural Norms

Socio-cultural norms were the second major determinant of female refugee adolescent access SRH services and information at 20% and even where they would access it from. The respondents blamed the cultural beliefs and the view it had on girls on their parents not allowing them to receive

SRH information. There were a few variants between nationalities on the of how these norms influences access to SRH information but most of them acted as barriers towards accessing SRH information. These findings are congruent with the research by Zaw et al (2012) who states that social pressure and cultural norms limits an adolescent's ability to access and utilize SRH services. The study was to include an almost equal number of very young adolescents aged 10-14 years as those aged 15-19 years. However, during mobilization of the participants, most of the parents to these young adolescents were skeptical about the study and what it would expose their children to. They were hesitant to allow their children to participate in the study they though their children would learn about sex.

“In our culture, when a girl starts a period, she should be married off. However, since we are in Kenya, some of these things changed. However, our parents still do not want us to get the information” (FGD participant)

“I have had to go to a health facility that is far away from where I live because I do not want people from my community to see me going into the RH clinic. If they see me, they would tell my parents who would ask me what I was doing there. They would also term me as a loose girl and perhaps tell their children not to interact with me” (17-year-old respondent)

“Most of the community practices do not favour our reproductive health rights as girls. In my community, if a girl is raped and she knows who raped her, the culture dictates that she should get married to that man. If a man likes you and you turn down his advances, he might come and rape you so that you can become his wife” (FGD participant).

In our culture, talking to children about such things (SRH topics) is not the norm. Since girls used to be married after they received their first period, they were seen as grownups being prepared to get married. Now girls stay very long before being married and this causes problems because they want to get information” (Key Informant)

4.4.5 Religion

The study findings show that religion did not encourage access to SRH services or information. For 70% of the adolescents, religion stressed abstinence as they were encouraged to wait to get married first before having sex. Cense et al (2018) state that there is a continuous fight amongst religious leaders and the state between the implementation of abstinence-only-until-marriage sexuality education versus CSE. Churches especially were said to teach on SRH aspects like STIs in a manner to instil fear so that adolescents remain celibate. In Islam, the social control exerted by the older family members and social network to a female adolescent act as a barrier to the adolescents adopting preventive behaviour and consequently leading to an increase in sexual risky behaviour by adolescent Muslims (Arousell & Carlbom, 2016). These findings are consistent with the research by Hall et al. (2012) who argues that adolescents who actively participate in religious activities make them less likely to access SRH information and services.

“In Church, we are told that having sex before marriage is a sin. We are told that we have to remain holy and pure. We are also told that our husbands will appreciate us more as women if we marry as virgins” (FGD participant)

“one day, we were told that a doctor would be coming to teach us about sexual and reproductive health. It started well because the doctor told us that he knew most of us were very curious to learn such things. However, the major topic was about STIs and he had very disturbing pictures of how people with STIs look. I was very afraid after that” (16-year-old respondent).

Hall et al (2012) continues to argue that adolescents who participate actively in religious activities and have strong religious beliefs are usually at an increased risk of negative SRH outcomes since they do not receive CSE due to the taboos around it which also makes them less likely to use contraceptives even when they are sexually active. There is a need to sensitise religious leaders on the importance of adolescents gaining information on SRH information even to those who were

not married. Religious institutions had good systems put in place for married people than those who were not. Those who get married out of wedlock were made to feel shame and isolated.

“There are many times where older women are called to give us advice as young mothers. When I was nearly due, we were called in a small group of young mothers and given advice on what to expect after child birth and how we should raise our children. It was really helpful because I had not been in the country for a long time and I got very close to those people in my group” (19-year-old respondent).

4.4.6 Media and popular Culture

The study observed that adolescents thought the media made every young person seem like they were having sex and they did not have to worry about getting STIs or getting pregnant. Having a boyfriend was made to seem like a mandatory thing for adolescents and young people and if one was not in a relationship then there was something wrong with them. This goes hand in hand with the research by Odo et al. (2018) who state that exposure to sexual content through television, movies, music and magazines which is now more accessible than before contributes to involvement of adolescents in sexual activities. The media portrayal of dating made most of them wish they lived in a liberal society. The adolescents felt that there was a divide between what the media showed and how they lived because of cultural differences.

“Every young person in the shows I watch has to have a boyfriend. The characters also move frequently from one boyfriend to another when they get bored of each other or one person is angry at the other. Most soap operas are interesting because they show how much people are in love” (FGD participant).

“If I tried being like those girls I see on TV who have many boyfriends some of whom are older, my parents would lock me in the house. There is a difference between westerners and us refugee girls because their parents would allow them to be free with boys whereas, I would be in trouble for staying out late and hanging out with boys” (FGD Participant)

The internet was the most preferred source of information on SRH topics at 47%. This goes hand in hand with the research by Nkam (2012) which found that adolescents turn to the internet because it was easier to get information and also because parents did not provide them with adequate information. This was because the adolescents felt that the internet offered privacy and they could go in search of any topic they wanted. There has been an increase in the use of technology to pass on health information. This is because it is easier to access mobile phones and service costs associated with owning one have decreased. Mobile phones also require few skills for their use. Nigenda et al. (2016) found similar results that these health information technologies, have the potential to overcome social exclusion faced by adolescent female refugees and cultural taboos that prevent informed discussions about SRH issues by providing information in a discreet manner. This is exemplified by one respondent who noted the following:

“I have a phone that I bought for myself. My guardian does not check it and I feel that I can go on the internet and check for any questions I have. It would have been very hard to get information if I did not have the mobile phone. The internet does not ask you why you are asking those questions and I can even search the same question many times. I think that is good for me” (18-year-old respondent).

TV and radio was not featured as a main source or preferred source of SRH information. Adolescent thought that they had no control over what programmes and could not wait to see if there were going to broadcast informative programs. Most of them watched TV for the entertainment. However, media is not always reliable as adolescents may go to sites that do not have verified information and get misleading information (Tanabe et al., 2013). When communication channels are used appropriately, they aid in breaking down and increasing adolescent access and utilization of SRH information and services (Mbeba, et al., 2012).

4.5 Facility-Based Determinants

4.5.1 Availability

Making health services accessible, acceptable, equitable, appropriate and effective is paramount in improving access to SRH services for adolescents (Pandey et al.,2019). The study found that there are SRH services available at the local health facilities. The services offered are however not adolescent specific. Adolescents are treated the same as adults. The study also noted that the health facilities were not adequately staffed and that adolescent had to wait for a long time to see the few available medical staff. The adolescents were also asked to buy medicines from external pharmacies as the local health centres did not have the medicines they needed.

“I had an infection once and when I told my brother, he took me to the hospital around this area. We went there early in the morning so that we would be among the first to be served., I told the doctor what my symptoms were. He seemed in a hurry to just prescribe medicine. He did not describe what was making me sick but just gave us a prescription and told us to go and buy those medicines” (15-year-old respondent).

“I did not know that I could get such services from a hospital. If more adolescents like me knew that there were such services, maybe they could be more of us visiting the health centre” (17-year-old respondent).

4.5.2 Accessibility

This was measured by whether an adolescent could reach the services in terms of opening times, wait period and appointment systems. Secondly, whether the service was affordable to an adolescent including indirect costs like transportation. Lastly, whether adolescents had information to know that the service existed.

A majority of refugees do not have national health insurance and have to bear the cost of health care themselves. Even those who do, some are forced to pay for some services because they are not offered through the card.

“I do not have national insurance and I have to pay for any service that I need at a hospital. After I gave birth, I have regular back pains. I would have liked to go to the hospital to get checked but I do not have that money. Most of the time, I opt to buy medicine from a pharmacy which is cheaper” (19-year-old respondent).

“I had a complicated pregnancy and was told that I needed a scan. I had not been in the city for a long time and I was relying on the help of friends and even getting to the first health centre was a problem. I had asked my friends to help me with the money to get to the health centre. When I was told to get a scan at a hospital that was even further away, I lost all hope. I could not afford the transport there leave alone the money for the scan. It was a very frustrating time” (FGD participant).

“Me and my siblings are mostly struggling to survive. I was raped during flight and as a result I have very heavy bleeding. I went to the hospital once but the medicine they gave me did not help much. I did not want to go back because that would mean that I spend money that can be used for other things” (16-year-old respondent).

4.5.3 Acceptability

This was measured by whether a service was provided in an area that was private and enhanced confidentiality. Secondly, whether a service was offered free of stigma and discrimination based on the age and migration status of the adolescent and also the characteristics of health care providers. Adolescents shied away from accessing services from a health facility because of fear of discrimination. This was based on a person’s previous experience or from the narrative they heard many times in their communities. Arousell and Carlbom (2016) posit that women with migrant background face increased inequalities in accessing health because of language barriers and cultural and socioeconomic factors. This is evidenced by these statements from the respondents:

“I feel that the people working at the hospital do not understand refugees. One health service provider kept shouting at me because I could not understand Swahili. I felt very frustrated and left” (FGD participant).

“In the refugee community, people tend to know each other because we are not very many. My community does not know my status and I have worked hard to keep it that way. I decided to be getting my medication from a health centre in another area where people do not know me. This is because, the waiting area can have many people and I am afraid that someone may spot me if I go to the health centre that is near where I live. Going to a health centre that is far away is costly for me and when I do not have money, I miss out on taking medicine” (18-year-old respondent).

“I am afraid of going to a health facility because they may not treat me well because I am a young person. I do not want to be asked why I want that information and I am a young person. I have heard that health care providers can sometimes just shout at you for no apparent reason” (15-year-old respondent).

Pandey et al. (2019) states that the markers of adolescent-friendly SRH services are those that are within reach to adolescent, affordable, treat adolescents with equality, respect and offer services in a non-judgemental manner while guaranteeing confidentiality. This is congruent with the research by Shaw (2009) which states that adolescents require confidentiality and privacy while at the health facility and non-judgmental attitudes from health care providers.

CHAPTER FIVE: SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

This chapter summarizes the key findings of this research project and gives recommendations in relation to the research objectives. The chapter also gives conclusion of the study and gives suggestions of areas of further research.

5.1 Summary of Findings

This study explored the determinants of access to sexual and reproductive health services. Specifically, it sought to find out the socio-economic determinants and facility-based determinants of access to SRH services. The socio-economic determinants under study were: Parental support and control; Peer influence; Socio-cultural norms; Religious beliefs; Media and popular culture; Financial status. The facility-based determinants studied were: Availability, accessibility, acceptability and, equality.

The study found out that access to SRH information and services remains low among female adolescent refugees. The major socio-economic determinant to access to SRH information and services was parental support and control. For a majority of the adolescents interviewed, the support or control they faced from their parents or guardians determined whether they would seek SRH services and information and also where they would access it from. Adolescents stated that though their parents or guardians were the ones who first told them about SRH issues, they were shy to ask their parent and other family members about SRH issues since talking about it would go against the cultural norms. Some stated that they had tried asking for information but were usually turned away.

Adolescents reported that school was the place where they received most of the information on SRH. This was however very limited in scope since there was no set syllabus in place to teach

SRH in most of the schools they attended in their countries of origin. They would have to rely on the discretion of the teacher on what aspects of SRH they would learn both in their country of origin and in Kenya. Due to the teacher-student relationship, most of them did not feel free to approach teachers to ask them questions if they had any. The most preferred source of SRH information was the internet followed closely by peers. The adolescent shared that the internet afforded them privacy and that they could ask any questions that they had without fear and judgement.

Access to SRH services from a health service were low at 23%. Most of the adolescents did not know of the availability of such services at the health facility. For those who knew, they were afraid of accessing the services due to the cultural perceptions of SRH services and due to the imagined cost of accessing SRH services. Of those who accessed the services, most were happy with the services that they received and reported that they would go back to the same facility for the same or different issue. A subset reported that the health practitioner seemed to be in a rush and talked down to them. The health practitioner did not explain the issue that they were facing but rushed through the interview and just prescribed medicines.

5.2 Conclusions

Access to SRH has been key to this study because it represents the ability of adolescent refugee girls to be able to exercise their right to have control over and decide freely and responsibly on matters related to their sexuality, reproductive health processes, function and systems. Exercising this right is key in the prevention of negative SRH outcomes that have lasting effects long past the adolescent years.

In the study, adolescents appreciated the need for SRH information and services that was specifically suited for people their age. However, most of them are not able to access this

information or services due to socio-cultural barriers that view most SRH aspects as taboo topics and therefore prevent adolescents from gaining access to such. Due to this perception, adolescents are also shy and afraid to approach grown-ups that they trust like parents, guardians, older siblings and teachers to ask them for SRH information. Adolescents also shy away from accessing SRH services from a health facility due imagined cost of accessing such services and the perceived negative attitude from health service providers.

To ensure proper access to SRH services and information by female adolescent refugees, the existing socio-cultural norms that prevent adolescents from accessing vital SRH information and services need to be challenged. Additionally, refugee adolescent girls need to be sensitized on their sexual and reproductive health rights. This has a double effect on countering barriers to access of SRH services and information.

5.3 Recommendations

Based on the study findings, the following recommendations are made:

1. Given the importance of knowledge of SRH issues during adolescence and the implications of negative SRH outcomes which can be life-altering, an increase of interventions to enhance the knowledge of SRH issues, especially to the out-of-school adolescent refugees who would not be able to access the information from a school, should be conducted.
2. There is a need to expand and enrich SRH programmes to include education activities that encourage in-school adolescent girls to stay in school and facilitate those who would want to go back to school. It should also include aspects of economic empowerment and wealth creation so as to address a broad range of adolescent girls needs.

3. The experiences adolescents have at a health centre play a major role in diminishing or increasing the probability of future return visits. Key to this is the attitude of the service provider and whether there is privacy when the adolescent is being attended to. It is therefore important that SRH service offered at the health facilities are adolescent friendly.

5.4 Recommendations for Further Research

1. There is more research looking into adolescent girls as a population more than there is about adolescent boys. The researcher recommends a similar study looking into the SRH needs and barriers to accessing SRH information and services among adolescent boys and also specifically among male adolescent refugees.
2. Though there has been extensive research on HIV/AIDs, there exists opportunities to study on challenges faced by HIV positive adolescent and youth aged refugees. This is due to the additional challenges they face due to their migrant status and diminished social support due to the breakdown of family structure due to migration.

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APPENDICES

APPENDIX I: Consent Form (Parent/Guardian)

Investigator: Patricia Waigwe Kamau

Institution: University of Nairobi, Institute of Anthropology, Gender and African Studies

Project Title: Determinants of Access to Sexual and Reproductive Health Services among Female Adolescent Refugees in Nairobi City County

My name is Patricia Waigwe Kamau, I am a student wanting to find out what determines whether a refugee adolescent girl will access and utilise sexual and reproductive health.

Whenever researchers study children, we talk to the parent(s)/guardians and ask them for their permission. You can choose whether or not you want her to participate. After you have heard more about the study, and if you agree, then the next thing I will do is ask your daughter/son for their agreement as well. Both of you have to agree independently before I can begin.

If you agree for the girl to be part of the study, she will be asked to participate in a group discussion with girls of the same age.

You do not have to decide today whether or not you agree to have your child participate in this research. Before you decide, you can talk to anyone you feel comfortable with.

When this study is completed, I will write a report of what was learnt. There shall be no mention of names or information that can be used to identify your child in the report or publications which may arise from the study.

The possible risk of participating in the study that your child might experience may be that of discomfort or embarrassment from disclosing certain information which they might consider personal, which could raise unwanted emotions or sensitivities. They may choose not to answer if the questions are very personal or an uncomfortable answering them.

There will be no direct incentive or benefit in participating in this study. There may be some words you do not understand or things that you want me to explain more about because you are interested or concerned. Please feel free to ask questions regarding the study and the participation of your child.

If you consent to her being in the study, please indicate your name and sign below:

Name: _____

Signature/Thumb print: _____

Date: _____

Signature of Reseacher/Assistant: _____

Date: _____

APPENDIX II: Assent Form for Minors

Investigator: Patricia Waigwe Kamau

Institution: University of Nairobi, Institute of Anthropology, Gender and African Studies

Project Title: Determinants of Access to Sexual and Reproductive Health Services among Female Adolescent Refugees in Nairobi City County

My name is Patricia Waigwe Kamau, I am a student wanting to find out what determines whether a refugee adolescent girl will access and utilise sexual and reproductive health.

If you agree to be part of the study, you will be asked to participate in a group discussion with girls of the same age. You can choose whether or not you want to participate. I have discussed this research with your parent(s)/guardian and they know that we are asking you for your agreement. If you are going to participate in the research, your parent(s)/guardian also have to agree. If you do not wish to take part in the research, you do not have to, even if your parents have agreed.

You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately. If you decide to stop the study after we begin, that too is okay.

When this study is completed, I will write a report of what was learnt. There shall be no mention of names or information that can be used to identify you in the report or publications which may arise from the study.

Participating in this study does not involve any form of risk. There will be no direct incentive or benefit in participating in this study. There may be some words you do not understand or things that you want me to explain more about because you are interested or concerned. Please ask me to stop at anytime and I will take time to explain.

If you decide you want to be in this study, please sign your name.

I, _____, want to be in this research study.

Signature/Thumb stamp: _____

Date: _____

APPENDIX III: FGD Guide

Introduction:

This study is to find out what determines whether a refugee adolescent girl will access and utilise sexual and reproductive health.

Question about your general well being

1. What are the main problems young girls are facing in your community today?
2. Are the problems different from what Kenyan girls face?
3. What are the biggest fears among young girls in your community today?
4. What could be done to improve these particular issues?

Questions about access to SRH services

5. What particular health concerns do girls have?
6. Would you say that girls in your community have access to sexual and reproductive health services? Why?
7. Are there any centres that are just for adolescents/youth?
8. Have you ever visited a centre that is specifically targeted for youth? If yes, what attracts you to the centre?
9. What if the problem concerned your sexual or reproductive health? What would you do? Would you go to see someone? Who would it be? Would there be people you could talk to about it? Who?
10. What are some of the challenges that you and other girls from your community face in accessing SRH services?
11. What do you think could be done differently in order to improve access to sexual and reproductive health services by girls in your area?

Adapted from: (IAWG, 2017)

APPENDIX IV: In-depth Interview Guide

Personal information

- Interview Code: _____
- 1. How old are you? _____
- 2. What is your Nationality? _____
- 3. What is your religion/denomination? _____
- 4. Do you go to school? YES____ NO____
- If yes, what level are you currently? _____
- If no, what is your highest level of education and do you engage in any income generating activity?

- 5. What is the occupation of your parent or guardian?

- 6. Do you have any children? YES____ NO____
- If yes, how many? _____

Reproductive health

7. Have you ever received information about any of the following? (Tick all that apply)
 - Body changes during adolescence
 - Menstrual period/ Menstrual hygiene
 - STIs/ STDs
 - Treatment of STIs
 - HIV/AIDs
 - Contraceptives
 - Pregnancy (how a person can get pregnant)
 - Child birth
 - Cervical screening
8. Where did you **first** receive the information from? Probe: parents/guardians, family member, friends, school, health facility, public health campaign

9. Where do you get the information (Q7) from? Probe on **major source** and **preferred source**_____

10. Is it very easy to get information about such things? (probe: are you able to ask your source of information questions or do they volunteer it?)

11. Have your parents, guardians or family members ever given you information on SRH issues? If yes, what information did they give you

12. If you answered yes to QS 11, were you the one who asked them about it or did they volunteer information?

13. Would you ask your parent, guardian or family members questions on SRH? Why or why not?

14. What is your most preferred source of information and why?

15. Does your culture encourage or discourage young people from getting such information?

16. Does your religion encourage or discourage young people from getting such information?

17. Do you and your friends talk about SRH issues? What do you talk about?

18. What SRH services are offered at health facilities in your community?

19. Have you ever gone to a health facility to get any SRH services or information? Probe: Menstruation/menstrual hygiene, STIs testing and treatment, HIV/ AIDs testing, pregnancy, child birth, ANC?

20. If yes, what was your experience? What was good about the service? What did you not like about the service? Would you go back to the health facility for a different or similar issue?

21. Is it important that adolescents access such (SRH) information and services? Why/why not?

22. What would make an adolescent not able to access such (SRH) services or information?

23. How would you like services to teenagers offered?

APPENDIX V: KII Guide

1. How would you rate female adolescent refugee access and utilisation of sexual and reproductive health services in Nairobi? (*Excellent, good, fair or poor. Please explain and give examples*)
2. Is access different for adolescent Kenyan girls as compared to refugee girls?
3. What are the social and economic factors that may influence female adolescent refugees access of SRH services?
4. Are there SRH services that are available, accessible and acceptable for adolescent refugees?
 - i. **Available:** Do the services exist? Do they have adequately skilled staff, medications and equipment? (*Please explain and give examples*)
 - ii. **Accessible:** Can adolescents reach the services, in terms of transportation and opening times? Can they afford them? (*Please explain and give examples*)
 - iii. **Acceptable:**
 - Please take into account confidentiality, stigma, discrimination and the characteristics of health care providers. (*Please explain and give examples*)
 - Are any services not acceptable to the adolescents’ “gatekeepers”, for example, parents or guardians who may determine whether an adolescent accesses a service? (*Please explain and give examples*)
 - iv. Are any of these factors different for younger adolescents (10-14) than for the older ones (15-19)?
5. Assuming services are available, accessible and acceptable to adolescents, are there any reasons why adolescents may still not use them when they need them? Do adolescents sometimes not realize they need health services? Or have incorrect beliefs about health services? Or prefer to use other services (such as traditional healers or private pharmacists)? Please explain and give examples.

Adapted from: WHO. (2019). *Handbook for conducting an adolescent health services barriers assessment (AHSBA) with a focus on disadvantaged adolescents*. Geneva: World Health Organisation.

APPENDIX VI: Research Budget

ITEMS	QUANTITY	UNIT PRICE	TOTAL COST
Project proposal and research project production			15,000
Study tools (guides, consent and assent forms)			500
Research project in DVD copy	1		300
Research Permit (NACOSTI and ERC)			4,000
Pilot Study			2,000
Note books			200
Field Assistant	1	8000	10,000
Transport			3,000
Field Guide/ Mobilizer Fee	1		4,000
Sub Total			38,000
Contingency			2000
Grand Total			42,000

APPENDIX VII: Work Plan

ACTIVITY	APRIL	MAY	JUNE	JULY	AUGUST	SEPT.
Proposal preparation and literature review						
Proposal Defense						
Data collection						
Data processing and analysis						
Draft research project presentation						
Research project correction and publication						