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SCALING DOWN UNMET FAMILY PLANNING NEEDS AMONG YOUTHS IN KAKAMEGA COUNTY

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ABSTRACT

Access to contraceptive services for the youth is still a challenge worldwide despite the fact that this commodity is vital to youth's well-being. Though Community Health volunteers (CHV) promote family planning in Kenya, the unmet need for contraceptives among youths remains high. Therefore, this study aims at scaling down unmet needs of family planning services among youths in Kakamega County. A qualitative study was conducted to explore the role of CHWs in increasing access and uptake of contraceptive services among youth aged 15-24 years in Kakamega County, Kenya. The study conducted 10 interviews and 5 focused group discussions involving CHVs, Youths, community members and leaders. Data was recorded, transcribed, translated, coded and thematically analyzed. The findings showed CHVs' roles regarding contraceptive services entailed creating awareness, counselling, distribution of male condoms and referral of the identified clients to the health facilities. Majority of the participants agreed that culture, religion and tradition often do not support the use of contraceptives. The CHVs acknowledged the need for training and regular updates. Some health care workers, were not confident in CHVs taking up new roles regarding contraceptive services even with training, for the fear that they would not be ready to deal with contraceptive side effects, among others. Though their services are still limited, CHVs have the potential to increase access to contraceptives for youths. It is also important for the Ministry of Health to enforce the 2017 task-shifting guidelines and CHVs to be empowered to address cultural and religious norms and create understanding and support for contraceptive services.

KEYWORDS: *Community health volunteers, Contraceptives, Youth, Family planning.*

INTRODUCTION

Contraceptive services to youths is still a challenge worldwide. Access to this commodity is vital to youth's well-being (Ormel *et al.*, 2021). Globally, community health volunteers (CHVs) are defined as health Volunteers 'carrying out functions related to health care delivery at household level. They are trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificate or degree in tertiary education [Lewin S et al,2010]. CHVs perform an integral component of the health workforce needed to achieve public health goals in low- and middle-income countries (LMICs) (Kok ,2015). Improving access to contraceptive methods is key to the well-being of youths and benefits to community health (UNFPA,2015). Yet there is a large unmet need for contraceptives in sub-Saharan Africa. Providing timely contraception information and services to youths at health facilities or in the communities can reduce unmet need (Peterson *et al*.,2013; WHO,2017).

Young people need special attention in terms of contraceptive services to promote sexual and reproductive health and avoid negative consequences of unprotected sex, such as unintended pregnancy, HIV and other sexually transmitted infections (STIs) (WHO,2017). In Kenya, 40% of married adolescent girls (15-19years) use contraception; for sexually active unmarried girls of the same age group this is 50%. Percentages are higher for the same groups aged 20-24 years (54 and 70%, respectively). Almost one in seven (14%) of girls aged 15-19 years begun childbearing and about half (47%) of these births are unintended. Unmet need stands at 23 and 19% for the 15-19 and 20-24 age groups, respectively, as compared to 18% for all currently married women age 15-49 (DHIS, 2014)

In Kenya, the Community Health Strategy (CHS) was launched in 2006 and later updated as the Strategy for Community Health 2014-2019 [MOH 2017]. Under the CHS, government employed facility-based community health extension workers (CHEWs) were to supervise a group of community health volunteers (CHVs) in every community health unit, each covering about 5000 people with an average of 1000 households. CHVs carry out promotive, preventive and some curative tasks in disease prevention and control, family health, hygiene and environmental sanitation (WHO 2017, MOH 2017). The 2012 WHO task-shifting guidelines in the field of maternal and newborn health suggest that certain interventions can be performed by CHVs, including contraceptive service delivery [WHO 2012].

Evidence shows that, globally, CHV programs can increase awareness and uptake of contraception, particularly where unmet need is high. Access is low and geographic or social barriers to the use of services exist. CHVs are particularly important to reduce inequities in access to services, by bringing information, services and supplies to women and men in the communities where they live and work (UNFPA,2015). In Kenya, CHV tasks include family planning and adolescent reproductive health [MOH,2006]. It includes promotion, discussion of all family planning methods and provision of basic counselling; addressing misinformation; and provision of selected contraceptive methods; mostly condoms at community level (MOH,2013).

More attention is needed for awareness of and counselling about contraceptives among young people in Kenya. It is valid to explore the potential role of CHVs in bringing about improvements in youth access to contraceptives. Only a few studies have been conducted on the latter, with little documentation of how CHVs engage with youth.

METHODOLOGY

We conducted a qualitative study exploring the role of CHVs in increasing access and uptake of contraceptive services among youth aged 15-24 years in Kakamega County, Kenya between March and April 2022. Ethical clearance to conduct the study was sought from Masinde Muliro Ethics and Review Committee. Participants signed an informed consent. Ten key informant interviews (KII) and five focus groups with CHVs, youth, community members, community leaders, and youth leaders were conducted. Data were recorded, transcribed, translated, coded and thematically analyzed, according to a framework that included community, CHW and health system-related factors.

RESULTS

CHV formal roles in providing contraceptive services

Our findings show that CHV's roles regarding contraceptive services entailed creating awareness, counselling, distribution of male condoms and referring the clients to health facilities for any other contraceptive method. CHVs, community members and key informants agreed that CHV contraceptive service provision skills and knowledge were quite limited as regards provision of actual methods. One manager said:

"*They are not well motivated. Not all are trained on family planning services. And then, they don't have enough commodities, so they are not well equipped.* [Female manager] this is not in line with the title of roles

Community norms and values

Most participants agreed that culture and tradition often do not support the use of contraceptives as illustrated by one youth:

I can say, the culture doesn't support family planning. Any young girl using family planning is believed to be a prostitute, which is against our culture. [Single youth, FGD]

The majority of participants agreed that (Christian and Muslim) generally opposes contraceptive use by single youth and even by those who are married. Some however perceived that the role of religion is being overstated and these days has less influence on decision-making on family planning.

The role of religion in my community, where I come from is diverse. They always advise people to use family planning, while certain religions, people are told not to dare use family planning. It's the leaders of the various denominations telling people what to do. [Married male youth].

Some CHVs acknowledged they did not offer contraceptive services to single youth because of their own religious (mostly Christian) values. A female County manager said that:

"*The cultural beliefs and values [CHVs] need to get from us. For example, as health care workers, we also have our values, but we need to tell them that you leave your values aside then you handle the client the way the client is* (Female manager).

There was consensus among the majority of the youth that culture and traditions dictate that contraceptives are only for those who are married and already have children. The use of contraceptives by married couples who do not have children was frowned upon.

"*There is no woman, who is newly married, [who] is allowed to use family planning. She has to have a child in that homestead first. That is the desire of in-laws. [l female CHV]*

Participants perceptions on CHVs as contraceptive providers for youth

In general, participants agreed that contraceptive services were equally offered to single youth as to the older,

mostly married population. There were some suggestions that CHVs play a major role in the youth uptake of contraceptives, which is especially important given the conservative family and cultural context. Some CHVs specifically expressed they were proud of their efforts to offer contraceptive services to youth.

"*The CHVs will really convince them. They know how to convince youths to go for it and they will go. Youths will go for family planning mostly because they [CHVs] have created the awareness ''*Married female youth leader"

At the same time, some youth reported not being aware of CHVs offering contraceptive services. This can be explained since some CHVs reportedly catered more for married clients as opposed to youths were single.

Many youthful participants maintained that CHVs were their contraceptive providers of choice. CHVs were perceived as more easily accessible, saving time and transport costs, and taking more time to interact with. This perspective was more pronounced among single youth yet also supported by several married youth.

CHVs knowledge and skills on contraceptive services

Preference for CHVs by youth often presupposed a perception of similar quality of services as compared to those provided by facility-based health workers. Some youth indeed perceived this or simply compared CHVs knowledge to their own lack of knowledge:

[CHVs] know more about family planning and we just know a little about it. So, they continue to open your mind on family planning with the information that they add on us, so my heart just loves them.[Married female youth].

Few youths as well as other participants perceived that facility services were of better quality, as they questioned the knowledge and skills of CHVs. As one single female youth leader put it, *CHVs dont give information that is sufficient or reliable.*

CHVs themselves, reported that their training was either an enabler or disabler in the provision of contraceptive services. Those who did not have adequate training expressed the need for refresher training:

Personally, I feel like I have not yet gotten proper training. And so, a young person may ask me a technical question and I fail to know what to answer to it. [female CHV]

Some health workers, were not in favor of CHVs taking up new roles regarding contraceptive services (task shifting). They felt that CHVs, even when trained, would not be ready to deal with contraceptive side effects, among others.

We found that confidentiality was very important, especially to single youth. Some youth found that CHVs could be trusted to keep confidentiality. Other youth doubted CHVs ability to maintain confidentiality and therefore were not confident to seek contraceptive services from CHVs.

Talking to a CHV I think sometimes that confidentiality may not be maintained. If I go for the contraceptive today and I go and share with a friend and the following day I go again, she might see me as someone who is highly promiscuous. So, I would rather go to the chemist.'' [Married male youth].

DISCUSSION

CHV formal roles in providing contraceptive services

Due to their knowledge limitations, participants felt that CHVs were limited in the their role as contraceptive providers. In a study that was done in Kenya by Ormel *et al.*, (2021), it was found out that, the CHVs role in providing family planning services in the community was mainly distribution of male condoms and referrals, which agrees with above results. In the systematic review of 56 studies on the effectiveness of CHWs roles as providers of contraceptive services in LMIC, Scott, (2015), concluded that CHWs were able to increase the uptake of modern contraceptives as well as improve levels of contraceptive-related knowledge and attitudes [Scott *et al*., 2015]; others reached a similar conclusion for Sub-Sahara Africa and beyond (WHO, 2012; Sedlander *et al.,* 2018*).*

Community norms and values

Most participants in the current study were of the opinion that culture ,religion and tradition greatly influence the use of contraceptives among both single and married youths. In conformity are findings of *a* study done in Homabay county, Kenya, Ormel *et al.*, (2021) in this study it was revealed that Luo culture opposes the use of contraceptives. However, in a similar study in Narok there was no opposition to the use of contraceptives by youths. Results also tally with studies done elsewhere. A study (Tavrow *et al*.,2012) done in Tanzania reported extensive contraceptive use by the youth. This could be as a result of CHVs belonging to and coming from the same communities that they serve, and as a result, having comparable cultural perspectives. As a result, this emphasizes the need for better instruction on how to distinguish between personal and professional values [GHWA, 2010]. Although there is a systematic focus on norms and values in CHV training programs around the world, this makes it difficult for CHW to deal with culturally sensitive situations (Kane *et al*., 2016).

Participants views on CHVs as contraceptive providers for youth

Many youth participants confirmed that CHVs were their contraceptive providers of choice. In general, participants agreed that contraceptive services were equally offered to single youth as to the older, mostly

married population. CHVs were perceived as more easily accessible, saving time and transport costs, and taking more time to interact with. This perspective was more pronounced among single youth yet also supported by several married youth. Comparable results were reported in a Malawian study, where an experimental study to assess the relationship between service features and 15-24-year-old youth contraceptive provider preferences was done. Findings show that CHVs were most preferred providers of contraceptives [Koki *et al.,2020*]. A similar preference was reported in a study done by Ormel *et al* (2021). The efforts for CHVs to better meet youth's unmet need for contraceptives was opposed in a study done Juma *et al*. Participants felt that CHVs lacked essential knowledge and skills on contraceptives (Juma *et al*.,2015).

CHV's knowledge and skills on contraceptive services

Few youths as well as other participants perceived that facility services were of better quality, as they questioned the knowledge and skills of CHVs. CHV's also reported that their training was either an enabler or disabler in the provision of contraceptive services. Those who did not have adequate training expressed the need for refresher training:

Some health workers, were not in favor of CHVs taking up new roles regarding contraceptive services (task shifting). They felt that CHVs, even when trained, would not be ready to deal with contraceptive side effects, among others.

Some interviewed CHVs confirmed the need for further training on contraceptive methods, side effects and counseling skills. A 2014 study in South Kivu province, DRC, on the interaction between CHWs and youth clients regarding sexual and reproductive health related services, showed that many CHWs reported low confidence in having sufficient knowledge to communicate with youth (Swiss *et al.,2014*). A Similar study done by Orme, *et al.,* (2021) also agrees with the results.

CONCLUSIONS

CHVs constitute a major potential to increase access to contraceptives for youth, reducing unmet need. It calls on the Ministry of Health to enforce the 2017 task-shifting guidelines. Many young people prefer CHVs as contraceptive service providers above facility-based health workers in the public or private sector. One precondition is that a trusting and confidential relationship is established between CHVs and their young clients. For this reason, and for building essential knowledge and skills to provide higher-quality contraceptive services in conservative social settings, the Ministry of Health and other stakeholders should provide CHVs with improved training It is also urgent that CHVs, often seen as important agents of change, get assistance from other stakeholders, such as religious leaders, to address prevailing cultural and religious norms and create more understanding and support for contraceptive services at community level, including for youth.

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