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ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND THE RETENTION OF ADOLESCENT GIRLS IN SECONDARY SCHOOLS IN NAROK, KENYA.

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ABSTRACT

Adolescent Sexual and Reproductive Health (ASRH) has acquired prominence and the services deemed as the effective strategy for reducing adolescent pregnancies, Sexually Transmitted Diseases (STDs) infections by various health stakeholders. Despite availability of the services, evidence presents escalation in percentage of early pregnancies and school dropouts among adolescent girls in Narok County. The study purposed to establish the prevalence of ASRH services and retention of adolescent girls' in secondary schools in Narok County. The total study population was 17813. The target population was secondary school girls aged 15 to 19 years, teachers, public health officers, Non-Governmental Organization officers working in ASRH program and administrators in Narok County. About 377 people were sampled, randomly and purposively. The cross-sectional descriptive design was used. Data was collected using questionnaires, key informant interviews and focus group discussions. Analysis was done using linear regression. Results of the study revealed that the higher the prevalence of SRH services, the higherthe retention of adolescent girls in secondary schools ($p = 0.001$). Awareness about ASRH services among adolescent girls reduced early pregnancy and also increased their retention in secondary schools ($R= 0.72$). Results indicated that the ASRH information, Voluntary counselling and HIV/AIDS testing, delivery services, screening for STDs, family planning services were significantly utilised (0.000). However, prenatal care was less significantly utilised by the adolescent girls (0.008). The study recommended reinforcement on provision of the ASRH servicesto the adolescent girls to further increase girls' retention in secondary schools.
Keywords: Adolescent girls, Sexual Reproductive Health, Retention in schools

INTRODUCTION

Reproductive health service is an important component of health whose impact is enhanced through informing, educating, and counseling, among other services (Pourkazemi *et al*., 2012). Young people under the age of 25 years who account for about 43% of the world's population experience high HIV infections, sexually transmitted infections (STIs), unplanned pregnancies, and maternal morbidity and mortality (WHO, 2012). While adolescents have the same reproductive needs as adults, they face more obstacles in trying to address the needs. Some of the obstacles include denial of access to reproductive health information and services, violence and exploitation and extreme hardship when faced with an unwanted pregnancy (Sedgh *et al*., 2016; UNFPA, 2013). Evidence is growingthat this neglect can seriously jeopardize the health and future well-being of young people (Sibeko, 2012). Adolescent Sexual and Reproductive Health (ASRH) services have emerged as an area of key concern in many partsof the world. Adolescent Sexual Reproductive Health services are a global initiative developed to enhance the sexualhealth status of adolescents

in the world as well as contribute towards the realization of their full potential innational development (WHO, 2010). Adolescent girls are more vulnerable to reproductive Health challenges, which lead to poverty and exclusion (UNFPA, 2013).

In sub-Saharan Africa, about 68% of adolescents have an unmet need for reproductive health services with 7.4 million adolescent girls experiencing unplanned pregnancies that negatively impact their general wellbeing (Mc Queston *et al.*, 2019; WHO, 2011). Various efforts have been made through summits to identify ways of accelerating universal access to SRH and rights. However, no sustainable strategies have been documented to date (WHO, 2013). Many discussions have taken place about high rates of pregnancy-related school dropouts, leading to the reported gender disparities in education, especially in the developing world (Guo & Cho, 2019). Teenage pregnancy results to situations such as dropping out of school, (Kanku & Mash, 2010). Adrian (2010) points out thatpregnancy in Africa has been increasingly mentioned as the reason for premature school dropout among adolescent girls, poverty, early marriage and contracting sexually transmitted diseases. However, less research work has been done to establish the role of ASRH services on school dropout and retention. In almost all developing countries, school dropout and retention rate has been a subject of interest to academics, researchers, and policymakers for a long time (Deogan *et al.*, 2019).

Since 2012, Narok County has been experiencing annual a decline in girls' enrolment in secondary schools (KICD, 2016). The drop in enrollment is largely associated with several reproductive health challenges in the county. The Government of Kenya developed a national Adolescent Reproductive Health and Development Policy in 2003 which aimed to address the various challenges facing adolescents in Kenya. Further, the Reproductive Health Policy of 2007 set to improve the reproductive health of adolescents and ensure adolescents and the youth has full access toSRH health information. It also sought to have youth friendly reproductive health services and to promote a multi- sectoral approach in addressing adolescents sexual and reproductive health needs (KNCHR, 2012). Therefore, this study seeks to find out why despite huge interventions by the government and other stakeholders on ASRH services many girls continue to drop out of school.

METHODOLOGY

The study was carried out in Narok North Sub County, which lies in the northern part in the Rift Valley. The Sub- County has a network of health facilities, including the sub-county hospital, health centers, and dispensaries as well as private healthcare facilities. The study used a cross-sectional descriptive design. It obtained an overall picture as itstands at the time of the survey. It employed both qualitative and quantitative approaches to data collection. The study aimed at finding out the influence of Sexual and Reproductive Health (SRH) services and retention of adolescent girls' in Secondary schools in Narok y, Kenya. The research design was fit for the study because it was a fact-finding study and it captured varied opinions at a given time.

A cross-sectional descriptive study design allows for the generalization of the study findings from a small sample to a wider representation of the population as opined by (Kothari, 2004). Descriptive survey allows a researcher to gather information, summarize, present and interpret for the purpose of clarification. Amin (2005) also noted that cross-sectional descriptive study design is best suited when gathering information, summarizing and interpreting for the purpose of classification. It will be easy to produce statistical information and more clearly. The design was usedto find out the influence of Sexual and Reproductive Health (SRH) services and retention of adolescent girls' in Secondary schools in Narok North, Kenya.

According to Amin (2005), population is defined as entire groups of individual, events or objects having a common observable characteristic. According to records from Narok North Sub County Director of Education, the Sub County had 19 mixed secondary schools and 7 girls secondary schools with 162 teachers and 17,813 adolescentgirls. The tabulation of the study population is shown in below.

Table 74: Study population

School category	Girls in girls only	Girls in mixed boarding	Girls in mixed day	Total population	Total schools	Total no of teachers
Public schools	8,282	4,334	4,675	17,552	54	135
Private schools		261		261	2	27
Total	8,282	4,595	4,675	17,813	56	162

Source: Narok North County Educational Office (2019)

The Narok North Sub County was purposively selected. Sampling procedure means selecting a given number of subjects from a defined population. Kothari (2003), states that, any statement made about the sample should also be true of the population and the larger the sample the smaller the sampling error. The study applied simple random sampling method to select 15 schools in their different categories; girls, mixed boarding, mixed day schools 5 ineach category. Simple random sampling was used to select the students, 26 in each school adding up to 390 students.Purposive sampling technique was employed to select key informants. 30 guidance and counselling teachers; 2 per selected school,2 public health officers, 3 chiefs, 2 program officers in NGOs dealing with Reproductive Health making a total of 429 respondents. The researcher prepared one consent letter for the girls which was signed by the school principal on behalf of the girls before administering the data tools. Sampling refers to the process of selecting a number of individuals or objects from a population such that the selected group contains element representatives ofcharacteristics found in the entire group (Orodho, 2009). According to Krejcie and Morgan (1970) the sample size for 17,975 is 377.

Data Analysis

Data analysis involves categorization, ordering, manipulating and summarizing of data collected with an aim of getting answers to research question. Quantitative data was analyzed using descriptive statistics and this was done with the help of Statistical Package for Social Science (SPSS) version 22. Data was presented in the form of frequency distribution and tables which facilitated in the description and explanation of the findings. *Linear regression was used to explain the relationship between dependent variable and independent variables.* Finally, Qualitative data which was generated from key informant and Focus Group Discussions was analyzed using themes reflecting the research questions. The sample size was 377 and 356 respondents returned the questionnaires. The response rate was 94.43% and a non-response rate was 5.57% and thus the response rate was valid to generalize the data presented. High response rate was achieved since it was above 50% thus making it valid (Mugenda, 1999).

Table 2: Explains the response rate of the respondents

Response Rate	Frequency	Percentage (%)
Response	356	94.43
Non-response	21	5.57
Total	377	100

Inferential Analysis

The study sought to explore the impacts of ASRH services available for the adolescent girls on the retention of adolescent girls in school. The types of ASRH services investigated were: ASRH information, Voluntary counselling and HIV/AIDS testing, delivery services, prenatal care, screening for STDs, family planning services.

Table 3: Model summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.849[a]	.720	.715	.255

The ANOVA statistics presented in Table above illustrates that the dependent variable (Adolescent girls' retentionin school) is explained by 72% of the independent variables (Delivery services, ASRH Information, Prenatal care, Family planning services, screening for STDs, Voluntary counselling and HIV testing) as indicated in the R square value. 28% represents other extraneous factors. P-value of the F Statistic is less than 0.001 which means that there isa strong evidence against the null hypothesis which states that there is no statistical significance between the variables. The squared multiple correlation R squared = Sum of squares for regression / sum of squares for totals i.e 58.632/81.404=0.7202, indicating that 72% of the variability in the dependent variable (Adolescent girls' retention in school) is explained by the independent variables (Delivery services, ASRH Information, Prenatal care, Family planning services, Screening for STDs, Voluntary counselling and HIV testing)

Table 3: Analysis of variance

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	58.632	6	9.772	149.762	.000[b]
	Residual	22.772	349	.065		
	Total	81.404	355			

a. Dependent Variable: Pregnant girls retention in school

b. Predictors: (Constant), Delivery services , ASRH Information, Prenatal care , Family planning services, Screening for STDs , Voluntary counselling and HIV testing

Table 4: Regression coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.191	.050		44.161	.000
	Voluntary HIV counselling and testing	.415	.116	.408	3.564	.000
	Screening for STDs	.296	.055	.584	5.399	.000
	Family planning services	.159	.012	.467	13.459	.000
	ASRH Information	.164	.010	.591	16.627	.000
	Prenatal care	.030	.011	.101	2.654	.008
	Delivery services	.041	.008	.235	5.331	.000

a. Dependent Variable: Adolescent girls' retention in school

The results above show a regression model

$$Y = 2{,}191 + 0.415\, X_1 + 0.296\, X_2 + 0.159\, X_3 + 0.164\, X_4 + 0.030\, X_5 + 0.041\, X_6 + e$$

Y= dependent variable
(Adolescent girls' retention in school)Independent variables
X_1 = Voluntary counselling and HIV testing X_2 = Screening for STDs
X_3 = Family planning ser

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X_6 =
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X_7 = Prenatal care
X_8 = Delivery services
e = error term

From the model above, the higher the independent variables the higher the retention of pregnant girls in school. The more the adolescent age girls are aware of the voluntary counselling and HIV testing, screening of STDs, Family Planning Services, ASRH information, Prenatal care, Delivery services, the more the retention of pregnant girls in school. The independent variables are directly proportional to the dependent variable.

DISCUSSION
Access to services and accurate information about prevention against HIV and AIDS and reproductive health for young people is problematic. This poor quality of care for young people encompasses limited access to services,poor reception and treatment from service providers and non-availability of preventive methods that young people need. Furthermore, the provision of accurate and specific information is an important primary goal for intervention programs (Karim & Karim 2010). Providing young people with SRH information and services through the existing healthcare system presents an opportunity that should be further optimized (Godia *et al.*, 2014).

CONCLUSION
From the findings, the study concluded that the types of SRH services available to adolescent girls were supply condoms, VCT, and information on SRH services, delivery and prenatal care. Also, access to SRH services by the adolescent girls can be improved through community awareness, providing sexual and reproductive health educationfor the girls, building facilities for the youth, and broadcasting in the media and improvement in transport infrastructure.

RECOMMENDATIONS
Providing young people with SRH information and services through the existing healthcare system, presents an opportunity that should be further optimized. Providing recreational activities via youth centres is reported by youngpeople themselves to not lead to increased uptake of SRH healthcare services. There is need for more research to evaluate how perceived non-health benefits young people do gain from youth centres could lead to improved SRHof young people Since delivery services and prenatal care services were the least cited as available by the adolescents, the government should place adolescent-friendly centers or clinics that will bring these SRH services close to adolescents.

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