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Sexual Reproductive Health Services and Rights (SRHR) from the Perspective of Youth Growing Up in Kibera, Nairobi

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YES07: Master Thesis

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Word count: 7996

June 23, 2023

Abstract English

This study explores the perceptions and experiences of sexual and reproductive health services and rights (SRHR) among youth in Kibera, an urban slum in Nairobi. The study aims to identify knowledge and access gaps and highlight challenges faced by young individuals in this community. Guided by the Pan American Health Organization's (PAHO) conceptual framework, qualitative methods including semi-structured interviews and open-ended questionnaires are employed. The findings uncover the complex interplay of individual, sociocultural, and environmental factors in shaping SRHR outcomes. Negative attitudes towards SRHR services are influenced by societal stigma, misinformation, and cultural and religious norms, promoting an abstinence-focused approach to sex education. Limited access to health services, economic barriers, and political challenges further hinder informed decision-making and access to SRHR services and information. The study highlights the importance of comprehensive sexuality education (CSE) to challenge misconceptions, dismantle myths, and promote evidence-based information. It emphasizes the need to engage various sectors, involve men in SRHR programs, and foster a culture of open dialogue, while addressing social issues such as gender-based violence (GBV). This qualitative study in Kibera fills a research gap by providing valuable insights into youth perceptions of SRHR in slum communities, contrasting with predominantly existing quantitative studies. The limitations, such as sample size and context-specific findings, are acknowledged, and further research is recommended to better understand the challenges faced by youth in Kibera and develop evidence-based programs to meet their SRHR needs.

Keywords: sexual and reproductive health services and rights (SRHR), youth, Kibera, stigma

Abstract Dutch

Deze studie onderzoekt de percepties en ervaringen van seksuele en reproductieve gezondheid en rechten (SRGR) onder jongeren in Kibera, een stedelijke sloppenwijk in Nairobi. Het identificeert kennis- en toegangstekorten en belicht uitdagingen waarmee jongeren in deze gemeenschap worden geconfronteerd. Geleid door het conceptuele kader van de Pan American Health Organization (PAHO), worden kwalitatieve methoden zoals semigestructureerde interviews en open vragenlijsten toegepast. De bevindingen onthullen complexe wisselwerking van individuele, sociaal-culturele en omgevingsfactoren bij het vormgeven van SRGR-uitkomsten. Negatieve attitudes ten opzichte van SRGR-diensten

worden beïnvloed door maatschappelijk stigma, misinformatie en culturele en religieuze normen die een op-onthoudingsgerichte benadering van seksuele educatie bevorderen. Beperkte toegang tot gezondheidsdiensten, economische barrières en politieke uitdagingen bemoeilijkten goedgeïnformeerde besluitvorming en toegang tot SRGR-diensten en informatie. De studie benadrukt het belang van alomvattende seksuele voorlichting om misvattingen uit te dagen, mythen te ontkrachten en op-bewijs-gebaseerde informatie te bevorderen. Het benadrukt de noodzaak om verschillende sectoren te betrekken, mannen te engageren bij SRGR-programma's en een cultuur van open dialoog te bevorderen, terwijl sociale issues zoals *gender-based violence* (GBV) worden aangepakt. Deze kwalitatieve studie vult een onderzoekslacune door waardevolle inzichten te bieden in de percepties van jongeren over SRGR in sloppenwijken, in tegenstelling tot overwegend bestaande kwantitatieve studies. De beperkingen, zoals de steekproefomvang en context specifieke bevindingen, worden erkend, en verder onderzoek wordt aanbevolen om de uitdagingen voor jongeren in Kibera beter te begrijpen en *evidence-based* programma's te ontwikkelen die aan hun SRGR-behoeften voldoen.

Trefwoorden: seksuele en reproductieve gezondheid en rechten (SRGR), jongeren, Kibera, stigma

Sexual Reproductive Health Services and Rights (SRHR) from the Perspective of Youth Growing Up in Kibera, Nairobi

Over the next forty years, urban areas are predicted to experience the vast majority of population growth in the world's economically least developed nations (Mberu et al., 2014). This growth is driven by both natural population increase and migration from rural to urban areas. Despite being the world's least urbanized region, sub-Saharan Africa is expected to witness a significant rise in its urban population (from less than 40% presently to over 60% by 2050). The region currently has about 70% of its urban population residing in slums or slum-like settings (ibid.).

One of these slum areas is Kibera, the largest slum in Nairobi and the second-largest urban slum in Africa (Wairiuko et al., 2017). Despite being home to over 200,000 people, Kibera is not officially recognized by the Kenyan government, resulting in a lack of essential basic services such as water supply, sanitation, electricity, education, health services, and waste management (Majale, 2008; Mutisya & Yarine, 2011). Furthermore, the urban poor are exposed to severe risks regarding their sexual and reproductive health and rights (SRHR) (Mberu et al., 2014; APHRC, 2014).

Boldosser-Boesch et al. (2014) define SRHR as the entitlement of every person to make choices about their reproductive and sexual activities without facing any kind of discrimination, pressure, or violence. SRHR guarantees individuals freedom to choose their sexual partners, decide the timing and frequency of their sexual encounters, make decisions regarding pregnancy and childbirth, and obtain necessary resources and knowledge to do so. The SRHR risks to which the urban poor is exposed include high rates of undesired pregnancies, sexually transmitted infections (STIs), and unfavorable health outcomes for both mothers and children (Mberu et al., 2014; APHRC, 2014). This vulnerability to SRHR-related risks is particularly acute for adolescents, who remain disproportionately affected by these challenges (Engel et al., 2019; Mberu et al., 2014; APHRC, 2014). The physical, mental, and social changes that occur in the lives of young people are associated with making them more vulnerable to poor outcomes in terms of SRHR (Bearinger et al., 2007).

In Kenya, over 20% of the population is youth, a number which is only going to increase quickly in the foreseeable future (AFIDEP et al., 2021). Given the youthfulness of the Kenyan population, and the unique challenges and risks they face in obtaining SRHR services, it is important to address the unique challenges and needs this group faces.

The realization that all individuals, especially adolescents and young people, need access to SRHR services was a breakthrough at the 1994 International Conference of Population and Development (ICPD). Since the 1994 ICPD, numerous national, international, and regional bodies have established mechanisms for monitoring ant implementing the SRHR goals outlined in the conference (Mberu et al., 2014). As a result, many countries in SSA have created reproductive health policies and established frameworks for SRHR program implementation. However, the belief that SRHR (or rather: SRH) is solely a matter for the health sector has led many SSA countries and their leaders to inadequately allocate resources to fund SRH programs. While progress has been made in the policy space surrounding SRH in SSA countries, challenges remain in implementing effective SRHR programs, particularly for the most vulnerable groups, such as youth (Mberu et al., 2014). Consequently, young people are at risk of becoming caught in a policy and service gap, in which their unique health requirements and accessibility are disregarded (Engel et al., 2019).

Despite increased global attention to youth SRHR, a significant portion of these efforts fails to address the needs of youth residing in rapidly expanding urban slums in low- and middle-income countries (LMICs) (Wado et al., 2020). While all young people require SRHR services and rights, those living in slums face greater risks of poor SRHR outcomes than their peers living in other areas, as evidenced in studies conducted in Kenya and elsewhere (Mberu et al., 2014; APHRC, 2014; Ngom, 2003; Wado et al., 2020). Unfortunately, the academic and programmatic discourse around youth SRHR largely ignores those living in urban slums in LMICs, leading to serious obstacles to their SRHR access and needs (Engel et al., 2019; Wado et al., 2020). As a result, they may experience negative consequences, including early pregnancy, STIs, and sexual assault (Wado et al., 2020).

To address this academic gap and contribute to the development of effective intervention programs that better serve the special needs of young people, this study aims to explore the perceptions and experiences of youth regarding SRHR in Kibera. The research question is: *''How are sexual and reproductive health services and rights (SRHR) perceived by youth growing up in Kibera, and where are any knowledge and access gaps?''* By prioritizing the voices and experiences of these underrepresented youth, this study attempts to shed light on realities lived by youth in Kibera. Moreover, this study seeks to highlight knowledge and access gaps, and suggest ways to improve service provision and empower youth by actively engaging them.

For this research, the conceptual framework for adolescents sexual and reproductive health promotion (Figure 1), developed by the Pan American Health Organization (PAHO, 1998, as cited in Meherali et al., 2021), is used as a guideline. This framework includes several key components affecting adolescents SRHR experiences, including:

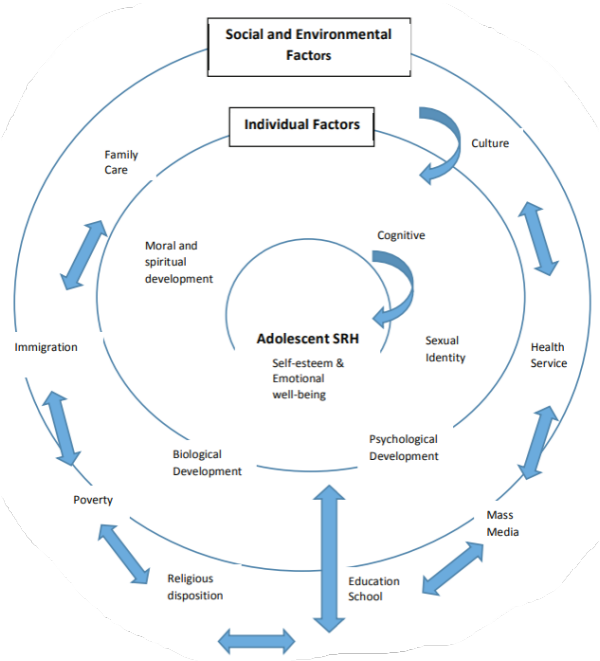
1. **Individual factors**: These consists of personal characteristics and behaviors that can affect sexual and reproductive health. These include knowledge, attitudes, and beliefs.

2. **Sociocultural factors**: These are cultural norms, values, and beliefs that can influence sexual and reproductive health, as well as social support systems and access to resources.

3. **Environmental factors**: These include physical, economic, and political environments that can influence sexual and reproductive health, for example access to healthcare services and education.

Figure 1

Conceptual framework for adolescents sexual and reproductive health promotion/development



The PAHO conceptual framework has been used as a guide throughout this study to explore through different qualitative methods how these three factors may be influencing the perceptions and experiences of SRHR among youth growing up in Kibera, as well as identifying any existing gaps in knowledge and access.

Methods

This is a qualitative study exploring the experiences and perceptions of SRHR among youth growing up in Kibera. The findings can be used to set up programs or interventions that serve the SRHR needs of these young individuals by investigating existing knowledge and access gaps related to this theme. This section provides a description of the methods used to investigate the research question.

Population

The target population for this study is youth growing up in Kibera, Nairobi. For the purpose of this study, the United Nation's definition of youth, which includes individuals between the ages of 15 and 24, is applied (United Nations, n.d.-b). It is important to note that in accordance with the Guidelines for Conducting Adolescents HIV Sexual and Reproductive Health research in Kenya (NASCOP & KEMRI, 2015), individuals under the age of 18 are not legally able to give consent themselves. Therefore, both voluntary consent from the research participant and consent from their parent or legal guardian were actively sought for all participants under the age of 18 in this study.

Sampling and procedure

The research participants for this study were selected from youth (both girls/women and boys/men) who participated in programs offered by Uweza. Trust and rapport with the participants were established by being present at Uweza programs attended by potential participants. Simple random sampling was used to select 21 informants for the questionnaires. With the assistance of key Uweza employees, participants were selected randomly from different programs to create a diverse group of study. For the interviews, a voluntary response sampling method was utilized, where those who completed the questionnaire had the option to voluntarily choose to participate in an interview. Ten participants were recruited in this manner.

Type of research and data collection methods

The data collection for this research was qualitative in its nature, as the aim was to understand experiences and perceptions of youth. It consisted of qualitative questionnaires and semi-structured interviews. Due to the combination of these different data collection methods, data triangulation is applied, which is considered a strategy to establish and check validity of the findings by approaching the research question from multiple perspectives, enhancing credibility, and strengthening the study's conclusions (Guion et al., 1969).

Questionnaires

Questionnaires were conducted, consisting of (mainly) open-ended questions about participants' SRHR perceptions. These open-ended questionnaires did not provide the participants with a prepared list of response options, but rather enabled them to respond in their own words, which enabled the researcher to take a holistic and comprehensive look at

the issue being studied (Allen, 2017). For example, respondents were asked what role their parents/guardians and friends play in their SRHR perceptions, whether they perceive SRHR information- and service provision in Kibera accessible or not, and if there are any specific SRHR themes they want to learn more about.

Because the participants could anonymously answer the questions, I expected them to be open and answer honestly. Compared to non-anonymous techniques, anonymous methods tend to encourage more revelation of sensitive or stigmatizing information (Murdoch et al., 2014). After a pilot of the questionnaire, the questions were simplified and extra information or examples were added. It turned out that an English version was sufficient, and a translation in Kiswahili would not be necessary neither helpful according to the pilot participants.

Semi-structured interviews (SSIs)

SSIs were conducted with questionnaire respondents who were open to talking more in depth about their SRHR perceptions. The flexibility of SSI as an interview method allowed the researcher to investigate more in depth on personal details (Adams, 2015). Beforehand, an interview guide was created and discussed with someone from Uweza to ensure it was sensitive to the context of the participant. Since the research topic might be considered as sensitive, the SSIs were on a voluntary basis only. In order to earn trust from my respondents, the aim of the research was clearly stated, complete anonymity was ensured, and it was stressed that participants were free to stop participating at any moment. Furthermore, the SSIs were conducted in private, with only one respondent at a time.

Data analyzing method

The data analyzing method for this research involved the application of the qualitative method ‘thematic analysis’ (TA), using the data analysis software ATLAS.ti. According to Braun and Clarke (2012), TA is useful when attempting to comprehend a set of collective or shared experiences, thoughts, meanings, or behaviors across a data set. TA allowed the researcher to identify themes regardless of the number of times a particular idea or item related to that theme is contained in the data set (Kiger and Varpio, 2020). These themes could be generated either inductively or deductively (Braun and Clarke, 2012). The approach to coding was inductive, since this usually offers a more thorough study of the complete body of data (Kiger and Varpio, 2020).

Some examples of the inductive codes applied to the data were: 'Lack of sex education', 'Negative attitudes towards abortion', and 'HIV stigma'. TA provided a valuable insight to the complexity of respondents' experiences, and was therefore an appropriate method for studying the research question.

My positionality as a researcher

To enhance transparency and reflexivity, I acknowledge my positionality as a researcher. As a 'foreign' researcher with distinct cultural, social, and educational experiences, my role may have influenced the research process. My identity and background cannot be perceived as neutral factors. Despite my familiarity with most participants through participating in Uweza programs, I may still have been perceived as an 'outsider' in the Kibera community, which could have impacted participants' responses during interviews and questionnaires. The inherent researcher-participant power dynamics, particularly considering difference in nationality, cultural background, and socio-economic status, may have influenced the participants' willingness to openly share their SRHR perceptions with me. Concerns about how their responses would be perceived by an outsider might have made them hesitant or cautious. However, based on my interpretation, participants were generally open and willing to share their stories with me. Being an 'outsider' may also have had positive effects, as people may have felt more comfortable opening up to someone who would soon leave the community.

Moreover, my personal background and cultural upbringing may have influenced my analysis and interpretation of the collected data. It is possible that my own beliefs and values influenced the identification of codes and themes during the TA process. However, I have actively worked to minimize the impact of these biases by engaging in reflective and critical analysis. Despite these potential influences, I have consistently maintained an open and respectful attitude throughout the entire research process.

Results

This section presents the findings of the qualitative study exploring the experiences and perceptions of SRHR among youth in Kibera. It is important to note that all the quotes included in this section, without reference, are directly from the research participants, encompassing a diverse group of youth between the ages of 15 and 24. Due to the need to ensure their anonymity and confidentiality, specific references to individual participants are not provided. The study reveals the prevalence of social issues, particularly gender-based

violence (GBV), in the Kibera community. These social issues were found to significantly influence attitudes towards sex, leading to the promotion of an abstinence-focused approach to sex education, which can be viewed as a response to trauma and a means of self-protection. Because of abstinence is the main lesson in sex education, a stigma around SRHR has emerged, resulting in various problems such as discomfort experienced when discussing SRHR topics, fear of utilizing SRHR-related services, and discrimination towards people who suffer from HIV. Despite these challenges, the research participants demonstrated a great willingness to break the stigma and emphasized the importance of prioritizing SRHR.

Gender based violence (GBV)

The Kibera community faces numerous social issues, including gender-based violence (GBV), sexual abuse, gender inequality, and substance abuse. Among these challenges, GBV emerged as a particularly prevalent and interconnected issue when exploring SRHR. The data strongly indicates a connection between GBV and the other social issues, emphasizing the complex nature of the challenges faced by the community. Using the *Ecological Model of GBV against Women and Girls* (Stark et al., 2021) and quotes from my data collection, this interconnectedness it demonstrated. The model (*figure 2*) depicts factors contributing to GBV across four distinct levels: the individual-, relation-, community-, and societal level. Through the data collection process, numerous of these risk factors on each level have been identified, which will be briefly discussed.

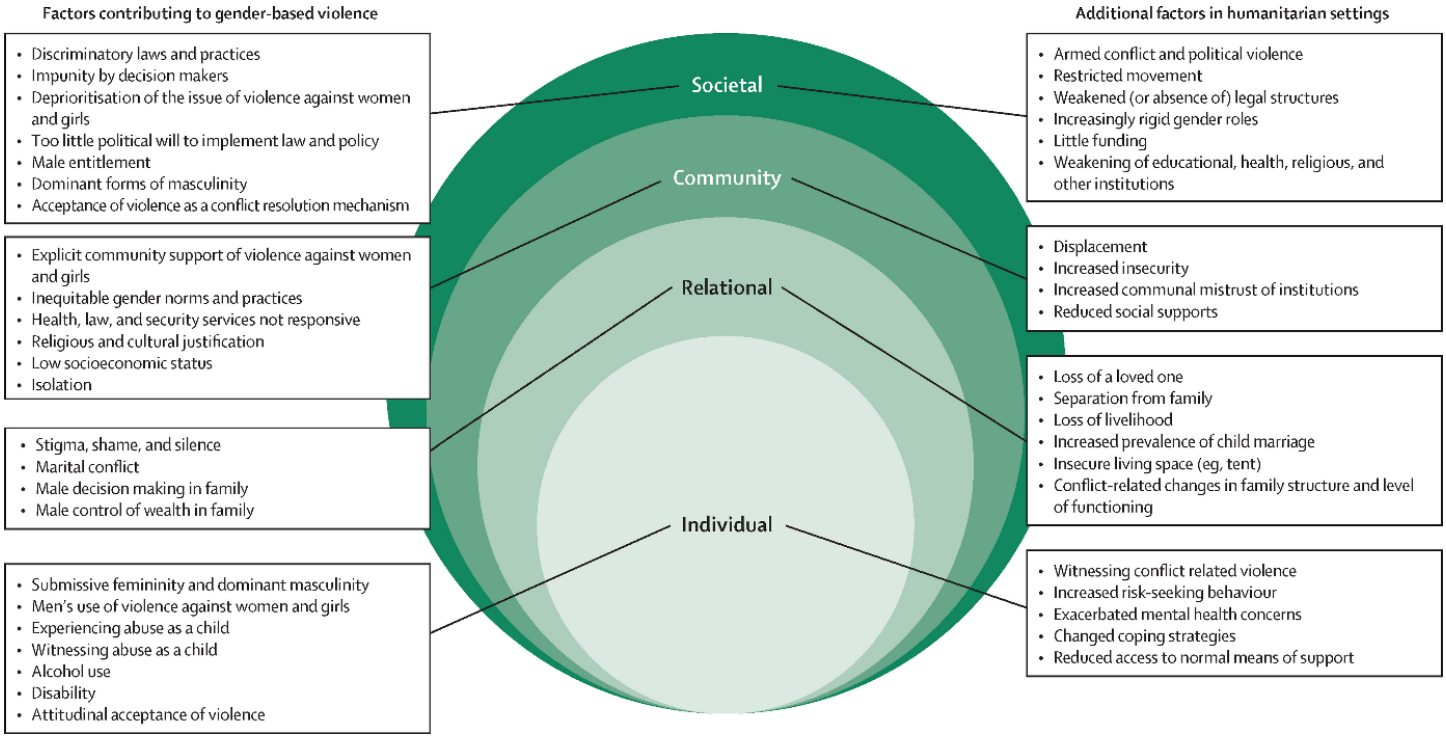
At the individual level, participants revealed challenges related to their mental health, particularly trauma experiences. Many shared experiences of childhood domestic abuse, exposure to substance abuse, or witnessed violence, all of which have left them with lasting trauma. The following quote illustrates an example of a participants' encounter with domestic violence and substance abuse:

> I think most of the GBV causes are connected to drug abuse… and, how you are raised. Let's say I was raised in an abusive family where I saw my mother is getting beaten every day… I see my uncle fighting with my aunt. I wake up… You see, where I lived, I used to live with my mom and my dad and mostly they fought. My dad used drugs… those legal weeds are cheap and you get it right at the corner. So, I lived in an abusive environment where I saw my mom getting beaten. There was nothing I could

do. There are memories you can't erase, no matter how hard you try. I think the community you are raised in is mostly the one that influences you.

Figure 2

Ecological model of GBV against women and girls



Additionally, various relational factors outlined in the framework (*Figure 2*) are evident within the context of Kibera. Many research participants have experienced the loss loved ones and are separated from families, being raised by guardians. Child marriage is also reported as a prevalent issue. At the community level, it is observed that abuse is quite normalized in Kibera, serving as a social norm:

People find it a normality. You find for example a couple that stays together. Maybe one violated the other, maybe one beats the other, but they believe it's normal. This started from long ago, it is what used to happen with our grandparents. You find a man beating his wife, but the wife says it's normal, because every marriage has altercations, so this is just part of the altercation.

Furthermore, Kibera exhibits other community factors like limited social support systems and low social economic status. The lack of official recognition of Kibera by the Kenyan government, coupled with the absence of political will to implement laws and policies, and insufficient funding, profoundly shapes societal dynamics (Majale, 2008; Mutisya & Yarine, 2011).

The findings highlight the complex nature of GBV in Kibera, influenced by interrelated social issues spanning from individual to societal levels. In the next paragraph, I will delve further into how these interconnected challenges have contributed to negative attitudes towards SRHR and the promotion of an abstinence-focused approach to sex education.

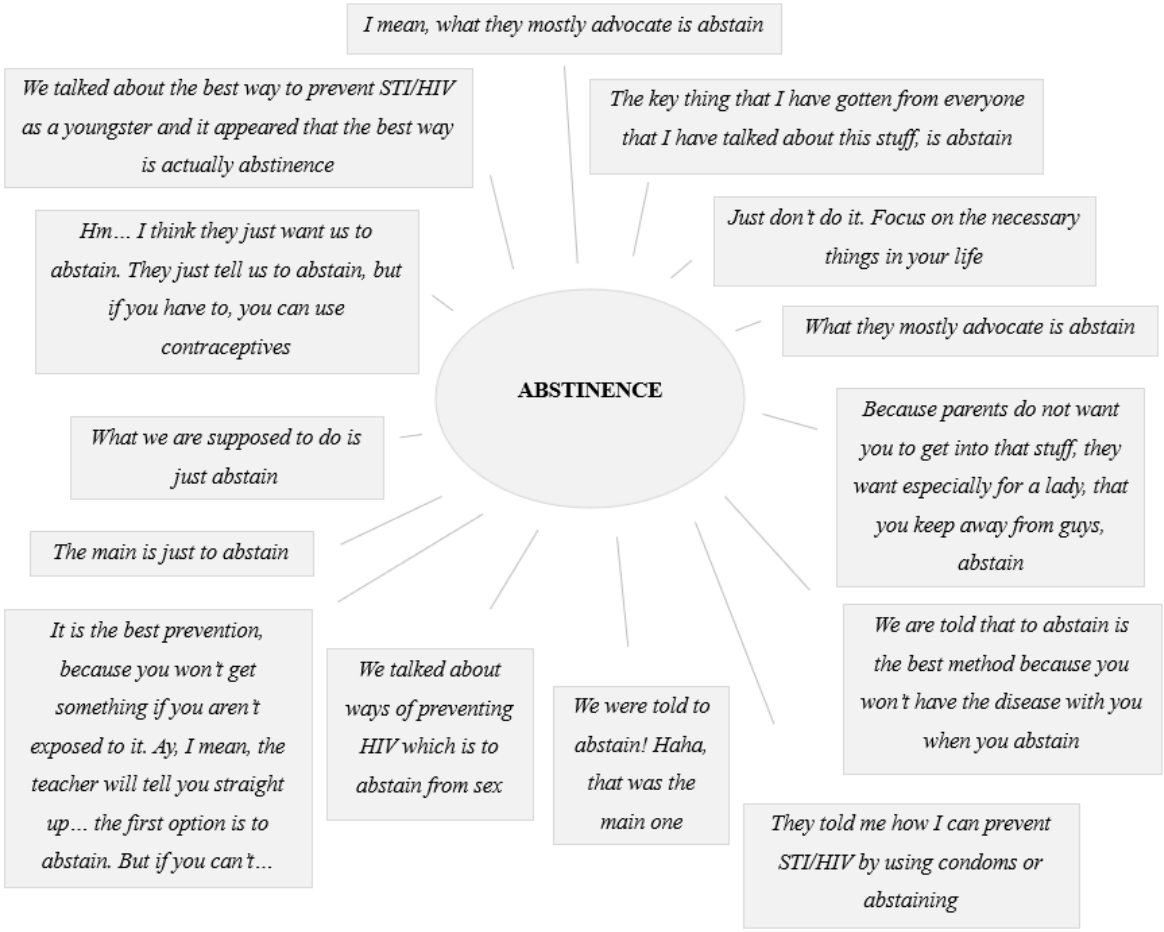
Abstinence-focused approach

Extensive research supports the effectiveness of comprehensive sexuality education (CSE) in promoting safer sexual behaviors among young people (Clark & Stitzlein, 2018; Stranger-Hall & Hall, 2011). Studies including those by Kohler, Manhart & Lafferty (2008) and Stranger-Hall & Hall (2011) have demonstrated that providing CSE can contribute to lower levels of teenage pregnancy compared to abstinence-only or no sexual education. Their findings also indicated that abstinence-only education (AOE), referring to programs that exclusively advocate for abstaining from premarital sexual activities as the only morally acceptable behavior (Alford, 2001), increase the likelihood of students engaging in unprotected sex when they become sexually active. Additionally, a comparative study conducted by DiCenso et al. (2002) found that AOE programs did not effectively reduce the likelihood of pregnancy. In fact, the study suggested that AOE programs may have increased the risk of pregnancy among young individuals, when compared to CSE programs.

Despite its proven inefficacy and risk to result in high-risk sexual behaviors, data collected in this study strongly indicates that abstinence-focused approaches to sex education prevail in Kibera, with educational institutions and parents often promoting abstinence as the safest choice. This prevailing attitude can be linked to social issues, including GBV, that foster negative attitudes towards sex. Experiences of GBV can lead to trauma, fear, and negative perceptions of sexual relationships. Therefore, these negative attitudes can contribute to a preference for abstinence-focused approaches to sex education. The collection of quotes in *Figure 3* from various participants in this study illustrate the prevalent abstinence-focused approach to sex education in Kibera.

Figure 3

Quotes abstinence-focused sex education



These quotes explicitly promote abstinence. However, abstinence promotion is also indirectly facilitated through the spread of fear, myths, misconceptions, and misinformation. Fear and risk perception are widely spread regarding SRHR services, such as family planning, abortion, and condom use, creating a negative attitude towards them. For instance, one participant was informed using family planning methods would prevent them from giving birth to a healthy child: ‘‘I did not take family planning. If you don’t have a kid, it’s bad! Some people say, if you take family planning, the next time you give birth, your baby will not be normal, but abnormal.’’ Infertility is also considered a potential risk associated with family planning and abortion. Research participants generally expressed a negative attitude towards abortion, citing risks such as bodily harm and even death. Similarly, the use of condoms was viewed as risky. This fear-based perception surrounding SRHR services fosters a pervasive negative attitude, leading peers to discourage each other from seeking them. One participant explained:

‘‘My colleague wanted to be involved in family planning methods at a young age, and we discouraged her.’’

Abstinence promotion coincides with the spread of misinformation, as revealed in this research. SRHR-related topics are surrounded by numerous myths and misconceptions, often rooted in cultural beliefs. *Figure 4* presents an overview of prevailing myths and misconceptions mentioned by research participants.

Figure 4

Quotes myths & misconceptions

Figure 3: Quotes Myths and Misconceptions

The spread of misinformation, myths, and misconceptions reinforces the promotion of abstinence and perpetuates fear. Some participants believe that parents intentionally disseminate false information to discourage young individuals from engaging in sexual activity and seeking SRHR services. One participant expressed this perspective: ‘‘Let’s say, I am a parent and I would not want at all my child to get into sexual activity, so, I will tell you something that is not real.’’

Educational institutions also contribute to discouraging sexual activity by implementing measures to prevent student pregnancies. Teachers were mentioned as perpetuating stigma against (unmarried) young mothers, treating them as societal outcasts. Random pregnancy tests were conducted in high schools, and girls who tested positive were sent home, sending a message of abstinence to other students. As one participant mentioned, pregnancy is hereby approached as some kind of disease that should be prevented:

> When you are pregnant, they assume that you affect others. They saw pregnancy as a disease. Let’s say, we are girls and get pregnant, then we are in school just being normal, like, I can come to school being pregnant… Other girls might then do the same. So, if you are pregnant, you are sent home. Maybe when the pregnant is not visible, they allow you, but once you start seeing it, you need to go home.

Abstinence-only sex education has failed to provide comprehensive information on a wide range of SRHR topics, resulting in a lack of awareness and knowledge. This leads to stigmatization and the perpetuation of harmful misconceptions, as further discussed in the next paragraph.

SRHR stigma

‘‘SRHR stigma is still a major challenge in Kibera, it is backed up by misinformation or cause of the lack of information of awareness.’’ This issue, highlighted by numerous research participants, underscores the urgent need to address the existing stigma in comprehensive SRHR approaches. Link & Phelan (2001) characterize stigma as the simultaneous presence of labeling, stereotyping, separation, status loss, and discrimination, within contexts where power dynamics are at play. Discrimination, on the other hand, is characterized by unjust and unfair actions directed at individuals or groups based on their real or perceived attributes, such as medical conditions, gender, or sexual identity (ibid.). It serves

as a fundamental aspect and manifestation of stigma. Link and Phelan (2001) consider discrimination as the end consequence of the stigmatization process, while others (Nayar et al., 2014) perceive it as a reflection of the stigmatization process. However, both viewpoints consider stigma and discrimination to be fundamental causes of health inequities (Bohren et al., 2022).

In their study, Starrs et al. (2018) shed light on stigma surrounding SRHR, emphasizing its negative consequences. Notably, unmarried women face stigmatization when seeking contraception and abortion, with the latter carrying additional burdens of stigma that negatively affect women's wellbeing and restrict their access to safe services (ibid.). This reality is also evident in Kibera, as highlighted by the following quote from a girl who got pregnant at the age of 20 and experienced stigmatization, leading to fear and isolation:

> I was afraid because some people are talking bad about you! You are small, you are not staying with your parents' house and you get pregnant… You are ashamed! Tsja… I was afraid. I was just staying inside the house…

This quote vividly illustrated the profound impact of stigma on individuals, in this case on young women who bear the weight of judgement and isolation due to societal attitudes surround SRHR matters. Furthermore, Starrs et al. (2018) shed light on the issue of HIV stigma, which hampers efforts to address structural factors like gender inequality. Their study reveals that HIV-related stigma and limited knowledge hinder individuals from accessing crucial testing and treatment services. This particular stigma was also prevalent among the research participants in Kibera, as evident from the following quotes: ‘‘People with HIV aren't able to get out of their house because some people could just laugh at them, their habit could have changed.'' Another participant expressed, ‘‘People do not like to be associated with those people.'' Additionally, one participant shared, ‘‘If you have HIV, some they don't want to talk to you anymore because they think they can get infected.''

Stigma carries significant implications, including the fear of discussing SRHR-related topics, as it generates feelings of shame, guilt, and social isolation (Courtwright, 2013). This was evident among youth in Kibera, with most participants expressing discomfort when discussing SRHR matters with their parents or guardians. A culture of silence prevails, leading young individuals to keep questions about sex to themselves, resulting in uninformed SRHR decisions. The majority of participants in this study fear judgement, gossip, and

rejection from their peers, teachers, and parents if they were to ask a SRHR-related question. They do not want others to assume they are sexually active or suffering from a STI. They exhibit caution and selectivity in choosing whom to confide in regarding their SRHR questions and concerns. The quotes in *Figure 5* demonstrate how this stigmatization suppresses open and honest dialogue.

Figure 5

Quotes culture of silence

The stigma surrounding SRHR creates an environment where individuals feel hesitant to seek information or openly discuss their experiences. This culture of silence perpetuates numerous negative consequences, deepening the challenges faced in this domain. One of the key

consequences of the stigma is the lack of SRHR knowledge and awareness among young individuals. Due to prevailing silence and limited opportunities for open dialogue, many youths remain uninformed about important aspects of their sexual and reproductive health. This knowledge gap leaves them ill-equipped to make informed decisions regarding, for example, contraception, family planning, and sexually transmitted infections (STIs). Moreover, the spread of misinformation is growing in the absence of open and accurate discussions on SRHR. When individuals are unable to access reliable and trustworthy sources of information, they may turn to unreliable or false sources, leading to misunderstanding of SRHR issues. Misinformation can perpetuate harmful beliefs and practices, further deepening existing challenges.

The presence of stigma appeared to be closely linked to the scarcity of availability and accessibility of SRHR-related services. The following quoted statement sheds light on this issue, as the individual expressed their perception that accessing SRHR information is primarily limited to hospitals:

> We are not able to access enough information on SRHR for sure, I can bet on that, like, for me speaking on behalf of other people. You see, we aren't educated by anyone, and if we are its once in a year and its by people who assume they know everything. That's the biggest challenge we have as youths. There aren't enough SRHR services available. If I want information on SRHR services I would definitely go to a hospital. That's the only place I can go, nowhere else.

This lack of diverse and accessible services imposes limitations on individuals' choices. It creates barriers for those who may feel uncomfortable or unable to seek assistance from healthcare facilities. One participant mentioned that due to the lack of hospitals in Kibera, individuals often have to travel to the urban center of Nairobi to access necessary healthcare facilities. Additionally, hospitals are frequently overwhelmed, as mentioned by one participant who stated: ''Yeah, hospitals are there, but sometimes we find that they are quite busy so you can't find the information you need.'' Consequently, individuals may face significant barriers in obtaining necessary information, support, and care related to their sexual and reproductive health.

However, it is important to note that while SRHR stigma poses certain challenges, some participants highlighted the presence of available services and initiatives in Kibera. They pointed out various resources and programs that have been established to address SRHR issues and provide support. For instance, several participants mentioned the widespread efforts of NGOs in installing condom dispensers at various locations, ensuring convenient access to free male condoms. Additionally, government-funded hospitals exist where individuals can receive free HIV tests and access family planning methods. One example comes from a 21-year-old boy who went for an HIV-test accompanied by his father:

> It was my first time taking the HIV-test. I was going to test with my father. For the first time I became scared. I was afraid if it would be positive or negative, but with the courage of my father… He told me that any result is a result.

Furthermore, research participants acknowledged the efforts of organizations that have set up programs to raise SRHR awareness and offer guidance. These organizations play a great role in providing information, support and education to youth.

Challenging the stigma

To foster a more inclusive and informed community in Kibera, it is crucial to challenge the stigma surrounding SRHR. Interestingly, despite the prevailing stigma, most participants expressed a strong desire to challenge and break down these barriers. They recognized the harmful effects that the stigma brings, and they acknowledged the need for greater awareness, knowledge and open dialogue on SRHR matters. Moreover, participants expressed a strong desire to be more informed about SRHR for their personal well-being. They recognized the significance of acquiring accurate knowledge and understanding to make informed and autonomous decisions regarding their sexual and reproductive health.

The constraints imposed by stigma and misinformation often hinder their ability to make informed choices. The following quotes reflect their pursuit of greater knowledge and awareness to assert control over their own sexual and reproductive health. One participant emphasized the importance of knowledge as a guide in navigating issues related to sex, stating, ‘‘If you get to know more on SRHR you got to know ways of guiding yourself especially when it comes to issues concerning sex.’’ Another participant highlighted the transformative power of knowledge, stating, ‘‘Knowledge is power and it becomes a game

changer in empowering young people in the long run.'' Furthermore, a participant questioned the reasons for societal shame and fear surrounding sexuality. They shared:

> I feel like SRHR should be more open, I feel very comfortable talking about it, I mean, why would you be ashamed of sexuality? Why do people feel afraid talking about such? I feel like we were told that we should not be talking, so let's continue with all that, just the traditional pattern… It's scary.

In their pursuit to challenge the stigma, participants put forth valuable suggestions for programs and interventions that could effectively address this issue. One common theme that emerged was the importance of including men in SRHR programs. Currently, awareness programs in SSA predominantly focus on women, as supported by Varga's (2001) study highlighting the need to involve boys and young men in efforts to improve SRHR outcomes in SSA. Varga emphasized the importance of recognizing male SRHR not only as an independent area but also as a means to enhance women's well-being. Engaging men actively is essential for the prevention of HIV and other sexual transmitted diseases (STD's), and efforts should be made to engage men as active contributors to the solution rather than perceiving them solely as part of the problem (ibid.).

Participants in this study conducted in Kibera also expressed concerns about the exclusion of men in in initiatives related to SRHR. Both female and male participants emphasized a strong desire to have men actively engaged in programs. For instance, one participant highlighted the assumption that boys are already knowledgeable while girls require education, stating, ''The problem is that they assume that boys know everything and that the girl is the one who is supposed to be educated. I think the boys should be educated as well.'' This participant's perspective underscores the need for equal educational opportunities for both genders. Another participant pointed out the disproportionate focus on supporting women, stating, ''I think young men suffer most, because everyone is just supporting women. Whenever an organization comes up, you will find that they involve women mostly.'' This comment reflects the participant's desire for more inclusive programs that address specific needs of men as well. Furthermore, another participant expressed frustration about the limited access to knowledge and resources for men, stating:

> I feel like men are being left behind. It should be changed, because, you can just go to a facility and find an awareness program which is filled by only women. If you go there as a man, you want to get the knowledge about what is being discussed, but they say it's a women-affair only… But we need be taught basically everything too, from pregnancy, abortion, child abduction… We need the knowledge so that we know how to go about it when an incident that demands attention comes up.

Moreover, participants recognized that addressing the stigma surrounding SRHR requires a comprehensive approach that takes into account the interconnected nature of these issues with other challenges such as substance abuse, mental health issues, and GBV. In order to fully address these complex issues, a multifaceted life-skills program that encompasses various challenges will be necessary to ensure meaningful progress and empowerment. However, it is important to acknowledge that while such a comprehensive life-skills program can be effective in addressing certain aspects of these interconnected issues, not all challenges can be fully tackled through a program alone. As one participant highlighted, additional measures such as opening rehabilitation centers for addressing substance abuse are necessary to provide the comprehensive support needed for individuals facing these unique challenges. This underscores the need for a holistic approach that combines multiple interventions, including programs, services, and facilities to address the complex nature of the issues at hand.

During the study, participants were asked to identify key stakeholders who should take an active role in making SRHR services and information more accessible and acceptable for youth in Kibera. Views on this varied among the participants, but the government and parents, guardians, or family members were most frequently mentioned as having the greatest responsibility. However, participants also acknowledged the challenges faced by parents, guardians, or family members in fulfilling this responsibility, primarily due to their extensive work commitments. One participant expressed this, stating: ‘‘You know, parents don't spend their time with their children. They just work. They work a lot, so they don't have time for their children. I don't blame them, because they are working hard for me.’’ The quote highlights the participant's understanding towards their parent's demanding work schedules, recognizing the sacrifices made to support their families. It also shed light on the practical difficulties parents face in actively engaging in SRHR discussions and support for their children.

Moving to the other often-mentioned stakeholder, the Kenyan government, it is important to acknowledge the uncertainty surrounding government investment in SRHR programs due to the lack of official recognition of Kibera by the Kenyan government (Majale, 2008; Mutisya & Yarine, 2011). However, participants in this study identified other stakeholders as well, including organizations (NGOs), young people themselves, hospitals, schools, and community leaders. Some participants expressed the belief that a collective effort is needed, as captured by the following quote: ‘‘I can’t point out one. I think everybody should be involved, from schools, hospitals, organizations, NGOs, the government: everybody. Even the internet should be made more affordable so that people can easily access it.’’ This response highlights the importance of engagement from various sectors, including educational institutions, healthcare providers, community leaders, NGOs, the government, and individuals themselves.

Considering these perspectives, it is evident that a multifaceted effort involving multiple stakeholders is crucial to promote comprehensive SRHR services and support in Kibera. Such a collaborative approach is essential to overcome barriers and foster an inclusive and informed community. It ensures that diverse perspectives are taken into account and that the specific needs of different groups are adequately addressed.

Conclusion and Discussion

This qualitative study conducted in Kibera, Nairobi, aimed to explore the experiences and perceptions of SRHR among youth living in the urban slum. Guided by the conceptual framework for adolescent SRHR promotion developed by the Pan American Health Organization (PAHO, 1998, as cited in Meherali et al., 2021, *Figure 1*), this study identified the challenges and gaps in knowledge and access to SRHR faced by youth in this community. Qualitative methods, including questionnaires and semi-structured interviews, were used. The findings shed light on the complex factors influencing SRHR outcomes and provide valuable insights for designing intervention programs. This section discusses the main findings and shortcomings of the study.

The PAHO framework, which encompasses individual, sociocultural, and environmental factors, served as a robust guide throughout this study. It structured the analysis and provided a comprehensive lens through which to understand the multidimensional nature of SRHR experiences and needs among youth in Kibera. The

framework allowed for exploring the interconnectedness of various factors and their impact on SRHR outcomes.

In line with the framework's individual factors, this study revealed that personal characteristics and behaviors, such as knowledge, attitudes, and beliefs, significantly influenced the youth's SRHR experiences. Participants consistently expressed fear and hesitancy to openly discuss SRHR-related topics due to the fear of judgement, criticism, or rejection. Negative attitudes towards utilizing SRHR-related services were prevalent among the participants, often driven by societal stigma and misinformation. This underscores the importance of addressing individual-level factors through comprehensive sexuality education (CSE) that dismantle myths, challenges misconceptions, and promote evidence-based information. By equipping these youths with accurate knowledge and promoting open dialogue, CSE can effectively challenge barriers posed by fear, hesitation, and societal biases, empowering them to make informed decisions regarding their sexual and reproductive health.

Sociocultural factors, as outlined in the PAHO framework, played a crucial role in shaping SRHR experiences among young individuals in Kibera. The normalization of gender-based violence (GBV) and the lack of social support systems contributed to the continuation of high prevalence of GBV and negative attitudes towards the utilization of SRHR-related services. The study shed light on the prevalent issue of GBV, as participants shared their experiences of childhood domestic abuse, exposure to substance abuse, and witnessing violence, which resulted in enduring trauma. Furthermore, cultural and religious norms and values influenced the promotion of an abstinence focused approaches to sex education, limiting access to essential SRHR services and information. The participants highlighted how educational institutions and parents frequently emphasized abstinence as the safest choice, keeping alive myths and misconceptions and spreading misinformation regarding SRHR-related services and knowledge. Consequently, an adverse attitude towards the utilization of SRHR-related services, including family planning methods, abortion, and condom use, became prevalent. The study revealed that both deliberately and unintentionally misinformation is employed to discourage young individuals from engaging in sexual activity and seeking SRHR-related services. These findings affirm the pressing need to challenge harmful cultural norms and advocate for CSE in Kibera.

Environmental factors, a third dimension of the PAHO framework, significantly impacted SRHR outcomes as well. Limited access to health services and education, economic barriers, and political challenges hindered young people's ability to make informed choices

and access to necessary SRHR services. By employing the PAHO framework as a guide, this study deepens the understanding of the complex challenges faced by young people growing up in Kibera regarding their SRHR and the need for comprehensive sexuality education (CSE) to address these issues effectively.

The participants in this study demonstrated a strong motivation and willingness to challenge the SRHR stigma in Kibera and learn more about the topic. Their perspectives underscore the importance of a multifaceted effort that engages various sectors, including educational institutions, healthcare providers, community leaders, NGOs, the government, and individuals themselves. These insights provide valuable guidance for the design of programs aimed at addressing the SRHR challenges in Kibera. Moreover, participants emphasized the need to involve men in these programs, recognizing that achieving comprehensive SRHR outcomes necessitates the active engagement of both men and women. By fostering a culture of open dialogue and understanding, the society can be transformed to effectively support and empower young individuals in making informed SRHR choices. This transformation requires breaking down the barriers of stigma and discrimination that currently hinder access to comprehensive SRHR services and information. In conclusion, this study has provided valuable insights into the experiences and perceptions of SRHR among youth living in the urban slum, emphasizing the need for CSE and the involvement of various stakeholders to address the multifaceted challenges they face.

Addressing research gaps

A scoping review conducted by Wado et al. (2020) mapped the available studies on adolescent SRHR in slums within SSA. The review encompasses a thorough analysis of a total of 54 studies published between January 2000 and May 2019. The studies predominantly focused on sexual behavior and HIV/AIDS, with limited attention given to other SRHR issues such as GBV, abortion, contraception, and STIs other than HIV. Furthermore, most of the conducted studies relied on observational and quantitative methodologies, which hindered the ability to establish causal relationships. The absence of qualitative studies further constrained a comprehensive understanding of individual's experiences and specific needs, leaving a critical gap in the existing literature. In an attempt to address these research gaps, this qualitative study conducted in Kibera explores the unique challenges and needs of young individuals residing in slum communities. By utilizing qualitative methods that prioritize participants' voices and explore the influence of contextual factors, this study seeks to provide a deeper understanding of adolescent SRHR. Taking a broader perspective than previous

studies primarily focused on prevalence numbers of HIV/AIDS, this research takes a comprehensive approach by examining various facets, such as individuals' experiences, perceptions, and the pervasive stigma surrounding HIV/AIDS, for example.

In the review conducted by Wado et al. (2020), eight interventions were identified with the aim of improving adolescent SRHR outcomes in slums in SSA. Half of these interventions focused exclusively on girls and young women. This serves to confirm the results of this study, as numerous research participants highlighted the narrow focus on women's empowerment as a prevalent issue. In light of this, this study conducted in Kibera emphasized the significance of involving boys and men in the design and implementation of SRHR programs. By doing so, we can ensure that their voices, experiences, and needs are equally prioritized, leading to a more comprehensive understanding of adolescent SRHR. This study seeks to contribute to a more holistic approach to improving SRHR outcomes in SSA. It highlights the necessity of recognizing the diverse perspectives and experiences of all adolescents in order to develop effective interventions that address the multifaceted challenges they face in relation to their SRHR and ultimately foster positive outcomes for all individuals.

Moving ahead, the insights gained from this study can guide the development of interventions and programs that address the specific SRHR needs of youth in Kibera. It is crucial to consider the interconnected nature of social challenges and incorporate a comprehensive approach that tackles the underlying factors contributing to inadequate SRHR outcomes. By prioritizing the voices of young individuals, this study highlights existing knowledge and access gaps, including limited awareness about SRHR, insufficient access to comprehensive sexuality education, contraceptives, and healthcare services. These gaps provide valuable insights to empower young individuals in their pursuit of SRHR, enabling them to make informed decisions and take control of their sexual and reproductive well-being.

Limitations and recommendations

However, it is important to acknowledge and address the limitations of this study. While considering the viewpoints of the research participants and adopting inclusive approaches involving various stakeholders to tackle SRHR challenges in Kibera, it is essential to recognize the inherent difficulties that may arise. The findings of this study highlight the practical difficulties faced by parents, guardians, and family members in fulfilling their role in sexual education of youth, primarily due to demanding work commitments. Also, when

considering the involvement of the Kenyan government as another key stakeholder, it is crucial to acknowledge the uncertainty surrounding government investment in SRHR programs within Kibera due to the lack of official recognition of Kibera by the Kenyan government. These challenges on both the individual and systemic level emphasize the complexity of implementing initiatives to address SRHR in Kibera. Despite these challenges, it remains crucial to persist in advocating for comprehensive SRHR programs, working towards overcoming barriers, fostering awareness, and ensuring access to essential SRHR-related services and information for youth in the Kibera community.

Furthermore, given the qualitative nature of this study, it is important to note that the findings are specific to the context of Kibera and may not be directly applicable to other settings. The limited sample size utilized in this study also restricts the generalizability of the findings. To obtain a more representative understanding of the challenges faced by youth in Kibera regarding their SRHR, it is recommended to conduct studies with larger sample sizes and to incorporate comparative studies that explore contextual factors. Additionally, the three-months duration of this research may have been insufficient to fully emerge myself in the context and gain a comprehensive understanding of the cultural factors at play. As a newcomer to the community, my familiarity with the nuances and complexities of Kibera's dynamics may have been limited. Addressing these research gaps will contribute to a deeper understanding of SRHR among youth in Kibera and enable the development of effective, evidence-based programs that meet their SRHR needs.

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Acknowledgements

I would like to express my appreciation to all those who have contributed to the completion of this study. Your participation, support, and guidance have played a crucial role throughout my research journey.

First and foremost, I would like to thank the youth who generously shared their experiences, time, and insights. Without their willingness to participate, this study would not have been possible. Their perspectives shed light on the challenges and needs of youth in Kibera, contributing to a better understanding of SRHR in this community. I would also like to thank my supervisors, Semiha and Jennifer, for their guidance and insightful feedback that have shaped this thesis. I am grateful for Uweza Foundation for granting me access to their programs and letting me connect with the young individuals they work with. I would like to thank all the staff members who assisted in the selection of participants and facilitated a smooth running of the data-collection. Their assistance was essential to the completion of this study. Finally, a special thank you to Maxwell for the positive energy he provided during our time in the office.